2025 State of Michigan Employee Benefits Open Enrollment

October 14, 2024–November 1, 2024

Contents

BOE Information

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BOE Dates to Know

Benefits Open Enrollment Period:
October 14, 2024–November 1, 2024

Documentation Deadline for individuals newly added to benefits during BOE:
November 8, 2024

Coverage Effective Date, Deductible Reset Date, and Out-Of-Pocket Maximum (OOPM) Reset Date:
January 1, 2025

Coverage Period:
January 1, 2025–December 31, 2025

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 start the process of adding new individuals to your benefits or begin the enrollment process.

Over the Phone:

Need help from an HR professional 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.**

HIPAA Notice

The HIPAA Notice of Privacy Practices for the benefit plans is available at the link below. For questions on HIPAA privacy practices, contact the Employee Benefits Division (EBD) at 800-505-5011.

www.michigan.gov/mdcs/-/media/Project/Websites/mdcs/EBD/HIPAAPlansPrivacyNotice.pdf

What's New for BOE

There are a few benefit 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.

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 2025. The deductible amounts for the State HDHP will be as follows effective January 1, 2025:

In-Network:

- Individual: $1,650
- Family: $3,300

Out-of-Network:

- Individual: $3,300
- Family: $6,600

HSA Maximum Contribution Level Increase

The IRS has increased the annual combined employee and employer HSA maximum contribution limit for 2025:

- Individual: $4,300 can be contributed between the employee and employer
- Family: $8,550 can be contributed between the employee and employer

HSA Employer Contribution Increase

The annual HSA employer contribution will increase to $800 for an eligible individual employee enrolled in the State HDHP and to $1,600 for an eligible employee who enrolls with one or more eligible dependents in the State HDHP.

What's New for BOE Continued...

Mental Health Parity and Addiction Equity Act (MHPAEA) Updates for the Self-Insured Health Plans

Effective January 1, 2025, federal legislation requires that the State Health Plan PPO (SHP PPO) and State HDHP comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), resulting in some benefit changes that will impact the deductible and coinsurance for certain services.

For example, both medical and behavioral health office visit copays for the SHP PPO will be $20 per visit. For the SHP PPO and State HDHP, inpatient substance use disorder services have changed from two 28-day admissions per year to unlimited days. Additionally for these plans, autism treatment is not subject to the combined benefit maximum of 90 visits for physical, occupational, and speech therapy services and In-network Residential Mental Health treatment will now be a covered benefit.

For a detailed list of covered services, review the SHP PPO and State HDHP Benefit Guides, or a high-level summary on the CY25 Health Plan Comparison Chart.

GLP-1 Coverage Under the State-Sponsored Health Plans

The category of drugs known as GLP-1 inhibitors has been in the news recently because of their widespread use, high cost, and medication shortages. Originally developed for management of diabetes they have been found to have other uses. These drugs have different names when prescribed for diabetes than for weight loss. Neither BCN nor HAP cover GLP-1 inhibitors for weight loss.

GLP-1 inhibitors such as Saxenda, Wegovy, and Zepbound will continue to be covered under the SHP PPO and State HDHP for those who meet the weight management prior authorization criteria. Be sure to check the formulary for your plan for prior authorization, quantity limits, or step therapy requirements, and be aware that tiers and requirements may change during the year. If you have questions related to this coverage, you will need to contact Optum Rx.

What's New for BOE Continued...

Insurance Premium Rate Changes

Employees are encouraged to review all aspects of their benefit elections every year, including rates. There will be changes to some of the biweekly premium rates based on anticipated higher costs of dental, medical, prescription, and behavioral health and substance use disorder claim expenses for the coming calendar year.

The State Dental Plan premiums and SHP PPO premiums will increase for the first time since 2007 and 2015, respectively. HMO rates will also increase but the employee share increase will be offset some due to a higher SHP PPO cap for plan year 2025. For HAP, the employee share will decrease. The employee share for BCN will increase.

The State HDHP premium will increase for the first time since the plan was first offered in 2021, but as stated in the HSA Employer Contribution Increase section, its annual employer contribution amount will also increase from $750 to $800 for individual coverage and from $1,500 to $1,600 for family coverage.

Additionally, due to there being 27 pay dates in 2025, State Vision Plan, Preventive Dental and Dependent Life Insurance biweekly employer and employee premium rates will be reduced for CY2025 to maintain annual premium totals.

Visit the Insurance Rates webpage to review premiums as part of your BOE preparation. The Understanding CY25 HMO Insurance Premium Rates resource is also helpful in illustrating the calculation breakdown for the required cost-share split between the state and employees for the HMOs.

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 1. Prescription drug formularies are subject to change and should be reviewed during BOE before making elections for 2025.

This information is available on the Carriers and Benefit Plans webpage.

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 2025. 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 2025 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 ($1,650) applies to employee-only coverage. The State HDHP with HSA family deductible ($3,300) applies to the coverage of employee plus spouse and other dependents. Except for certain covered preventive services, the applicable deductible must be met before services are paid by the plan. Any member of the family or combination of family members can meet 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 2025 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 Blue Cross for an allowed amount of $550.

Joan has not accrued any medical expenses for 2025 toward her $400 deductible. Blue Cross 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 $800 annual employer contribution into her HSA with the first paycheck of 2025.* 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 Blue Cross for an allowed amount of $550.

Susan has not accrued any medical expenses for 2025 toward her $1,650 deductible. Blue Cross will not pay the provider since the bill balance is less than the remaining deducible. 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 the 2025 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 (OEAIs)

OEAIs 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 8, 2024**, 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: OEAIs 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, 2025. 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 is no longer 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, 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 8, 2024,** 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 8, 2024.

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, 2025.

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

Blue Cross Blue Shield of Michigan (Blue Cross)

Phone: 800-843-4876
Phone: 855-859-0035 (BOE-dedicated Customer Service line only available 9/30/24 through 11/1/24)
www.bcbsm.com/som
Blue Cross Find-a-Doctor Tool
Guide: Navigating the Blue Cross Find-a-Doctor Tool

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: 855-662-6667
Phone: 855-859-0035 (BOE-dedicated Customer Service line only available 9/30/24 through 11/1/24)
www.bcbsm.com/som
Blue Cross Find-a-Doctor Tool
Guide: Navigating the Blue Cross Find-a-Doctor Tool

Health Maintenance Organization (HMO)

Health Alliance Plan (HAP)

Phone: 800-422-4641
www.hap.org/som
HAP Find-a-Doctor Tool
Guide: Navigating the HAP Find-a-Doctor Tool

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

2025 FSA Plan Booklet