



**2024 State of Michigan Employee
Benefits Open Enrollment
October 16, 2023 – November 6, 2023**



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BOE Dates to Know

Benefits Open Enrollment Period:

October 16, 2023 – November 6, 2023

Documentation Deadline for individuals newly added to benefits during BOE:

November 13, 2023

Coverage Effective Date, Deductible Reset Date, and Out-Of-Pocket Maximum (OOPM) Reset Date:

January 1, 2024

Coverage Period:

January 1, 2024 – December 31, 2024

How to Review and Update Benefits

Reviewing and updating your benefit elections remains the same simple process, either online through HR Self-Service or by phone with the MI HR Service Center.

Online:

Visit the HR Gateway page at www.mi.gov/selfserv and log in to HR Self-Service. Click the “Menu” button in the top-left corner to expand the bookmarks tray on the left. Select “Benefits Open Enrollment” from the list to expand the options. From there, you can choose to start the process of adding new individuals 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 Benefits Open Enrollment? Call the MI HR Service Center, Monday through Friday, 8:00 a.m. to 5:00 p.m., at **877-766-6447**.



What's New for BOE

There are a few changes to note for BOE this year. While it is important to review your benefits annually to ensure your elections will meet your needs for the coming plan year, it is particularly important to weigh your options when changes are occurring. In addition to this BOE Booklet, www.mi.gov/BOE, and www.mi.gov/employeebenefits is the home for all things benefits now and throughout the year.

McLaren Health Plan and Physicians Health Plan (PHP) Discontinuation

Effective January 1, 2024, McLaren Health Plan and PHP have elected to no longer offer health insurance to state employees, retirees, and dependents. Enrollment and coverage in both plans will end after December 31, 2023.

Current enrollees must elect a new health plan during BOE to have state health coverage after December 31, 2023.

Current plan enrollees will be contacted directly by both email and mail with additional details. Visit the [Health Plan Discontinuation](#) webpage for more information.

State High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Updates

Deductible Increase

The IRS has increased the minimum deductible amount that must be charged for a high deductible health plan for plan year 2024, therefore the deductible amounts for the State HDHP will be as follows effective January 1, 2024:

In-Network:

- Individual: \$1,600
- Family: \$3,200

Out-of-Network:

- Individual: \$3,200
- Family: \$6,400

HSA Maximum Contribution Level Increase

The IRS has increased the annual combined employee and employer HSA maximum contribution limit for 2024:

- Individual: \$4,150 can be contributed between the employee and employer
- Family: \$8,300 can be contributed between the employee and employer

What's New for BOE Continued...

Health Maintenance Organization (HMO) Insurance Premium Rate Increases

Employees are encouraged to review all aspects of their benefit elections every year, rates included. This year, the HMOs have an increase in biweekly premiums. Rates for the SHP PPO and State High Deductible Health Plan (HDHP) with Health Savings Account (HSA) remain the same.

It is important to take these changes into account when making your benefit elections. The [Understanding HMO Insurance Premium Rates](#) resource is available to show premium split (employee/employer share) calculations. Please visit the [Insurance Rates](#) page to review premiums as part of your BOE preparation this year.

Changing your health plan is a significant decision. It is important to select a plan that best meets your needs by covering services and medication you require. Contact your health care providers (e.g., primary care physician, specialists, therapists, facilities, etc.) to verify if they are in-network with other State of Michigan health insurance plans you are considering.

Review prescription drug formularies to determine tier placement of current medications, if covered. Be aware of prior authorization or other requirements and work with prescribers to help avoid disruption when the new plan coverage begins January 1st.

Prescription drug formularies are subject to change and should be reviewed during BOE prior to making elections for 2024.

Health Care and Dependent Care FSAs

Effective January 1, 2024, flexible spending account (FSA) annual goals must be spread over 25 bi-weekly pay periods. IRS regulations require FSA contributions be uniform intervals for all participants.

A 25 bi-weekly pay period interval allows employees to elect up to the FSA annual maximum(s) if desired. Visit www.mi.gov/FSA for additional FSA related information.

Comparing Health Plans

There are many important factors to review when selecting a health plan, especially if you have been enrolled in your current plan for many years. The information below highlights some differences between the plans offered to State of Michigan employees for 2024. A detailed [comparison chart](#), [health plan cost scenarios](#), [plan summaries](#), [insurance rates](#), and other information are also available by visiting www.mi.gov/BOE.

HMOs

- Generally higher premiums
- Lower deductibles
- No coinsurance
- 100% coverage for preventive services
- Provider networks may be limited to a geographic region
- Eligibility subject to [residential zip code](#)

SHP PPO

- Premiums higher than the State HDHP with HSA but lower than HMOs
- Deductibles lower than the State HDHP with HSA but higher than HMOs
- 10% coinsurance on many services
- 100% coverage for preventive services
- National Blue Cross provider network

State HDHP with HSA

- Lower premiums
- Generally higher deductibles
- 20% coinsurance on most services
- Includes HSA and employer contribution
- 100% coverage for preventive services
- National Blue Cross provider network

How Do Deductibles Work

A deductible is a specified amount you must pay each plan year for services before your insurance plan begins to pay. The deductible does not apply to all services. In-network preventive services under the SHP PPO, HMOs, and the State HDHP with HSA do not require any copay or deductible. Under the SHP PPO and HMOs, in-network office visits, consultations, and urgent care visits only require a copay. Refer to the [2024 Health Plan Comparison Chart](#) or individual plan summaries at the [Insurance Carriers and Plans](#) page for lists of covered in-network services after the deductible.

Your deductible amount will vary based on your plan. For HMOs and the SHP PPO, the individual in-network deductible (\$125 for an HMO or \$400 for the SHP PPO) is the maximum for any one family member. The family deductible (\$250 for an HMO or \$800 for the SHP PPO) is the combined maximum for all family members for in-network services. One family member cannot contribute more than the individual maximum deductible toward the family deductible. A family member is not required to reach the individual deductible before the family deductible can be met.

For the State HDHP with HSA, the individual deductible (\$1,600) applies to employee-only coverage. The State HDHP with HSA family deductible (\$3,200) applies to the coverage of employee plus spouse and other dependents. Except for certain covered preventive services, the applicable deductible must be fulfilled before services are paid by the plan. Any member of the family or combination of family members can fulfill the entire family deductible.

Some HMOs, the SHP PPO, and the State HDHP with HSA can have separate deductible calculations for out-of-network services.

Understanding Deductible Costs

Health Maintenance Organization (HMO) Deductible Example:

Jacob receives services for a benefit that is covered 100% after deductible (e.g., ambulance services, x-rays, MRI, etc.). The provider submits a claim to the HMO for an allowed amount of \$550. Jacob has not accrued any medical expenses in 2024 toward his \$125 deductible. The HMO will pay the provider \$425; the provider will bill Jacob for his member cost share of \$125 deductible).

State Health Plan PPO Deductible Example:

Joan receives services for a benefit that is covered 90% after deductible (e.g., ambulance services, x-rays, MRI, etc.). The provider submits a claim to BCBSM for an allowed amount of \$550.

Joan has not accrued any medical expenses for 2024 toward her \$400 deductible. BCBSM will subtract the \$400 deductible from the allowed amount and pay the provider for 90% of the \$150 remaining balance (\$135). The provider will bill Joan for her member cost share of \$415 (\$400 deductible + 10% coinsurance of \$15 on the \$150 balance).

State High Deductible Health Plan with HSA Example:

Susan received a \$750 annual employer contribution into her HSA with the first paycheck of 2024.* She receives services in February for a benefit that is covered 80% after deductible (e.g., ambulance services, x-rays, MRI, etc.). The provider submits a claim to BCBSM for an allowed amount of \$550.

Susan has not accrued any medical expenses for 2024 toward her \$1,600 deductible. BCBSM will not pay the provider since the bill balance is less than the remaining deductible. The provider will bill Susan for her member cost share of \$550. Susan may pay the provider \$550 from her HSA or use a different payment method available to her.

*An employee can make additional contributions once their HSA account is active.

Frequently Asked Questions

What's an out-of-pocket maximum and how does it work?

The annual out-of-pocket maximum (OOPM) is the total amount you can be required to pay for in-network covered services during a plan year. In-network deductibles, fixed-dollar copays, prescription drug copays, and coinsurance all count toward the annual OOPM.

Once this maximum amount is reached, you will not pay any additional coinsurance, deductibles, or copays for covered in-network services for the rest of the plan year.

The individual OOPM applies to any one family member; the family OOPM is the collective amount that could be paid by any combination of family members. There are separate OOPMs for in- and out-of-network services. In-network OOPM amounts are below. See [2024 Health Plan Comparison Chart](#) for other details.

- SHP PPO & HMO in-network: \$2,000 individual / \$4,000 family
- State HDHP in-network: \$4,000 individual / \$8,000 family

These charges cannot be used to meet your annual in-network OOPM:

- Out-of-network coinsurance, deductibles, or fixed dollar copays
- Charges for non-covered services or treatments
- Charges above the approved amount the plan pays for a benefit
- Biweekly premiums

How does coinsurance work?

Coinsurance is your share of the costs of a covered health care service, calculated as a percent, after meeting your annual deductible. For example, for in-network services, if you have met your annual deductible and then have surgery, the insurance plan will pay a percentage of the allowed amount for the surgery and you will pay the remaining percentage as coinsurance. All in-network coinsurance charges apply toward the annual in-network OOPM, which limits the amount you can be required to pay for services during a plan year.

Frequently Asked Questions

What other insurance terms should I know?

Premium: The amount paid each pay period to enroll in insurance benefits. You and the state both pay a share for most plans.

In-Network/Out-of-Network: Each plan has a network of providers. If you obtain services from these providers, you usually pay less for services covered under your plan.

Each plan's website has a list of its network providers. This information can also be found from the [Carriers and Benefit Plans](#) page of the Employee Benefits website.

Out-of-network providers can cost you more, or not be covered at all, depending on your plan.

Copay: A copay is a fixed-dollar amount you may be required to pay when receiving services. These most commonly apply to office visits and prescriptions and are generally paid when services are performed or prescriptions are received.

Formulary (Drug List): A formulary is a list of generic and brand-name prescription drugs covered by your health plan. It is divided into tiers that correspond to the plan's copay structure. The SHP PPO and State HDHP with HSA both include prescription coverage administered by OptumRx using the same formulary.

Each HMO plan includes its own formulary. Prescription copays are the same for all plans, but under the State HDHP with HSA, non-preventive medications are subject to meeting the plan deductible before copays apply.

Eligibility Guidelines

Eligible Dependents

Eligible dependents may be enrolled in your health, dental, vision, and dependent life insurance plans. Children by birth or legal adoption, or stepchildren are eligible for dependent life insurance until the day before their 23rd birthday, and eligible for health, dental, and vision insurance through the last day of the month in which they turn 26.

Children for whom you have legal guardianship or provide foster care (placed in your home by a state agency or court) are eligible for health, dental, vision, and dependent life insurance until the day before their 18th birthday, unless the placement expires before that date.

If you and your retiree or state employee spouse are both covered by state group insurance plans, you may maintain separate coverage or enroll together with one spouse as a dependent. If you maintain separate coverage, your children can only be listed as a dependent on one plan. If both employees want to carry a child and cannot agree on who will cover, the children will be covered by the parent who covered the children first during their state employment. This applies even if you are divorced.

For specific eligibility information, visit [Dependent Eligibility Guidelines](#).

Other Eligible Adult Individuals (OEAls)

OEAls are eligible to be added to health insurance plans only for all represented and non-exclusively represented (NERE) employees except Legislative and Deferred Retirement Option Plan (DROP) employees.

To add an OEAI to your health insurance, you can enroll through HR Self-Service (www.mi.gov/selfserv) or by calling the MI HR Service Center during BOE. After enrollment, the MI HR Service Center* must receive all supporting documentation by **November 13, 2023**, to complete the enrollment process or the OEAI and OEAI dependent(s) will not be enrolled. Eligibility criteria and documentation requirements are included on the second page of the [Enrollment Application and Affidavit \(CS-1833\)](#).

Note: OEAls are excluded from enrollment in the State High Deductible Health Plan with HSA.

Eligibility Guidelines

OEAI Tax Implications

In accordance with IRS regulations, state employees are responsible for paying taxes associated with the fair-market value of enrolling an OEAI and the OEAI's dependents. The [Taxation of OEAI Benefits](#) resource will help you determine your approximate tax obligation.

Qualifying Life Events & Canceling Coverage

Changes made during BOE are effective January 1, 2024. If you experience a qualifying life event (QLE) such as marriage, birth, gain of coverage, etc. and would like changes to begin prior to that date, contact MI HR Service Center* as soon as possible, but no later than 31 days after the QLE. Do not wait until you have the official documentation to contact the MI HR Service Center*.

An employee's spouse, OEAI, or dependent in the armed forces on active duty is ineligible for coverage.

Immediately notify the MI HR Service Center* to cancel coverage when your dependent no longer meets the definition of an eligible individual.

Ex-spouses are ineligible and must be removed from coverage effective the date of the divorce. You must provide, within 31 days of the divorce, a copy of your divorce decree to the MI HR Service Center*.

Note: The State may use vital statistics records to audit spousal eligibility and take appropriate action to remove ineligible individuals.

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 their employer stops contributing towards the coverage, you may be able to enroll in a state health plan. You may also be able to enroll in the plan, or add new dependents to the plan, because of marriage, birth, adoption, or placement for adoption. You must request enrollment within 31 days after the QLE occurs.

*Auditor General and Judicial employees should submit all supporting documentation to their HR office instead of the MI HR Service Center.

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

To request special enrollment or obtain more info, contact [MI HR Service Center](#).

Required Documentation

Legal documentation such as marriage certificate, birth certificate, adoption papers, or court documents are required when adding a new individual to your benefits during the BOE period. For additional information and specific requirements, visit [Required Documentation](#).

Copies of documentation emailed, faxed, or mailed to the MI HR Service Center* must be received by **November 13, 2023**, or individual(s) will not be added to coverage. Contact information is provided at the end of this section. Legible copies are required. Please do not provide originals; documents will not be returned.

*Auditor General and Judicial employees should submit all supporting documentation to their HR office instead of the MI HR Service Center.

MI HR Service Center Contact Information

Phone: 877-766-6447

Email: MCSC-MIHR-Docs@michigan.gov

Fax: 517-241-5892

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

Note: HR offices must receive all supporting documentation from Auditor General and Judicial employees by November 13, 2023.

HIPAA Exemption Notice

Group health plans sponsored by state and local governmental employers must generally comply with requirements in title XXVII of the federal Public Health Service Act. Federal law permits, however, these sponsors 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 has elected to exempt the SHP PPO and State HDHP with HSA from the requirements of protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan. The exemption from these federal requirements will continue in effect for the period of plan coverage beginning January 1, 2024, and ending December 31, 2024. The election may be renewed for subsequent plan years.

As required by MCL 550.544, notice is also 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.

The HIPAA Notice of Privacy Practices for the benefit plans is available at <https://www.michigan.gov/mdcs/-/media/Project/Websites/mdcs/EBD/HIPAAPlansPrivacyNotice.pdf>. For Questions on HIPAA exemption, contact the Employee Benefits Division at 800-505-5011.



Insurance Carrier Information

Note: Employees who enroll in a different insurance plan should receive ID cards prior to the start of coverage on January 1, 2024.



State Health Plan PPO State High Deductible Health Plan (HDHP)

Blue Cross Blue Shield of Michigan (BCBSM)

Phone: 800-843-4876

www.bcbsm.com/som



Prescription Drug Administrator: State Health Plan PPO Prescription Drug Administrator: State HDHP

OptumRx

Active Employees & Non-Medicare Retirees

Phone: 866-633-6433

OptumRx: Medicare-Eligible Retirees

Phone: 866-635-5941

www.optumrx.com/som



HSA Administrator for the State HDHP with HSA

HealthEquity

Phone: 877-284-9840

Log in at www.bcbsm.com/som to manage your HSA from HE.



State Long Term Disability (LTD) Plan

Sedgwick

Phone: 800-324-9901

Insurance Carrier Information



Health Maintenance Organization (HMO)

Blue Care Network

Phone: 800-662-6667

www.bcbsm.com/som



Health Maintenance Organization (HMO)

Health Alliance Plan (HAP)

Phone: 800-422-4641

www.hap.org/som



MSPTA-Represented Employees Only

C.O.P.S. Health Trust Plans

C.O.P.S. Health Trust

Phone: 800-229-2210

Phone: 248-524-0454

www.bluewaterbenefitsadmin.com



State Dental Plan

Preventive Dental Plan

Delta Dental Plan of Michigan

Phone: 800-524-0150

www.deltadentalmi.com/som



State Vision Plan

EyeMed

Phone: 833-279-4355

www.eyemedvisioncare.com/som

Rates

Visit the Employee Benefits website to view insurance benefit rates:

www.mi.gov/mdcs/employeebenefits/rates

Additional Resources

www.mi.gov/BOE

www.mi.gov/employeebenefits

[CY24 Benefit Comparison Tutorial](#)

[2024 FSA Plan Booklet \(mi.gov\)](#)