2018 State of Michigan Employee

Insurance

Open Enrollment

August 1st, 2018–August 24th, 2018
### Contents

**IOE Information**

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Photo Credits: MDOT Photography
August
8/1/18–Insurance Open Enrollment begins
8/24/18–Insurance Open Enrollment ends

September
9/30/18–Deadline to submit documentation for newly-added individuals

October*
10/7/18–2018 plan year begins; new rates and elections take effect
10/18/18–First earnings statement with 2018 rates and elections

How to Enroll in Benefits During IOE

Online:
Visit the HR Gateway page at www.mi.gov/selfserv and log-in to HR Self-Service. Select “Benefits” from the left-hand menu, then select “Enroll/Change Benefits.” From that menu, you can choose to start the process of adding new dependents to your benefits or begin the enrollment process!

Over the Phone:
Need help from an HR professional who is trained to help guide you through Insurance Open Enrollment? Call the MI HR Service Center, Monday through Friday, 8:00 a.m. to 5:00 p.m., at 877-766-6447.

Should I Participate?

- "I want to make changes to my current benefit elections."
- "I want to add or change someone’s coverage on my health, dental, vision, or life insurance."
- "I want to enroll in disability insurance."
- "I want to review my current coverage."
- "I want to update the beneficiaries for my life insurance online."

If any of these statements sound like you, then you should participate in IOE this year!

Visit the HR Gateway page at www.mi.gov/selfserv to log-in to HR Self-Service and enroll online or contact the MI HR Service Center at 877-766-6447.

Insurance Open Enrollment is your annual opportunity to review and change your benefit elections (health, dental, vision, life, and disability insurance). You are strongly encouraged to do so to ensure you and your covered eligible dependents have the necessary coverage for the coming year.

If you do not make any changes, your coverage and covered individuals will remain the same.
What’s New for IOE 2018

IOE only comes once a year, so it’s important to stay on top of the news. Luckily, you can find all the updates here and on the 2018 IOE Plan Changes web page.

2018 brings a new carrier for the State Vision Plan, a new HMO option, and while it’s not a change, the Employee Benefits Division (EBD) is encouraging all employees to update their beneficiaries for life insurance online in HR Self-Service. Learn more below!

New Vision Insurance Carrier: EyeMed

Effective October 1, 2018, EyeMed will be replacing Blue Cross Blue Shield of Michigan/VSP as the administrator of the State Vision Plan. For existing enrollees in the current State Vision Plan, BCBSM/VSP coverage will end on September 30, 2018. Current enrollees in the State Vision Plan under BCBSM/VSP will be automatically transitioned to EyeMed on October 1, 2018 and there will be no gap in coverage. Benefit coverage will not be changing. EyeMed will send member cards to enrollees in September. To view In-Network Providers within your area, use EyeMed’s Provider Locator Tool.

New HMO Health Insurance Option: United Healthcare

United Healthcare will be offered as a Health Maintenance Organization (HMO) option for the first time in the 2018-2019 plan year. Like all other HMOs, eligibility for enrollment in this plan is based on your residential zip code. Whether considering United Healthcare or any other State of Michigan HMO health plan option, employees are encouraged to use the EBD web site’s HMO/DMO Zip Code Tool. This tool will allow you to determine your eligibility for all HMO plans, dictated by their coverage area. To learn more about the plan design for United Healthcare, contact information, and rates, visit the Insurance Plans web page. All previous HMO options remain available.

Update Your Beneficiaries Online

Did you know you can designate your life insurance beneficiaries online? While you may have filled out a hard-copy form when you were hired, designating your beneficiaries online in HR Self-Service can expedite and simplify the payout process of your employee life insurance policy. Log-in to HR Self-Service through the HR Gateway at www.mi.gov/selfserv and get up-to-date!
Other Eligible Adult Individuals (OEAI)

Enrolling an OEAI and an OEAI’s Dependent Children

If you wish to enroll an OEAI in your health insurance, you may enroll via HR Self-Service (www.mi.gov/selfserv) or by calling the MI HR Service Center. After enrollment you must submit the following documents to the MI HR Service Center by September 30, 2018 to complete OEAI enrollment or the added dependent(s) will be removed from coverage:

- Enrollment Application and Affidavit (CS-1833)
- Copy of age verification that the OEAI is 18 or older:
  - birth certificate,
  - passport,
  - driver’s license, or
  - other governmental document indicating date of birth
- Documents establishing joint residence for the past 12 months (e.g., bank statement, utility bills, etc.). In addition, required documentation must be submitted to maintain enrollment of an OEAI’s dependent.

Tax Implications

In accordance with IRS regulations, State of Michigan employees are responsible for paying taxes associated with the fair-market value of enrolling an OEAI and the OEAI's dependents. Additional information on OEAI tax implications is available on the Employee Benefits Division web site at www.mi.gov/IOE.

Termination of Benefits

OEAI and OEAI dependent coverage will not take effect if documentation is not received by the MI HR Service Center by September 30, 2018.

Note: When criteria for enrollment are no longer met, you must notify the MI HR Service Center within 14 calendar days. Coverage will end effective the date OEAI eligibility criteria are no longer met.

Documentation Deadline

All Insurance Open Enrollment documentation must be received by the MI HR Service Center by September 30, 2018

OEAI Bargaining Group Eligibility

OEAs are eligible to be added to benefit plans for all represented and non-represented (NERE) bargaining groups except: MSPTA, Judicial, and Legislative.
Eligible Dependents

Eligible dependents may be enrolled in your health, dental, and vision plans. (OEAI and their dependents may only be enrolled in health plans.) Dependents include your spouse and any of your unmarried children until the day before their 19th birthday. In addition to being unmarried, your eligible children must be one of the following:

- Child by birth, legal adoption, or legal guardianship. For legal adoption, a child is eligible for coverage from the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child.

- Step-child that lives with you at least 50% of the time and for whom your spouse provides at least 50% of their support is eligible to receive health, dental, and vision coverage. All step-children are eligible for health coverage regardless of residence and support.

- Foster child placed in your home by a state agency or the court.

Note: State-employed married or divorced employees carrying independent enrollments may cover their children in either parent's plan, as long as each child is only covered once. If employees cannot agree which parent will cover the children, the parent who has covered the children first during their employment with the State of Michigan will cover the dependent children.

Note: For a grandchild to be eligible, the parent of the grandchild must be a covered dependent AND, if the parent of the grandchild is between the ages 19 up to their 25th birthday, a student as well.

Student Eligibility

To enroll or continue enrollment in dental and vision plans (health coverage continues automatically until the end of the month in which the dependent turns 26), a dependent must be your child by birth, legal adoption, or a step-child from the age of 19 up to their 25th birthday meeting the following criteria:

- Enrolled and regularly attending an accredited educational institution (may have a lapse in attendance for only one term or semester per calendar year to be considered regularly attending); AND
- You provide at least 50% of their support; AND
- Unmarried.

Adult Children (Health Only)

Eligible children from the age of 19 up to their 26th birthday may be enrolled in your health coverage regardless of marital status, student status, or dependency upon you for support. Coverage does not extend to dental or vision plans or to their spouse or children.

To be eligible for health coverage, a dependent must be a child by birth or legal adoption, a step-child, or a dependent of an Other Eligible Adult Individual (OEAI). Coverage will terminate at the end of the month in which the dependent turns 26.
Dependent Life Insurance

Eligible dependents can include your spouse and unmarried children from the age of 14 days up to their 23rd birthday for whom you provide at least 50% of their support. These dependents are not required to be enrolled in school. Your spouse is also eligible if they are not a state employee or state retiree.

As a state employee or retiree, you are automatically enrolled in life insurance. If this coverage is maintained, you are not eligible to be covered as a spouse or dependent on another employee or retiree dependent life insurance plan.

Eligibility Exclusions

If you and your retiree or active spouse are both covered by state group insurance plans, you may maintain separate coverage through your individual plans or enroll in one plan with one of you listed as a dependent. If you choose to maintain separate coverage, your children can only be listed as a dependent on one plan. This applies even if you are divorced.

An employee’s spouse, OEAI, and dependents are not eligible for coverage if he or she is in the armed forces. Individuals who are called to active military duty are eligible for coverage under TRICARE, effective the date of active duty orders.

Continuing Coverage for Incapacitated Children

Your child who is unmarried and unable to sustain employment because of a developmental or physical disability can continue enrollment in health, dental, vision, and dependent life insurance beyond normal age limits if all the following conditions establishing incapacitated status are met:

- Your child became incapacitated before reaching the age limit for the coverage (19 for dental and vision, 23 for dependent life, and the end of the month of turning 26 for health).
- You have submitted documentation verifying your child’s incapacity within 31 days after the child reaches the age limit for termination of the coverage.
- Your child continues to be incapacitated and chiefly dependent on you for support and maintenance.
- Your coverage does not terminate for any other reason.

Providing documentation before an incapacitated child turns 19 is recommended to ensure continuing eligibility for all plans.

Canceling Coverage

Immediately notify the MI HR Service Center to cancel your dependent’s coverage when he or she no longer meets the definition of an eligible individual. Ex-spouses are not eligible and must be removed from coverage effective the date of the divorce.
Required Documentation—Part 1 of 2

The documents listed in this section are acceptable proof of dependent, adult child, and OEAI eligibility for insurance coverage. Documents must be provided to the MI HR Service Center by fax or mail. Contact information is provided at the end of this section. Legible copies are required for each type of document. Please do not provide originals; documents will not be returned. Copies of documentation must be faxed or mailed to the MI HR Service Center by September 30, 2018 or the added dependent(s) will be removed from coverage.

Life Events

To add or change eligible dependents due to a life event (such as marriage, birth, divorce, etc.), call the MI HR Service Center as soon as possible, but no later than 31 days following the life event. Do not wait until you have the official documentation to contact the MI HR Service Center.

Required Documents for Health, Dental, and Vision Coverage

- **Adopted Child**
  - *Adoption Papers* or sworn statement with the date of placement

- **Biological Child**
  - *Birth Certificate* (hospital verifications are not accepted)

- **Foster Child**
  - *Court Document* placing the child in the employee’s home for foster care

- **Grandchild**
  - *Birth Certificate* (hospital verifications are not accepted)
  - **Note:** For a grandchild to be eligible, the grandchild’s parent must be a covered dependent AND, from 19 up to their 25th birthday, a student as well

- **Incapacitated Child**
  - *Birth Certificate* (hospital verifications are not accepted)
  - *Verification Documentation* that the child’s condition was confirmed by the insurance carrier before the child reached the usual age limit for coverage

- **Legal Guardianship**
  - *Court-Ordered Letters of Guardianship*

- **Loss of Coverage**
  - *Document Detailing Loss of Coverage* from employer or insurance carrier specifying the benefits for which coverage has been lost (e.g., health, vision, dental) and individuals covered

- **Spouse**
  - *Marriage Certificate*

“Required Documents for Health, Dental, and Vision Coverage” continued on next page…
Required Documents—Part 2 of 2

Required Documents for Health, Dental, and Vision Coverage—Continued

- Step-Child
  - Birth Certificate (hospital verifications are not accepted)
  - Marriage Certificate
  - Legal Document Specifying Physical Custody (e.g., divorce decree stamped by court that identifies custody agreement) OR Verification of Step-Child Eligibility Form (CS-1847)
  - Note: A step-child for which an employee's spouse is required to provide at least 50% support, and who resides with you at least 50% of the time is eligible for health, dental, and vision coverage. An employee’s step-child is eligible for health coverage regardless of residence and support. Coverage will terminate at the end of the month in which the dependent turns 26. Once a step-child reaches the age of 19 until their 25th birthday, refer to the appropriate student section for requirements.

- Student (Age 19 to 25)
  - Student Verification of Eligibility (CS-1830) and school records proving attendance
  - Birth Certificate (hospital verifications are not accepted)

Required Documents for Health-Only Coverage

- Adult Child (Age 19 to 26)
  - Birth Certificate (hospital verifications are not accepted)

- OEAI (Other Eligible Adult Individual)
  - OEAI Enrollment Application & Affidavit (CS-1833)
  - Joint Residency Documentation establishing shared residency for the past 12 months (e.g., bank statement, utility bill, lease agreement, etc.
  - Proof of Age (birth certificate, passport, driver’s license, or other governmental document)

- OEAI Dependent
  - OEAI Enrollment Application & Affidavit (CS-1833)

And any of the four documents below establishing the relationship between the OEAI and the OEAI dependents you wish to enroll:

- Birth Certificate (hospital verifications are not accepted)
- Adoption Papers or sworn statement with the date of placement
- Court Document placing the child in the employee’s home for foster care
- Court-Ordered Letters of Guardianship

- Note: Dependent children of an OEAI may enroll in health insurance only up to their 26th birthday with a CS-1833 and the same required documentation that applies to equivalent dependent children of employees. Coverage will terminate at the end of the month in which the dependent turns 26.
MI HR Contact Information

MI HR Service Center Contact Information

Phone: 877-766-6447
Fax: 517-241-5892

Mailing Address:
MI HR Service Center
P.O. Box 30002
Lansing, MI 48909

Note: Legislative, Judicial, and Auditor General must submit required documentation to their respective Human Resource Office by September 30, 2018.

IOE Reminder!
Copies of documentation must be faxed or mailed to the MI HR Service Center by September 30, 2018.
Frequently Asked Questions

Q: How does a deductible work?
A: A deductible is the amount you must pay for some covered health care services before your insurance plan begins to pay. The deductible does not apply to all services. Services such as in-network office visits, consultations, and urgent care visits only require a copay at the time of service, and preventive services do not require any copay or deductible. Refer to individual plan summaries at www.mi.gov/EmployeeBenefits for a list of covered services after the deductible.

Your deductible amount will vary based on whether you are enrolled in an HMO or the State Health Plan PPO (SHP PPO), as well as how many people are covered by your plan and how many of them seek services. The individual deductible applies to any one family member. The family deductible ($800 for the SHP PPO and $250 for an HMO) is the combined amount that could be paid by any combination of family members, as long as one individual has reached the individual deductible.

Deductible amounts for the SHP PPO are effective January 1st, and renew annually on a calendar-year basis. Deductible amounts for the HMOs are effective October 7, 2018, and renew annually each October with the start of the new plan year. All deductibles count toward the out-of-pocket maximum. Not all services require co-insurance, as they are covered at 100% by your insurance plan; check individual plan summaries for details and coverage amounts.

Q. What’s an out-of-pocket maximum and how does it work?
A: The annual out-of-pocket maximum (OOPM) is the limit to the total dollar amount you could be required to pay for covered services during the plan year. In-network deductibles, fixed dollar copays, prescription drug copays, and co-insurance all apply towards this annual out-of-pocket limit. Once this maximum amount is reached you will not pay any additional co-insurance, deductibles, or copays for covered services for the remainder of the plan year. The individual OOPM ($2,000) applies to any one family member, and the family OOPM ($4,000) is the combined amount that could be paid by any combination of family members. The OOPM is the same for the PPO and all HMOs.

The OOPM does not include:
- Bi-weekly premiums
- Charges above the allowed amount the plan pays for a benefit
- Charges for non-covered services or treatments
- Charges for out-of-network services or treatments

Q: How does co-insurance work?
A: For in-network services under the SHP PPO, co-insurance is your share of the costs of a covered health care service, calculated as a percent, after your annual deductible is met. For example, if you have met your annual deductible and then have surgery, the insurance plan will pay 90% of the allowed amount for the surgery, and you will pay the 10% co-insurance. All co-insurance charges apply toward the annual out-of-pocket maximum, which limits the amount you can be required to pay for services during a plan year to $2000 for an individual and $4000 for a family.
Understanding State Health Plan PPO Costs

Example of Deductibles, Co-Insurance, and Out-of-Pocket Max
(All examples are in-network services.)

**Example 1: Total Cost of an X-Ray**
A State employee and her family are enrolled in the State Health Plan PPO. When the plan year started in October, the employee received an X-ray. According to the plan, this is an after-deductible service with a co-insurance of 10%. What would she pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$400 - Annual Individual Deductible + 10% Co-Insurance</td>
<td>90% of the remaining cost after the annual individual deductible is met.</td>
</tr>
</tbody>
</table>

**Note:** If an employee’s spouse or dependent never receive deductible-applicable services during the plan year, only the individual deductible of $400 would need to be met. The same is true if a dependent or spouse seeks deductible-applicable services and the employee does not; only the individual deductible would apply.

**Example 2: Total Cost of a Surgery**
The same State employee’s spouse needed surgery shortly after. According to the plan, surgery (in-network) is an after-deductible service with a co-insurance of 10%. What would they pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$800 - Annual Family Deductible + 10% Co-Insurance</td>
<td>90% of the remaining cost after the annual individual deductible is met.</td>
</tr>
</tbody>
</table>

**Note:** If a spouse (or dependent) was the only individual to receive deductible-applicable services during the plan year, only the annual individual deductible of $400 would need to be met. In this case, since both the employee and spouse received deductible-applicable services, the entire $800 family deductible would need to be met before the plan paid for the spouse’s surgery.

**Example 3: Total Cost of a Surgery**
During the plan year, the same State employee has paid the $2,000 out-of-pocket annual maximum for her individual deductibles, co-insurance, and prescription copays and now needs a surgery. What would she pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>100% The plan will pay the total approved amount for this surgery as she paid the annual maximum amount for out-of-pocket expenses for the plan year.</td>
</tr>
</tbody>
</table>
How Do HMO Costs Work?

Example of Deductibles and Out-of-Pocket Max
(All examples are in-network services. HMOs do not carry co-insurance.)

Example 1: Total Cost of an X-Ray
A State employee and her family are enrolled in an HMO. When the plan year started in October, the employee received an X-ray (in-network). According to the plan, this is an after-deductible service. What would she pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$125</td>
<td>100% of the remaining cost after the annual individual deductible is met.</td>
</tr>
</tbody>
</table>

**Note:** If the employee’s spouse or dependents never receive deductible-applicable services during the plan year, only the individual deductible of $125 would need to be met. The same is true if a dependent or spouse seeks deductible-applicable services and the employee does not; only the individual annual deductible would apply.

Example 2: Total Cost of a Surgery
The same State employee’s spouse needed surgery shortly after. According to the plan, surgery (in-network) is an after-deductible service. What would they pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250</td>
<td>100% of the remaining cost after the annual family deductible is met.</td>
</tr>
</tbody>
</table>

**Note:** If a spouse (or dependent) was the only individual to receive deductible-applicable services during the plan year, only the annual individual deductible of $125 would need to be met. In this case, as both the employee and spouse received deductible-applicable services, the entire $250 annual family deductible would need to be met before the plan paid for services.

Example 3: Total Cost of a Surgery
During the plan year, the same State employee has paid the $2,000 out-of-pocket annual maximum for her individual deductibles and prescription copays and now needs a surgery. What would she pay for this service?

<table>
<thead>
<tr>
<th>Employee Cost</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>100% The plan will pay the total approved amount for this surgery as she paid the annual maximum amount for out-of-pocket expenses for the plan year.</td>
</tr>
</tbody>
</table>
Insurance Carrier Information—Part 1 of 2

State Health Plan PPO—Blue Cross Blue Shield of Michigan (BCBSM) &

State Catastrophic Health Plan—Blue Cross Blue Shield of Michigan (BCBSM)

BCBSM State of Michigan Service Center
Phone: 800-843-4876
Web site: www.bcbsm.com/som

HMOs—Health Maintenance Organizations

Blue Care Network
Phone: 800-662-6667
Web site: www.bcbsm.com/som

Health Alliance Plan (HAP)
Phone: 800-422-4641
Web site: www.hap.org

McLaren Health Plan
Phone: 888-327-0671
Web site: www.mclarenhealthplan.org

Physicians Health Plan (PHP)
Phone: 800-832-9186 or 517-364-8500
Web site: www.phpmichigan.com

Priority Health
Phone: 800-446-5674
Web site: www.priority-health.com

United Healthcare
Phone: 844-554-5499 (Live 8/1/2018)
Web site: www.myuhc.com
# Insurance Carrier Information—Part 2 of 2

**State Health Plan PPO Prescription Drug Program**

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<tr>
<th>Plan Type</th>
<th>Carrier</th>
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<tbody>
<tr>
<td>OptumRx: Medicare-Eligible Retirees</td>
<td>OptumRx: Medicare-Eligible Retirees</td>
<td>866-635-5941</td>
<td><a href="http://www.optumrx.com">www.optumrx.com</a></td>
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**State Health Plan PPO Mental Health/Substance Abuse Services**

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Phone</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magellan Health of Michigan</td>
<td>866-503-3158</td>
<td><a href="http://www.magellanassist.com">www.magellanassist.com</a></td>
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**State Dental Plan and Preventive Dental Plan**

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<tr>
<th>Carrier</th>
<th>Phone</th>
<th>Web Site</th>
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</thead>
<tbody>
<tr>
<td>Delta Dental Plan of Michigan</td>
<td>800-524-0150</td>
<td><a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a></td>
</tr>
</tbody>
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**Dental Maintenance Organization (DMO)**

<table>
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<tr>
<th>Carrier</th>
<th>Phone</th>
<th>Web Site</th>
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</thead>
<tbody>
<tr>
<td>Midwestern Dental Plans, Inc.</td>
<td>800-544-6374</td>
<td><a href="http://www.midwesterndental.com">www.midwesterndental.com</a></td>
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</tbody>
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**State Vision Plan**

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**State Long Term Disability (LTD) Plan**

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Phone</th>
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<tbody>
<tr>
<td>York Risk Services Group</td>
<td>800-324-9901</td>
</tr>
</tbody>
</table>
HIPAA Exemption Notice

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The State of Michigan has elected to exempt the State of Michigan State Health Plan PPO from the following requirements:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan. The exemption from these federal requirements will continue to be in effect for the period of plan coverage beginning October 7, 2018, and ending October 5, 2019. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a pre-existing condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy. As required by state law (MCL 550.544), notice is provided that, as a rider under your health coverage, elective abortion is included and may be used by a covered dependent without notice to the employee.

Special Enrollment Rights

If you decline to enroll because you have other health coverage, and you or your dependent loses eligibility for the other coverage or the employer stops contributing towards the coverage, you may be able to enroll in this plan. However, you must request enrollment within 31 days after you or your dependent’s other coverage ends or after the employer stops contributing toward the other coverage.

Special enrollment is also available to (1) those who become eligible for premium assistance under Medicaid or the Children’s Health Insurance Program (CHIP) and (2) those who lose coverage under Medicaid or CHIP because they are no longer eligible, not because of non-payment. The deadline for these two enrollments is 60 days after eligibility or termination.

To request special enrollment or obtain more information, contact the MI HR Service Center.

For Questions about HIPAA Exemption:
Contact the Employee Benefits Division at: 800-505-5011

HIPAA Privacy Notice