The Weekly Plus
JANUARY 15, 1996

MANAGED CHOICE:
The Best of Both Worlds

Health CARE UPDATE

AETNA'S NEW MANAGED CHOICE HEALTH PLAN FEATURES 90 AND 100 PERCENT COVERAGE ON MOST SERVICES DELIVERED IN-NETWORK, NO DEDUCTIBLES OR CLAIM FORMS AND WELLNESS BENEFITS. ■ STILL, PARTICIPANTS ARE FREE TO LEAVE THE NETWORK AT ANY TIME, FOR ANY MEDICAL SERVICE.

CONSUMERS POWER AND CMS ENERGY are offering a new health care plan this year called Managed Choice. New from Aetna, the plan combines the best features of HMO-style plans with the best features of traditional health care coverage.

Managed Choice will be available April 1 to employees in Grand Rapids, Muskegon, Lansing, Saginaw, Flint, Bay City, Port Huron, Detroit, Kalamazoo and their surrounding areas. (Other areas may be added prior to open enrollment.)

Like an HMO (health maintenance organization), Managed Choice contracts with a network of physicians, medical facilities and other health care providers. When you seek medical care from a network provider, you will have fewer out-of-pocket expenses than with the traditional Aetna plan.

With Managed Choice, there are no claim forms or deductibles. There are no price disputes over whether your medical bills are within the "reasonable and customary" range of charges. And the plan covers wellness and preventive care. Routine gynecological exams, physicals and well baby care are all covered—services that traditional plans usually don't pay for.

Unlike an HMO, however, Managed Choice members can opt out of the Managed Choice network for any medical service. As a participant in the plan, you have the freedom to seek care from a non-network physician or facility. The plan then acts like the traditional Aetna plan, with Aetna covering 80 percent of all "reasonable and customary" medical charges.

This is why Aetna's Managed Choice plan is called a "point of service" (POS) plan. At any point in time, if you need medical service, you may stay with your network provider for higher benefits or opt out of the network and pay a greater share of your medical bills.

> ***Unlike an HMO, Managed Choice members can opt out of the network for any medical service.***

Encouraging employees to try Managed Choice is a way for CPCo and CMS Energy to manage health care costs, while continuing to provide comprehensive health care coverage at no premium cost to employees.

Last year, CPCo paid roughly $5,000 per employee for health care coverage — for a staggering total of $70 million.

"Health costs continue to rise," said Tom McNish, vice president and secretary for CPCo and CMS Energy. "In order to control those costs, the company has considered several options. One option is to charge employees health care premiums. Another option is to change the design of the 80-20 plan, making deductibles higher or reimbursement lower. For instance, employees might be responsible for 30 percent of the health care charges they incur or have to pay a $400 individual deductible, instead of a $200 deductible."

All of these options shift more cost to the employee, but do little to lower the total cost of health care for either the employee or the company, McNish said.

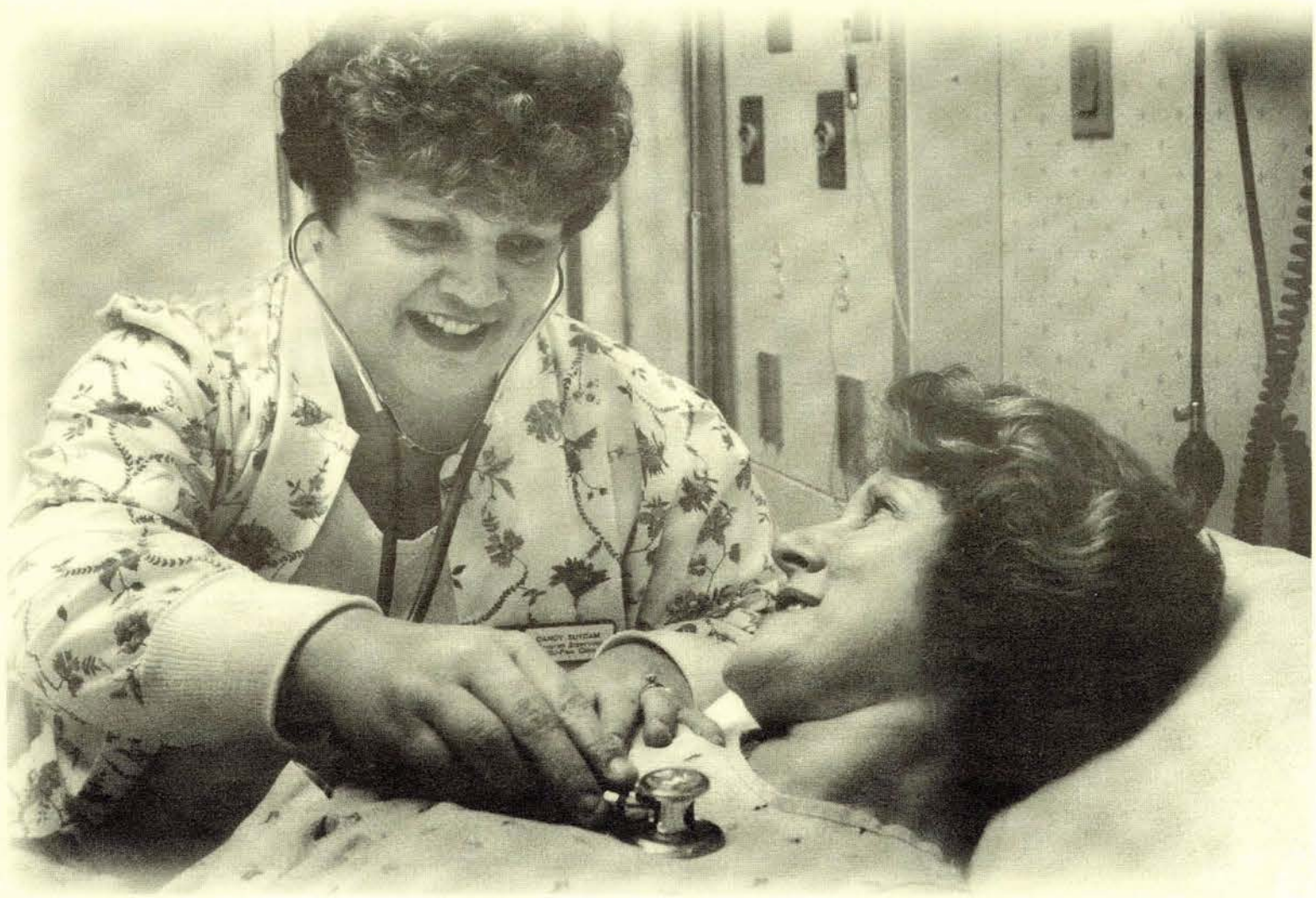
"We really don't want to control the company's health care costs by shifting the costs to employees," he said. "We want to work with health care providers to lower total health care costs as much as we can. Lower costs are best accomplished through the use of managed care plans such as HMOs or the new Aetna Managed Choice plan."

MANAGED CHOICE/PAGE 2

BY PARRI SONTAG

Fewer Out-of-Pocket Expenses With Managed Choice

MANAGED CHOICE *FROM PAGE 1*



Health CARE UPDATE

Like HMO health care providers, Managed Choice physicians and medical facilities have agreed to accept fees which are often below their normal rates. They are willing to negotiate, because they expect to see more patients as a result of being part of a busy Aetna network.

Because CPCo and CMS Energy are able to reduce costs through negotiated fees with health care providers, the company will share the savings with employees by offering higher reimbursement to Managed Choice participants.

While the traditional Aetna plan is an 80-20 plan in which employees pay 20 percent of their health care bill after a deductible, the Managed Choice plan covers employees for 90 or 100 percent of their medical costs, when using "in-network" providers — with no deductible. And because prices are prenegotiated, there are no reasonable and customary fee reductions. Employees will not have to haggle over price.

Many companies are looking to control health costs through managed care plans. Most already require premium contributions from employees in an effort to control costs.

According to a 1994 survey by Foster Higgins, a national benefits consulting firm, about three-quarters of employers in the nation require at least some employee premium contribution for individual health care coverage. About 84 percent of employers require an employee premium contribution for family coverage.

Among plans that do require a premium contribution, the average contribution for individual coverage is 20 percent of the premium cost, or $33 a month ($110 for a family policy).

Deductibles, too, continue to creep upwards.

"Clearly, increased cost sharing of health care expenses with employees is a national trend," said Herb Kops, CPCo director of employee benefits. He noted that CPCo and CMS employees are not required to make premium contributions.

"At Consumers Power, we're working hard to avoid premium contributions," Kops said.

As a member of a managed care health plan such as Aetna's Managed Choice or an HMO, you choose a personal doctor called a primary care physician. He or she "manages" all of your medical care and becomes your advocate in an increasingly complex health care system. Because your primary care physician is the one who refers you to specialists or for testing, managed care should eliminate unnecessary, time consuming and costly doctors visits, tests, and duplication of services.

Managed care also gets its name because HMOs and point of service plans such as Managed Choice are able to "manage" costs by negotiating payment rates with physicians, medical facilities and other providers who form the network.

Managed care is on the rise. In 1994, 65 percent of U.S. workers were enrolled in such plans, up from 47 percent in 1991. In recent years, the biggest enrollment gains were made by point of service plans such as Aetna's Managed Choice.

While Managed Choice is a new offering this year, 51 percent of CPCo employees have already entered a managed care setting by moving into HMOs.

"If you are already enrolled in an HMO, we encourage you to stick with it," Kops said. "While Aetna's Managed Choice is an attractive plan, HMO participants are generally receiving a higher level of benefits. Hospital stays and surgery, for instance, are covered at 100 percent in the HMOs.

"The out-of-network coverage feature makes Managed Choice ideal for those people who have been reluctant to leave the traditional Aetna plan and move to an HMO."

Aetna's Managed Choice network in Michigan includes more than 1,800 primary care physicians, 3,800 specialists and 70 hospitals. The plan is national in scope, with additional networks established throughout the United States.

REIMBURSEMENT

With Managed Choice, doctors office visits with your primary care physician are covered 100 percent, after a $10 copayment. There is no deductible. If you choose to opt out of the network, visits are covered at 80 percent, after a $300 individual or $600 family deductible.

If employees opt for managed care plans such as HMOs and Aetna's new Managed Choice plan, we may be able to avoid employees having to share health care premiums or pay higher deductibles.

Managed Choice participants also are covered 100 percent, after a $10 copayment, for in-network routine physical exams, well baby care, routine gynecological exams including pap smears and lab work, and routine eye and hearing exams. These services are generally not covered by the traditional Aetna plan.

Other services, such as X-rays, are covered at 90 percent, if delivered within the Managed Choice network and referred by your primary care doctor.

The Managed Choice plan also will protect you from high out-of-pocket costs with its out-of-pocket cap of $850 for an individual and $1,700 for a family for services delivered through the network.

If you opt out of the network, the plan pays 80 percent of your expenses and there is a separate out-of-pocket cap of $1,700 for an individual, $3,400 for a family, which includes the deductible.

Some other comparisons between Managed Choice and the traditional Aetna plan:

- Managed Choice covers 100 percent, after a $10 copayment, of a routine mammography (the traditional Aetna plan only covers 80 percent of the cost of mammography, after the deductible).
- Managed Choice covers 90 percent of the costs associated with surgery (including oral surgery), physician hospital services, diagnostic X-ray and lab work, and inpatient and outpatient hospital stays — with no deductible. Again, the traditional Aetna plan only covers 80 percent of these costs, after the deductible.
- Other services covered 90 percent, without a deductible, by Managed Choice include: 120 days per year in a convalescent facility; up to 120 home health care visits a year; up to 45 days of hospice care; ambulance service, outpatient skeletal adjustments, medical equipment and prosthetic devices and sterilization. Aetna's traditional plan covers only 80 percent of these costs, after the deductible.
- Managed Choice covers 90 percent of the costs associated with two in-network infertility treatments such as in vitro fertilization — without a deductible.
- Substance abuse treatment also is covered under Managed Choice. Inpatient and outpatient services are covered 90 percent in-network, without a deductible. Under the traditional Aetna plan, such services are covered only 80 percent, after the deductible.
- The dental plan for Managed Choice participants offers several improvements over the dental program available under the traditional Aetna dental plan.

Under Managed Choice, the dental plan is separate. There is a $25 individual or $50 family dental deductible. Medical expenses do not count towards meeting the dental deductible.

Under the traditional Aetna plan, the annual $200 per person and $400 per family deductible can be met through dental, orthodontic or medical expenses.

In both the Managed Choice separate dental plan and the traditional Aetna dental plan, there are no deductibles for preventive dental services.

Advantages of Aetna's Managed Choice plan

When you're treated or referred by your chosen primary care physician, there will be:

- **No deductible**
- **100% coverage on doctor's visits, after $10 copayment**
- **100% coverage (after a $10 copayment) for preventive care such as routine physical exams, well baby care, yearly gynecological exams and pap smears, routine eye and hearing exams and mammography**
- **90% coverage on most medical services, including surgery, hospital stays, diagnostic X-ray and laboratory tests, home health care and ambulance service**
- **No claim forms**
- **No price disputes (reimbursement is not based on "reasonable and customary" charges)**
- **Out-of-pocket maximum of $850 individual/$1,700 family**

One key feature of the plan is freedom of choice. While you have the freedom to choose from many primary care physicians in the network, you may elect to go out-of-network for health services. The plan then reverts to a traditional type Aetna plan with:

- **80% reimbursement of "reasonable and customary fees"**
- **$300 individual/$600 family deductible**
- **Claim forms required**
- **Out of pocket maximum of $1,700 individual/$3,400 family**

Compare Your Health Care Options

Following are some point-by-point comparisons of the traditional Aetna plan, Aetnas new Managed Choice point of service plan and HMOs:

PLAN PROVISIONS AND BENEFITS	HMO (In Network)	AETNA MANAGED CHOICE (In Network)	AETNA MANAGED CHOICE (Out-Of-Network)	TRADITIONAL AETNA
DEDUCTIBLE	None	None	$300 Individual $600 Family	$200 Individual $400 Family
OUT-OF-POCKET LIMIT	None	$850 Individual $1,700 Family	$1,700 Individual $3,400 Family	$850 Individual $1,700 Family
CLAIM FORMS	None	None	Required	Required
DOCTOR'S OFFICE VISIT	$10 copay	$10 copay	80% after deductible, R&C*	80% after deductible, R&C*
PRESCRIPTION DRUGS	Usually $5 copay	Local pharmacy: $5 copay for 21-day supply. Must be filled at CCN II pharmacy. Voluntary formulary. Mail service: $3 copay for 90-day supply. Voluntary formulary.		
ROUTINE PHYSICAL	$10 copay	$10 copay	Covered in-network only	Not covered**
WELL BABY CARE	$10 copay	$10 copay	Covered in-network only	Not covered**
ROUTINE GYN EXAM	$10 copay	$10 copay	Covered in-network only	Not covered**
ROUTINE EYE AND HEARING EXAMS	May or may not be covered	$10 copay	Covered in-network only	Not covered
MAMMOGRAPHY	$10 copay	$10 copay	80% after deductible, R&C*	80% after deductible, R&C*
SURGERY, INCLUDING ORAL SURGERY	100%	90%	80% after deductible, R&C*	80% after deductible, R&C*
PHYSICIAN HOSPITAL SERVICES	100%	90%	80% after deductible, R&C*	80% after deductible, R&C*
DIAGNOSTIC X-RAY AND LAB WORK	100%	90%	80% after deductible, R&C*	80% after deductible, R&C*
INPATIENT/OUTPATIENT HOSPITAL STAY	100%	90%	80% after deductible, R&C*	80% after deductible, R&C* 90% if Partners By Choice hospital
TRANSPLANT AT INSTITUTES OF EXCELLENCE	Not applicable	90% (plus up to $10,000 travel expenses)	80% after deductible (plus up to $10,000 travel expenses)	90% after deductible (plus up to $10,000 travel expenses)
EMERGENCY ROOM	Usually $25-$50 copay	$50 copay (waived if confined)	$50 copay (waived if confined)	80% after deductible 90% at Partners By Choice hospital
AMBULANCE	80-100%	90%	80% after deductible	80% after deductible

* R&C = reasonable and customary charges ** Participants do receive a $150 per family wellness benefit that may be applied.

In addition, the Managed Choice dental plan has no network of dental providers. You may go to any dentist. Whether you are in the Managed Choice dental plan or the traditional Aetna dental plan, reimbursement is based on "reasonable and customary" charges.

Like the traditional Aetna dental plan, Managed Choice's separate dental plan pays 50 percent of orthodontic work; 100 percent of preventive dental work; and 80 percent of restorative work such as fillings, root canals and non-surgical extractions.

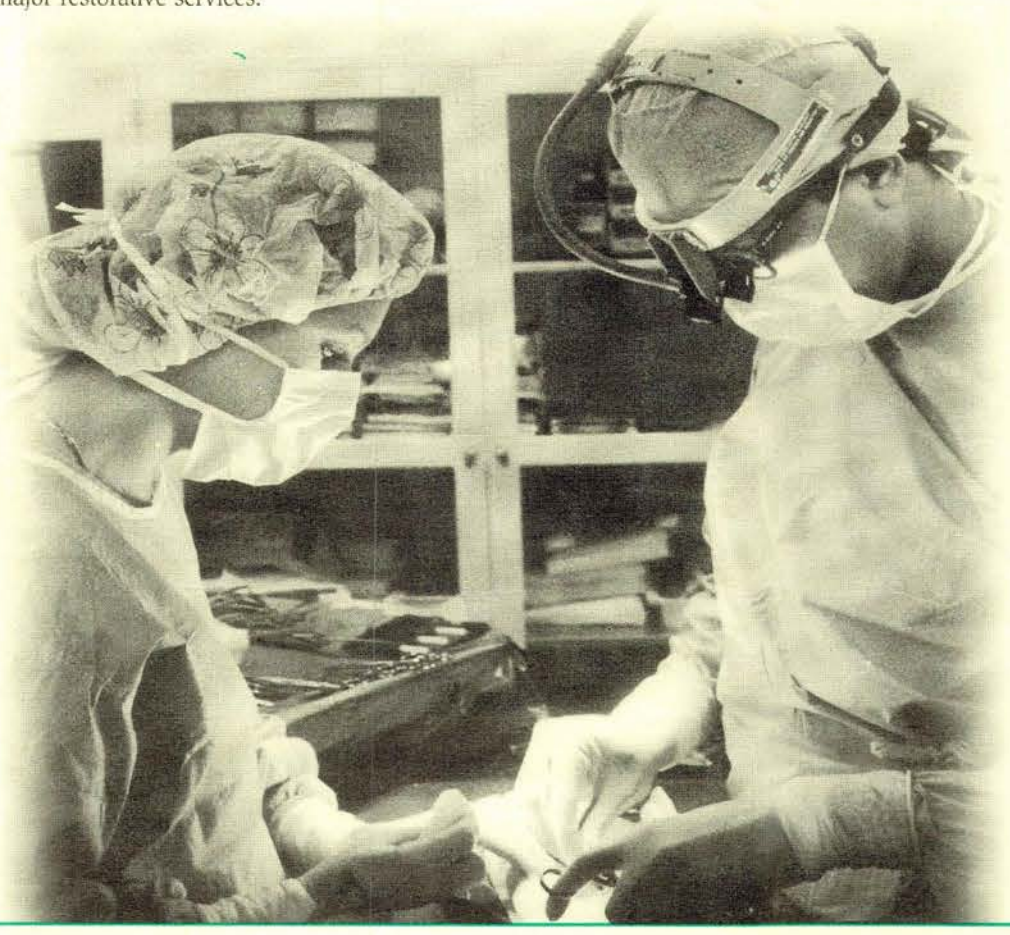
The Managed Choice dental plan also pays 60 percent of major restorative work, such as bridge work, crowns, partials and dentures. Under the traditional Aetna plan, you are only covered for 50 percent of the costs of these major restorative services.

In addition, Managed Choice's separate dental plan pays up to $1,500 in dental benefits a year, compared to $1,200 in the traditional Aetna plan.

"There are clear benefits for Aetna-covered employees to switch to the Aetna Managed Choice plan, if it's available in their area," Kops said. "Reimbursement is higher, so employee out-of-pocket costs should be lower. Plus, a managed care setting eliminates the hassle of meeting deductibles, filling out claim forms and arguing over what constitutes 'reasonable and customary' charges.

"Managed Choice truly provides the best of both worlds. If at any point you wish to go to a specialist or facility not in the network, you

MANAGED CHOICE/PAGE 4



Health Benefits Changes as of April 1996

IN ADDITION TO THE NEW Managed Choice offering, there will be several other changes in next year's health benefits:

■SURVIVOR COVERAGE — CPCo and CMS currently subsidize the widows, widowers and other survivors of retirees and certain employees over the age of 55 with six months of company-paid health care coverage. This coverage period will now be extended. The survivors of these employees and retirees now will be covered for six years or until they become eligible for Medicare, whichever comes first.

■SPOUSE COVERAGE — If you are a CPCo or CMS employee whose spouse is employed full-time (32 hours or more a week) and their employer offers health care benefits for $50 or less per month, he or she should take that coverage. The company will provide only secondary coverage for these spouses. This new rule applies to all employees and retirees, both in Aetna and HMOs.

■COORDINATION OF BENEFITS — Aetna benefits for secondary coverage will be coordinated in a new way. In the past, if a spouse's insurer paid 80 percent of covered medical costs, CPCo and CMS generally would pay the remaining 20 percent. In 1996, CPCo and CMS will cover a percentage of the remaining charges. For instance, if you are on the traditional Aetna plan, an 80-20 plan, and your spouse's visit to the doctor costs $100 and his or her insurer pays $80 of that, Aetna will no longer pay the remaining $20. Instead, Aetna will pay $16 (80 percent of the remaining $20).

This new method of coordinating benefits applies only to employees and retirees in Aetna's Managed Choice or the traditional Aetna plan.

■PRESCRIPTION DRUG PLAN — Effective Jan. 1, PAID Prescriptions implemented the Preferred Prescriptions Formulary for employees and retirees covered by Aetna. This is a list of commonly prescribed generic and name brand medications, selected by an independent panel of nationally recognized physicians and pharmacists, based on their effectiveness and favorable cost. The objective is to encourage doctors to prescribe and CPCo employees to use the most clinically appropriate and cost-effective high-quality drugs. Employees and retirees are asked to share the formulary list with their doctors.

Prescriptions will continue to cost $5 for a 21-day supply at participating Coordinated Care II network pharmacies or $3 for a 90-day mail order supply. This applies to employees in both Managed Choice and the traditional Aetna plan.

■INSTITUTES OF EXCELLENCE — In 1996, Aetna-covered employees will see a new, improved benefit for transplants. This benefit is voluntary, should a transplant need arise. Aetna has selected 23 hospitals around the country renowned for bone marrow, heart, lung, liver, kidney and pancreas transplants. To be designated an Institute of Excellence, these hospitals have had to meet certain requirements including: performing transplants with frequency; demonstrating excellent survival rates; and providing quality follow-up care.

Employees, retirees and their dependents are encouraged to consider these Institutes of Excellence for transplant needs. If such a procedure is performed at one of Aetna's designated facilities, up to $10,000 in travel and accommodation expenses associated with the transplant will be provided for the patient and one companion.

Please stay tuned for more details on these and other benefits changes in upcoming issues of The Weekly.

FROM PAGE 3

Managed Choice: Convenient, Affordable

Health CARE UPDATE

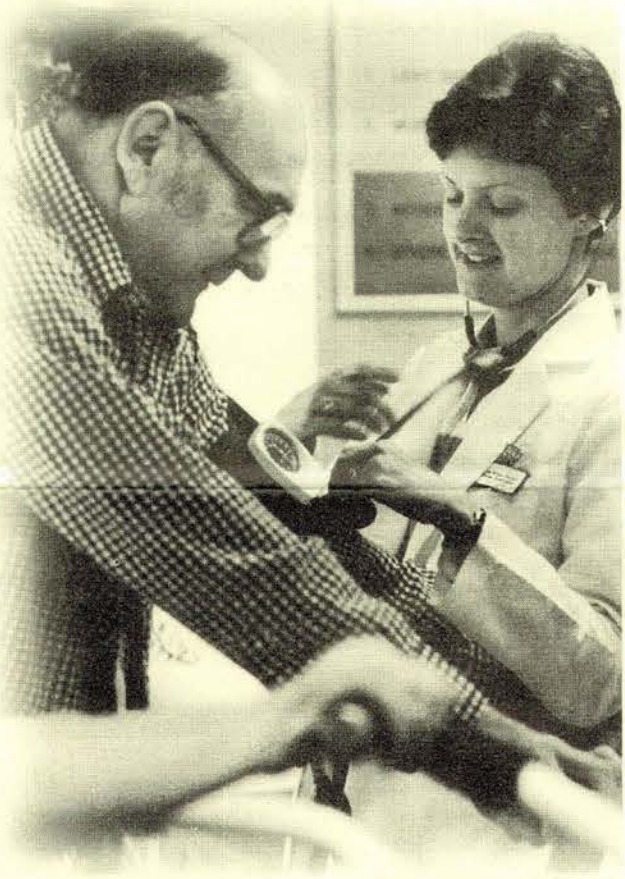
can opt out of the network and be reimbursed 80 percent, after the deductible — just like under the traditional Aetna plan."

CHOOSING A PRIMARY CARE PHYSICIAN

AS A MEMBER OF A managed care health plan, you choose a primary care physician who knows your medical history, helps you make decisions about your health and coordinates all of your medical care. Primary care physicians are licensed physicians who practice in family medicine, internal medicine, pediatrics or general practice.

Managed Choice provides higher-level benefits when you're treated or referred by your primary care physician. When you seek care through your primary care physician, you pay just $10 for an office visit. That means you can afford to seek medical care whenever you need it.

One of the biggest advantages of managed care is affordability. There are no deductibles when you see your primary care physician. In fact, the company wants you to see your doctor for routine exams, immunizations and screenings that are recommended for your age and health status. These regular visits allow your doctor to catch any problems early, when he or she has a greater chance of treating them successfully.



One stumbling block you may encounter if you're considering managed care is that your doctor may not be in the network.

"The company doesn't underestimate the emotional tie between you and your doctor," Kops said. "We realize that such relationships often span years, even decades. Still, we encourage you to take a look at Managed Choice's Member Guide and Provider Directory, which will be mailed to your home during open enrollment. Many employees will find their current physicians do participate in Aetna's network. If not, there are many highly-respected physicians in the network.

"Aetna goes through an extensive provider credentialing process to make sure its providers are highly-qualified and competent. It continues to monitor providers as long as they are part of the network.

"The network also includes some of the most respected and widely-recognized hospitals in your area. The financial benefits and convenience of the Managed Choice plan may outweigh the inconvenience of having to choose a new primary care physician."

If your current primary care physician is not on the Managed Choice network, he added, you can nominate him or her by contacting Aetna.

REFERRALS

WHEN YOU NEED specialty care, your primary care physician will arrange for your referral to the appropriate participating specialist — and you'll receive the higher level of benefits for covered services.

If you seek care from a specialist on your own, without a referral, you'll still receive benefits, but at the plan's reduced 80-percent-after-deductible benefit level.

In other words, unlike many HMOs, Managed Choice allows you to maintain your freedom of choice, when it comes to choosing a health care provider.

"Some people don't join HMOs, because they don't want to get locked into a network," Kops said. "They want to be able to go to renowned facilities such as the Mayo Clinic if they need specialty care. Leaving the network, however, often means having to pay 100 percent of your own medical expenses.

"With Managed Choice, if you like a doctor in the network, or don't mind switching, you'll be covered for 90 to 100 percent of your medical costs, when they are coordinated through your primary care physician. But if that 'big concern' does come along and you feel the need to seek treatment outside the network, you can opt out and receive 80 percent reimbursement after your deductible." ■

Photographs on pages 2, 3 and 4 provided by Foote Hospital Community Relations Department.