Office of the State Employer

EMPLOYEE BENEFITS DIVISION
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RETIREE BENEFITS BULLETIN

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SUBJECT:

IMPORTANT INSURANCE INFORMATION

CHANGES IN YOUR HEALTH PLAN

For Retirees Enrolled in Blue Cross-Blue Shield or Aetna Who Are NOT on Medicare or Who Have a Dependent NOT on Medicare

AND

All HMO Enrollees

Advisories are issued from time to time to retirees and others to communicate benefits information.

In response to the rapidly rising cost of health care, you will see changes in the State Health Plan, HMOs, and the dental plan. These changes are designed both to improve quality and to keep insurance benefits affordable for plan members, as well as the State.

The State Employees' Retirees Association, the Office of Retirement Services, and the Office of the State Employer have worked together to develop informational seminars to explain the changes that will be occurring in the State Health Plan, HMOs, drug co-pays, and dental insurance.

An open enrollment period for all retirees will be held from now through November 30, 2002. Information will be mailed to you in the next few weeks—watch your mailbox for premium information and a seminar schedule. Meanwhile, the summary below will give you a preview of the coming changes in your health, prescription drug, and dental plans.

STATE HEALTH PLAN

Blue Cross Blue Shield Preferred Provider Organization (PPO)

Effective January 1, 2003, all non-Medicare enrollees in the State Health Plan will be enrolled in the State Health Plan PPO administered by Blue Cross Blue Shield of

Michigan (BCBSM). This means that if you are currently enrolled in the State Health Plan (whether BCBSM or Aetna), you will automatically be transferred to the PPO and will receive a new identification card. There will be no increase in your monthly premium as a result of this change to a PPO. If you or your spouse are on Medicare, all services will be considered in-network as described on the next page.

The PPO offers an extensive network of select health care providers and facilities in and outside of Michigan who agree to provide services at a lower cost in return for a greater, predictable volume of patients. In Michigan, approximately 90% of BCBSM providers are also in the PPO network. Providers must meet Blue Cross quality standards to be selected for the network, and Blue Cross regularly monitors their practices to make sure they continue to meet these standards. To find out if your doctor is a PPO network provider, we suggest you:

- Ask your doctor
- Call Blue Cross-Blue Shield of Michigan (see last page)
- Visit the Blue Cross-Blue Shield of Michigan website (see last page)

After you meet applicable deductibles, your cost will depend on whether there is a co-payment for the services you use. If you don't use network providers, you will have to pay more out of your pocket for covered care, **unless:** a) your network provider refers you to a non-network specialist; b) you receive emergency services at a non-network facility; or c) you are out of state and/or there are no network providers in your vicinity.

A PPO is *not* an HMO (health maintenance organization). Differences between a PPO and an HMO include the following:

- An HMO requires you to choose a primary care physician who coordinates and approves ALL services and refers you to other providers as needed. A PPO allows you to go to any network provider without a referral.
- HMOs require you to notify them when changing physicians. Under the PPO, there is no notification requirement.
- There is no deductible requirement under an HMO. A PPO requires a deductible, and the amount of the deductible depends on whether services were in-network or out-of-network.
- An HMO restricts coverage to services received in-network. A PPO provides choice but varies the member's out-of-pocket costs for services in-network and out-of-network.

The State Health Plan PPO will have the following coverage levels:

In-Network

- The deductibles will be lowered from $300 per person and $600 per family to $200 and $400 respectively.
- Deductibles will become comprehensive and apply to many of the services currently considered Basic Benefits, such as hospital stays, laboratory services, etc. Many of these services, however, will be paid at 100% after the deductible is met.
- The annual out-of-pocket maximum will be $1,000 per person and $2,000 per family. The current out-of-pocket maximum is $1,000 per person. The out-of-pocket maximum refers to the amount of co-pays you pay during a calendar year (but does not include the $10 office call fee).
- You will have a $10 co-pay for all office visits (not applicable towards your deductible).
- The preventive services described below will be covered at 100% up to a limit of $500 per calendar year per person. The 2003 $500 cap rises to $750 per year beginning January 1, 2004. These services are not subject to deductibles or co-pays:

  - ✓ Health screening
  - ✓ Annual gynecological exam
  - ✓ Pap smear (lab test)
  - ✓ Immunizations (including flu shot and Hepatitis C screening for those at risk)
  - ✓ Fecal occult blood screening
  - ✓ Sigmoidoscopy
  - ✓ Colonoscopy
  - ✓ Prostate Specific Antigen screening

- The Health Screening Unit (HSU) clinics will no longer be open. The health screening benefit that was previously provided in HSU clinics around the State will now be conducted in your doctor's office. Retirees and their covered dependents all over the United States will be able to take advantage of this benefit, not just retirees and spouses in Michigan. You will be able to make your own appointment with your doctor every 12 months.

Out-of-Network Services

- The deductibles are $500 per person and $1,000 per family. In-network deductibles cannot be used to satisfy out-of-network deductibles and vice versa.
- The annual out-of-pocket maximum is $2,000 per person and $4,000 per family.
- Office visits will be paid at 90% after the deductible is met.
- None of the preventive services described above are covered.

Please note that these provisions do not apply to persons eligible for Medicare. For example, if one spouse is on Medicare and the other is not, these provisions apply only to the spouse who is *not* on Medicare.

Drug Co-Pay Changes

- Drug costs are the single most influential factor in rising health care costs. As a result, the cost of retail and mail order drugs will increase from $5 for generic and $10 for brand name drugs to $7 for generic and $12 for brand name drugs. Effective January 1, 2004, the cost of brand name drugs will increase to $15, while generic drugs will stay at $7.

HMO BENEFIT DESIGN CHANGES

Effective October 1, 2002, benefit design changes will occur for all persons enrolled in an HMO. Without these changes, the premiums paid by enrollees for most HMOs would have increased dramatically. Even with the changes listed below, some of the HMO offerings will require premiums.

- The current drug co-pay of $2 will increase to $5 for generic drugs and $10 for brand name drugs for both mail order and retail prescriptions.
- A $10 co-pay will be required for doctor office visits and urgent care facility visits.
- A $50 emergency room co-pay will be required if you go to the emergency room at a hospital but are not admitted.

DENTAL PLAN CHANGES

Effective January 1, 2003, the annual general dental maximum for covered services will increase from $1,000 to $1,250. Effective January 1, 2004, the annual general dental maximum will increase to $1,500.

FOR MORE INFORMATION

Again, you will be receiving more details about these changes with your open enrollment materials along with a schedule of planned seminars throughout the state.

If you have questions now concerning the PPO, you can call Blue Cross-Blue Shield of Michigan at (800) 470-9633. You can also visit their website: www.bcbsm.com. Select "Members & Groups", then select "Physician Search", then select "Community Blue/Blue Preferred PPO".

Questions concerning the HMOs can be directed to:

Blue Care Network	(800) 662-6667	www.bcbsm.com/bcn
Health Alliance Plan	(800) 422-4641	www.hapcorp.org
HealthPlus	(800) 332-9161	www.healthplus.com
M-Care	(800) 658-8878	www.mcare.org
Priority Health	(800) 446-5674	www.priority-health.com