



Open Enrollment

To make your benefit choices for 2026

Active U-M Faculty & Staff

**Open Enrollment is Oct. 13 through 5 p.m. Oct. 24, 2025
for 2026 benefits**

Open Enrollment

Benefits Information by Phone

Call the Shared Services Center - HR Customer Care at (734) 615-2000 locally or (866) 647-7657 toll-free, Monday through Friday from 8 a.m. to 1 p.m. and 2 to 5 p.m.

Benefits Information on the Web

hr.umich.edu/benefits-wellness

711 for Telecommunications Relay Service

The Federal Communications Commission adopted use of the 711 dialing code for access to Telecommunications Relay Services (TRS). Dial 711 and ask the operator to connect you to the SSC - HR Customer Care at: (734) 615-2000. Representatives will be happy to assist you..

Sign Up for U-M Emergency Alerts

Sign up to receive a voice or text message from the U-M Division of Public Safety and Security alerting you to a major campus emergency.

- Register now at wolverineaccess.umich.edu. Search for Employee Self-Service and click the tile, log in (2 factor authentication is required), select Campus Personal Information, then select Phone Numbers.
- For more information, go to dpss.umich.edu/content/emergency-preparedness/emergency-alerts/

Campus Safety

U-M publishes an Annual Security Report and Annual Fire Safety Report that include statistics for the previous three years concerning reported crimes that occurred on campus; in certain off-campus buildings owned or controlled by the University of Michigan; and on public property within or immediately adjacent to and accessible from the campus. The report also includes institutional policies concerning campus security, such as alcohol and drug use, crime prevention, the reporting of crimes, sexual assault, and other matters. The updated version of the report is available each year on Oct. 1. You can obtain a copy of this report by visiting the Division of Public Safety and Security's website at: dpss.umich.edu or by contacting DPSS at (734) 763-8391.

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Limitations

The university in its sole discretion may modify, amend, or terminate the benefits provided in this booklet with respect to any individual receiving benefits, including active employees, retirees, and their dependents. Although the university has elected to provide these benefits for the upcoming year, no individual has a vested right to any of the benefits provided. Nothing in these materials gives any individual the right to continued benefits beyond the time the university modifies, amends, or terminates the benefit. Anyone seeking or accepting any of the benefits provided will be deemed to have accepted the terms of the benefits programs and the university's right to modify, amend or terminate them.

Open Enrollment

Each year during Open Enrollment, benefits-eligible faculty and staff can use Wolverine Access to enroll, change coverage, or add or delete dependents to the following plans:

- Health Plan
- Dental Plan
- Vision Plan
- Legal Services Plan
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

The benefit plans you select during Open Enrollment will become effective on Jan. 1, and will remain in effect for the entire 2026 calendar year, as long as premiums are paid and you remain eligible. Outside of the Open Enrollment period, changes to these plans are only allowed within 30 days of a qualified family status change, such as marriage, divorce, or the birth or adoption of a child. Only changes consistent with the status change are allowed.

Open Enrollment Deadlines

Open Enrollment is:

October 13–24, 2025

All elections must be submitted by:

October 24, 2025 at 5 p.m. (Eastern Time)

Changes are effective on:

January 1, 2026

View benefits plan information at:

hr.umich.edu/benefits-wellness

View plan rates and enroll online at:

wolverineaccess.umich.edu



Questions about Benefits?

**Call the SSC - HR Customer Care at (734) 615-2000.
The SSC - HR Customer Care is open Monday through Friday
8 a.m. to 1 p.m. and 2 to 5 p.m.**

What's New

Below is a summary of important changes to your U-M benefits for the upcoming year.

Michigan Care Health Plan Discontinued

- **What is changing?** The Michigan Care health plan will be discontinued as of Dec. 31, 2025.
- **What should you do?** Review your health plan options during Open Enrollment to make the best choice for you and your family.
- **What if you don't do anything?** If you are currently enrolled in Michigan Care and do not choose a new health plan, you will automatically be moved to the U-M Premier Care plan.
- View more information about other health plan options on page 6.

New! Chiropractic Coverage to U-M Premier Care Plan

- **What is changing?** Starting Jan. 1, 2026, U-M Premier Care will include coverage for chiropractic services.
- **What does this mean?**
 - » You can use this benefit for up to 24 visits per year.
 - » You will pay a regular office visit copay for chiropractic appointments.
- View more information on page 6.

Consumer-Directed Health Plan (CDHP) and Health Savings Account (HSA) Changes

If you are enrolled in or plan to enroll in the Consumer-Directed Health Plan, the following limits will apply for 2026:

- **CDHP - Deductible:**
 - » Individual deductible will be \$1,700
 - » Family deductible will be \$3,400
- **CHDP - Out-of-Pocket Maximum (in network)**
 - » Individual will be \$5,500
 - » Family will be \$10,600
- **HSA - University's Maximum Contribution**
 - » Individual will be \$850
 - » Family will be \$1,700
- **HSA - Maximum Contribution (Employee + University)**
 - » Individual will be \$4,400
 - » Family will be \$8,750
- View more information on page 7.

Dental Plan Annual Benefit Maximum Increased

- **What is changing?** The Dental Plan annual maximum benefit will increase to \$1,500.
- **What does this mean?** Beginning Jan. 1, 2026, individuals enrolled in Option 2 and Option 3 may have more coverage for dental services requiring more extensive treatment.
- View more information on page 25.

Increased Health Care Flexible Spending Account (FSA) Limit

- **What is changing?** The IRS annual limit for the Health Care FSA is increasing to \$3,300 on Jan. 1, 2026.
- **What does this mean?** You can set aside more money before taxes to pay for eligible medical care expenses.
- **Special Reminder:** Employees must re-enroll each year to participate in an FSA. The Internal Revenue Service (IRS) does not allow FSA enrollments to carry over from one year to the next.
- View more information on page 34.

Increased Dependent Care FSA Limit

- **What is changing?** The IRS annual limit for the Dependent Care FSA is increasing to \$7,500 on Jan. 1, 2026.
- **What does this mean?** You can set aside more money before taxes to pay for eligible dependent care expenses (like daycare).
- **Special Reminder:** Employees must re-enroll each year to participate in an FSA. The Internal Revenue Service (IRS) does not allow FSA enrollments to carry over from one year to the next.
- View more information on page 36.

Information

If you have dependents covered under your benefits, it's important to verify that their information on record with the university is accurate. Having the correct information may help avoid delay in receiving health care services and speed claims processing. To view your dependent information:

1. Go to Wolverine Access: wolverineaccess.umich.edu
2. Search for **Benefits Self Service** and select the tile.
3. Select the Dependent/Beneficiary tile.

Check that names are spelled correctly, birth dates and social security numbers are correct and verify the relationship. If the information is correct, no action is required. If the information is incorrect, complete the Dependent Information Form available at myumi.ch/uhr-update-dep-info, and submit it to Shared Services Center - Benefits Transactions as indicated on the form. Submitting this form only corrects the information currently on record with the university and does not change benefits enrollment.

ID Cards

Health Plan ID Cards

If your health plan changes for 2026, new ID cards will be mailed to you directly from your health plan company.

If you change plans but do not receive new cards by January 2026, call the health plan company to request a card and inquire about how to obtain services before your new card arrives. Phone numbers can be found at the back of this book.

Prescription Drug ID Cards

Prescription drug ID cards are the same across all health plans. If you need additional cards for dependents, or a replacement for a lost card, please call Prime Therapeutics at (888) 272-1346.

Review Your Benefits Options

and Enroll Online

1. Review the Health Plan Coverage Comparison Chart in this publication, the benefits plan information at hr.umich.edu/benefits-wellness and the plan rates on Wolverine Access. Benefits Mentor, a decision support tool, also can help you choose a health plan that meets your needs.
2. Determine which plans and options most closely meet your needs and those of your dependents while minimizing your out-of-pocket costs.
3. Enroll online using Wolverine Access. Supported browsers are Chrome, Edge, Firefox, and Safari. You will need a University of Michigan unickname and UMICH password to log in. Faculty and staff members without a unickname or password should contact their supervisor.

Do You and Your Spouse/Other Qualified Adult Both Work at U-M?

Choose the medical insurance coverage that best meets the needs of you and your dependents at the lowest cost. Two adults who work at U-M and have no dependent children could minimize the amount of their employee premium contribution if each person chooses “You Only” coverage.

When there are two adults and one child or more, the lowest medical premium contribution is achieved when one person chooses “You Only” coverage and the other chooses coverage for “You + Child” or “You + Children.”

Both employees should review their rates by going to Wolverine Access, searching for Benefits Self-Service and selecting the tile, then selecting the Display Benefit Plan Rate tile.

How to Enroll

Make your elections online as many times as needed until 5 p.m. Eastern Time on Oct. 24, 2025.

If you do not want to change your benefit elections, no action is required unless you want to enroll in a Flexible Spending Account (FSA). FSA enrollments do not carry over year-to-year; you must re-enroll to participate in 2026.

October 13 – 24, 2025 (5 p.m. Eastern Time deadline)

Step 1: Go to Wolverine Access: wolverineaccess.umich.edu

Step 2: Enter **Benefits** in the search bar and click **Search**.

Step 3: Click the **Benefits Self-Service** tile.

Step 4: Enter your unickname and UMICH password; two-factor authentication is required.

Step 5: Click the **Open Enrollment** tile.

Follow the online instructions to view your benefits and rates and make your elections.

When you have successfully submitted your elections, you may view or print a Confirmation Statement summarizing your choices.

Benefits Plan Rates

Each benefit plan has its own rate structure. The cost of each benefit for which you are eligible is displayed on Self Service > Benefits on Wolverine Access when you select Display Benefits Plan Rates, and when you enroll in benefits.

To view your 2026 benefits plan rates:

1. Go to **Wolverine Access**. Enter **Benefits** in the search bar and click **Search**.
2. Select the **Benefits Self-Service** tile.
3. Select the **Display Benefit Plan Rates** tile.

For the best viewing experience, use a laptop/computer or a large tablet.

Frequency of Deductions

You are responsible for making sure that your pay can cover the cost of the benefits you choose.

Bi-weekly

If you are paid bi-weekly and you participate in benefits plans, payroll deductions will be taken in equal installments from the first two paychecks each month. If there are three paychecks in a month, Retirement Savings Plan contributions are the only benefit deductions that will be taken from the third paycheck.

Monthly

If you are paid monthly, payroll deductions will be taken in one equal installment from each monthly paycheck.

Tax Information for Coverage of Other Qualified Adults

You'll pay the same amount for other qualified adult (OQA) coverage that you would pay for other eligible adult dependents. The contribution amount is determined according to the coverage selected. However, the Internal Revenue Service requires employers to report the value of any medical and dental coverage for other qualified adults and their children who do not satisfy the definition of a dependent under the Internal Revenue Code. As a result of this law, U-M must add to your compensation reported to the Internal Revenue Service the amount representing the fair market value of providing the medical and/or dental coverage for your other qualified adult less your after-tax contribution. You will pay tax on this imputed income. This amount is also subject to applicable income taxes, as well as FICA/FUTA.

If you marry your OQA, you must complete and submit a Dependent Information Form within 30 days of your marriage to report your change in relationship. The Dependent Information Form is available at myumi.ch/uhr-update-dep-info, and should be submitted to Shared Services Center - Benefits Transactions as indicated on the form. Call the Shared Services Center - HR Customer Care at (734) 615-2000 locally or toll-free at (866) 647-7657, or email sharedservices@umich.edu for questions on the Dependent Information Form. Because benefits provided to your legal spouse are not considered a taxable fringe benefit, you will no longer be subject to tax withholding for OQA coverage as of the date of your marriage.

Health Plans

The university offers a number of health plan options. These options differ in the benefit levels they provide, the doctors and hospitals you can use and the cost.

View more detailed information at hr.umich.edu/health_plans.

You may select your coverage from the following plans:

- U-M Premier Care, if eligible (service area restrictions)
- BCBSM Community Blue PPO
- Comprehensive Major Medical (CMM)
- BCBSM Consumer-Directed Health Plan with Health Savings Account
- GradCare, if eligible

Physician and Hospital Plan Participation

Participating physicians and participating hospitals are always subject to change. Contract renewal dates between medical plans and their doctors and hospitals vary, and renewal is optional for either party.

In the event your Primary Care Provider's (PCP's) affiliation ends midway through the calendar year, you will need to select another PCP within your plan's service area. You will not be able to change plans midyear due to a physician's or hospital's disaffiliation with your health plan. Before enrolling in a new medical plan, check the provider directory to make sure it includes a doctor and hospital of your choice. You can find provider information on the plan's website, or call the plan's customer service number for provider information.

U-M Premier Care

U-M Premier Care is administered by Blue Care Network (BCN) and offered only to the University of Michigan community.

U-M Premier Care has a two-tier provider network. U-M Premier Care network 1 providers are centrally located around Ann Arbor and neighboring areas. Network 1 is the preferred network of providers, facilities and other health care entities where you will receive the highest level of benefit.

There is no annual deductible for using network 1 providers. You must select a Primary Care Provider (PCP) located in Michigan from network 1.

U-M Premier Care network 2 is the BCN statewide participating provider network made up of providers, facilities and other health care entities that are not part of network 1.

There is an annual deductible when utilizing network 2 providers. A referral is necessary from your PCP to access a covered service from a provider in network 2.

Services received outside of network 1 or network 2 are not covered, except in the event of an emergency (refer to plan documents for details).

Consider the U-M Premier Care Plan if you:

- Would like a plan that lowers your overall medical costs
- Agree to choose from a list of approved physicians that includes Michigan Medicine providers
- Understand that you need a referral from your Primary Care Provider (PCP) if you need to see a specialist
- Agree to consult with your PCP for all services
- Live in the state of Michigan, or within Fulton, Lucas, Williams or Wood counties in Ohio

Important information for those living in or near Ohio:

Please note that this plan is a Michigan-based health plan. All providers, facilities and services are rendered in Michigan. You may not be able to receive services in your home, or durable medical equipment deliveries, if you live outside Michigan. **If you plan to use providers and hospitals outside Michigan, you must select one of the BCBSM health plans.**

U-M Premier Care Out-of-Area Dependent Coverage

U-M Premier Care provides coverage for members' dependents who reside outside the network service area and who qualify under existing eligibility guidelines.

Pre-certification is required for certain services. The member must register with U-M Premier Care to obtain approval for out-of-area dependent coverage.

BCBSM Community Blue PPO

The Community Blue PPO plan offers members the flexibility to see any provider throughout the U.S. without a referral, and with lower out-of-pocket costs when you use in-network providers. The plan is administered by Blue Cross Blue Shield of Michigan (BCBSM). Members are covered at the in-network benefit level when receiving care for approved services while outside the U.S., where no network is available. The PPO is the only plan that offers this enhanced level of coverage.

Consider a PPO if you:

- Would like a health plan that allows you to visit any in-network doctor or hospital without a referral
- Want the flexibility to use non-network providers, with higher out-of-pocket costs
- Agree to choose providers from a national network of providers for the greatest out-of-pocket savings
- Understand that in-network preventive services are covered, but out-of-network preventive services are not
- Live or travel outside Michigan
- Would like coverage within the U.S. and globally

Comprehensive Major Medical

The Comprehensive Major Medical plan (CMM), administered by Blue Cross Blue Shield of Michigan, offers comprehensive benefits with a wide selection of providers and lower monthly contributions, but requires more out-of-pocket expense at the time of care. As a member you are free to use any provider you choose, including specialists, though you will pay less out-of-pocket if you use a participating Blue Cross Blue Shield (BCBS) provider.

Consider the Comprehensive Major Medical Plan if you:

- Want a plan with a lower rate and less financial risk than the CDHP
- Want a plan that provides comprehensive coverage at a lower monthly rate, but requires more out-of-pocket costs at the time of service
- Would like to use Blue Cross Blue Shield participating providers and access to non-contracted providers with additional out-of-pocket costs
- Want coverage within the U.S. and globally
- Would like a plan with flexible provider choices, but don't mind paying an annual deductible and coinsurance for services

Consumer-Directed Health Plan

The university offers a Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA).

The CDHP covers the same medical services as other plans, including no out-of-pocket costs for preventive care and screenings. You have access to a national network of PPO providers and, after the deductible is met, you will pay coinsurance for all medical services.

If you are generally healthy and don't need to visit your health care provider often, choosing the CDHP may save you money.

- While the CDHP has the lowest premium cost, by selecting the plan, you take on more financial risk — a higher deductible and out-of-pocket limit.
- If you get sick or injured and need significant medical care, you'll likely pay more out-of-pocket than you would with other U-M health plans.
- Financial hardship created from the costs for the deductible and out-of-pocket maximum is not a qualifying event to change plans.

When paired with a Health Savings Account (HSA), the CDHP provides flexibility in how you spend and save for your health care. With an HSA, you can put away money for future health care costs while saving on taxes.

2026		
	Individual	Family
In-Network Deductible (aggregate*)	\$1,700	\$3,400
Out-of-Network Deductible (aggregate*)	\$1,700	\$3,400
In-Network Out-of-Pocket Max**	\$5,500	\$10,600
Out-of-Network Out-of-Pocket Max**	\$11,000	\$21,200
HSA U-M Contribution	\$850	\$1,700
Health Savings Account Maximum Contribution	\$4,400	\$8,750
HSA over 55 Catch-up Maximum Contribution	\$1,000	\$1,000

* The entire family deductible must be satisfied, by one or any combination of the family members, before the plan begins to pay.

** In-network and out-of-network services accumulate separately towards the associated deductible and out-of-pocket maximum.

CDHP limits are adjusted annually based on IRS requirements for HSA and high-deductible health plans.

Consider the Consumer-Directed Health Plan if you:

- Want lower monthly deductions from your paycheck in exchange for higher out-of-pocket costs at the time of care
- Can afford to cover the deductible and out-of-pocket maximum if an unexpected medical expense arises
- Want flexibility in how you spend and save for your health care
- Are generally healthy and do not have significant, ongoing medical needs or costs
- Want pre-tax savings to pay for eligible medical expenses with an HSA
- Want a health care emergency safety net

Eligibility Requirements

Due to the unique tax advantages of Health Savings Accounts (HSAs), which are governed by the Internal Revenue Service (IRS), certain circumstances prevent you from enrolling. You must meet the following eligibility requirements:

- You ARE enrolled in the BCBSM Consumer-Directed Health Plan
- You MUST HAVE a Social Security number (SSN)
- You are NOT claimed as a dependent on someone else's tax return
- You are NOT covered under any other non-High Deductible Health Plan coverage
- You have NOT received any medical benefits (excluding dental, vision or preventive) during the previous three months from:
 - » The Indian Health Service (IHS)
 - » The US Department of Veterans Affairs (VA) except for treatment for a service-connected disability

Members living in Canada or other countries with government-funded health care should consult with a qualified tax advisor before selecting the CDHP with HSA, as there are tax implications associated with the HSA. Review the 2026 Health Plan Coverage Comparison Chart for plan options.

The HSA is managed by HealthEquity, a health savings company. For more information on the CDHP and eligibility requirements please visit hr.umich.edu/cdhp.

IMPORTANT: If you enroll in the CDHP and currently have a Health Care FSA, you must spend your remaining balance AND have all claims processed with \$0 in your account by Dec. 19, 2025. Otherwise, you will not be eligible for HSA contributions until April 1, 2026.

Not sure if the CDHP is right for you?

- Review the Frequently Asked Questions web page (myumi.ch/uhr-CDHP-FSA-FAQ)
- Visit Benefits Mentor (hr.umich.edu/benefits-mentor)

GradCare

GradCare, administered by Blue Care Network (BCN), is a health plan exclusively for Graduate Student Instructors, Graduate Student Staff Assistants and Graduate Student Research Assistants.

Consider GradCare if you:

- Want a plan with low out-of-pocket costs
- Want to use U-M Premier Care Network 1 physicians
- Understand that when you are in the GradCare service area, you must use your network Primary Care Provider and get a referral if you need to see a specialist
- Understand that out-of-network, non-emergency services will not be available to you unless you receive special permission from the plan

hr.umich.edu/health-plans

2026 Health Plan Profiles

Plan Type	Managed Care (HMO) Plans	
Plan Name	U-M Premier Care Provider Network 1	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups
Plan Administrator	Blue Care Network	Blue Care Network
Service Area	Genesee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties	Genesee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties
Residency Requirement	Must reside in Michigan or within Fulton, Lucas, Williams or Wood counties in Ohio ²	Level 1 and continuance: U-M academic campus
Coverage when Traveling Outside of the Service Area	Limited to urgent and emergency care outside of the service area (including global travel). Copay may apply.	Participant is responsible for charges above BCN fee schedule. Prior authorization required. Must be medically necessary.
PCP Selection Required	Yes	Yes
Health Care Flexible Savings Account (FSA) Compatibility	Compatible	Compatible
Health Savings Account (HSA) Compatibility	Not compatible	Not compatible
Customer Service and Provider Directory	800-658-8878	800-658-8878
Number of U-M Members Enrolled in Each Plan	62,214	7,716
Number of PCPs in the Network	3,280	3,280
Number of Specialists	30,831	30,831
Number of Hospitals	40	40
Percentage of Board Certified PCPs	98%	98%
Percentage of Board Certified Specialists	97%	97%
Website	bcbsm.com	bcbsm.com
Address	20500 Civic Center Dr. Southfield, MI 48076	20500 Civic Center Dr. Southfield, MI 48076
Group Number	001243160001	001243160002

1 For members living in Canada, or where government funded health care is provided, before selecting the CDHP with HSA, consult with a qualified tax advisor for information on tax implications associated with the HSA.

2 This is a Michigan-based health plan. All providers, facilities and services are rendered in Michigan. If you plan to use Ohio providers please select a BCBSM health plan.

Preferred Provider Organization (PPO)	Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO	Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
Blue Cross Blue Shield Michigan	Blue Cross Blue Shield Michigan	Blue Cross Blue Shield Michigan
Nationwide/Worldwide	Nationwide/Worldwide	Nationwide/Worldwide
Within the U.S.	Within the U.S.	Within the U.S.
Covers non urgent and non emergency care outside of the service area (including global travel when pre-approved). Copay may apply.	Covers non urgent and non emergency care outside of the service area (including global travel when pre-approved). Copay may apply.	Covers non urgent and non emergency care outside of the service area (including global travel when pre-approved). Copay may apply.
No	No	No
Compatible	Compatible	Limited Purpose FSA only
Not compatible	Not compatible	Compatible ¹
855-669-8040	855-669-8040	855-669-8040
18,004	7,278	2,905
National network.	National network.	National network.
National network.	National network.	National network.
National network.	National network.	National network.
National network.	National network.	National network.
National network.	National network.	National network.
bcbsm.com	bcbsm.com	bcbsm.com
600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226
007005187	007005187	007005187

2026 Health Plan Coverage Comparison Chart

This chart is not intended to be a full description of coverage. The complete plan description is contained in the appropriate certificate of coverage or plan document issued by each plan. Every effort has been made to ensure the accuracy of this chart. If statements in this chart differ from applicable plan documents then the terms and conditions

of those documents prevail. This chart assumes all services are provided by a participating medical care provider when required. All benefits are subject to change. Contact the health plan for detailed information about benefit coverage and medical necessity requirements.

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)	
Plan Name	U-M Premier Care Provider Network 1 ²	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups	BCBSM Community Blue PPO	
			In-Network	Out-of-Network
General Information				
Deductible	\$0 for Network 1	\$0		\$0
Annual Out-of-Pocket Maximum	\$3,000 individual \$6,000 family ⁴	\$3,000 individual \$6,000 family ⁴	\$3,000 individual \$6,000 family (in-network) ⁴	\$5,000 individual \$10,000 family (out-of-network) ⁴
Lifetime Maximum Benefit	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	Not covered
Important Information About the Terms Used in This Chart	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service. ^{2,6}	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means the set dollar amount you pay for a covered service. ^{2,6}	Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.
Preauthorization Required	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	
Preventive Services^{7,8}				
Routine Physical Exams	Covered	Covered	Covered	Not covered
Routine Pediatric Exams	Covered	Covered	Covered	Not covered
Routine Immunizations	Covered	Covered	Covered	Not covered
Cervical Cancer Screen	Covered	Covered	Covered	Not covered
Breast Cancer Screen	Covered	Covered	Covered	Not covered
Prostate Cancer Screen	Covered	Covered	Covered	Not covered

2 Coverage described applies to the U-M Premier Care Provider Network 1. Network 2 providers (BCN statewide network) are covered with a \$2,000-individual \$4,000-family annual deductible. A Network 1 PCP referral is required to access Network 2 providers.

3 Deductible and out-of-pocket is medical and pharmacy combined.

4 The out-of-pocket maximum does not include non-covered charges, and costs that exceed the plan's allowed amount for a particular service for all plans.

5 In-network and out-of-network services accumulate separately toward the associated deductible and out-of-pocket maximum.

Traditional Plan	Consumer-Directed with Health Savings Account	
Comprehensive Major Medical	Consumer-Directed Health Plan	
	In-Network	Out-of-Network
\$500 individual \$1,000 family	\$1,700 individual \$3,400 family ³	\$1,700 individual \$3,400 family ^{3,5}
\$3,000 individual \$6,000 family ⁴	\$5,500 individual \$10,600 family ^{3,4}	\$11,000 individual \$21,200 family ^{3,4,5}
\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	Not covered
Partially covered means you pay a \$500/\$1,000 deductible, then 20% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.	Partially covered means you pay a \$1,700/\$3,400 ³ deductible then 10% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.	Partially covered means you pay a \$1,700/\$3,400 ³ deductible then 50% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.
Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	
Covered	Covered	Not covered
Covered	Covered	Not covered
Covered	Covered	Not covered
Covered	Covered	Not covered
Covered	Covered	Not covered
Covered	Covered	Not covered

6 Copays may differ for individuals represented by a union.

7 Preventive Services as recommended under the Affordable Care Act.

8 Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills the plan for the preventive services separately from the office visit.

2026 Health Plan Coverage Comparison Chart

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)	
Plan Name	U-M Premier Care Provider Network ^{1,2}	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups	BCBSM Community Blue PPO	
			In-Network	Out-of-Network
Hospital Services — Inpatient				
Hospital Admissions	Covered	Covered	Covered	Covered at 50%
Days of Care	Unlimited days	Unlimited days	Unlimited days	
Room Type	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	
Hospital Physician Service	Covered	Covered	Covered	Covered at 50%
Consultation Between Physicians	Covered	Covered	Covered	Covered at 50%
Surgery	Covered	Covered	Covered	Covered at 50%
Outpatient Services				
Office Visits	\$25 copay for PCP \$30 copay for specialist	\$25 copay for PCP \$30 copay for specialist	\$25 copay for PCP \$30 copay for specialist	Covered at 50%
Outpatient Physical, Occupational and Speech Therapy ⁹	\$25 copay per visit; limited to a combined 60 visits per condition per year	\$25 copay per visit; limited to a combined 60 visits per condition per year	\$25 copay per visit; limited to a combined 60 visits per year	Covered at 50% ; limited to a combined 60 visits per year
Applied Behavioral Analysis for ASD	\$25 copay per visit	\$25 copay per visit	\$25 copay per visit	Covered at 50%
Therapeutic Radiology	Covered	Covered	Covered	Covered at 50%
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered	Covered at 50%
Outpatient Surgery	Covered	Covered	Covered	Covered at 50%
Allergy Testing	\$30 copay	\$30 copay	\$30 copay	Covered at 50%
Injections ¹⁰	Covered	Covered	Covered	Covered at 50%

2) Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a \$2,000 individual, \$4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

9 Physical, occupational, and speech therapies are covered for acute conditions and may be subject to plan prior authorization/medical necessity. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.

10 Provider may charge office visit when receiving an injection.

Traditional Plan	Consumer-Directed with Health Savings Account	
Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan	
	In-Network	Out-of-Network
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Unlimited days	Unlimited days	
Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible; unlimited visits	10% coinsurance after deductible; limited to a combined 60 visits per year	50% coinsurance after deductible; limited to a combined 60 visits per year
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible

2026 Health Plan Coverage Comparison Chart

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)	
Plan Name	U-M Premier Care Provider Network 1 ²	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups	BCBSM Community Blue PPO	
			In-Network	Out-of-Network
Emergency Care				
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	
Emergency Department	\$100 copay copay waived if admitted	\$100 copay copay waived if admitted	\$100 copay copay waived if admitted	
Observation Stay	\$100 ER copay. All services provided while in observation are covered at the outpatient benefit level	\$100 ER copay. All services provided while in observation are covered at the outpatient benefit level	\$100 ER copay. All services provided while in observation are covered at the outpatient benefit level	
Mental Health Care				
Inpatient Days of Care	Covered	Covered	Covered	Covered at 50%
Outpatient Individual Therapy	\$25 copay	\$25 copay	\$25 copay	Covered at 50%
Group Therapy	\$25 copay	\$25 copay	\$25 copay	Covered at 50%
Psychological Testing	\$25 copay	\$25 copay	\$25 copay	Covered at 50%
Substance Use Care				
Inpatient Days of Care	Covered	Covered	Covered	Covered at 50%
Outpatient Individual Therapy	\$25 copay	\$25 copay	\$25 copay	Covered at 50%
Group Therapy	\$25 copay	\$25 copay	\$25 copay	Covered at 50%

² Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a \$2,000 individual, \$4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

Traditional Plan	Consumer-Directed with Health Savings Account	
Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan	
	In-Network	Out-of-Network
20% coinsurance after deductible when medically necessary.	10% coinsurance after deductible when medically necessary	
20% coinsurance after deductible	10% coinsurance after deductible	
20% coinsurance after deductible. All services provided while in observation are covered at the outpatient benefit level	10% coinsurance after deductible. All services provided while in observation are covered at the outpatient benefit level	Emergency room coinsurance applies. All services provided while in observation are covered at the outpatient benefit level, 50% coinsurance after deductible.
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible

2026 Health Plan Coverage Comparison Chart

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)	
Plan Name	U-M Premier Care Provider Network ²	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups	BCBSM Community Blue PPO	
			In-Network	Out-of-Network
Maternity Care				
Prenatal and Postnatal Care ¹¹	Covered	Covered	Covered	Covered at 50%
Delivery	Covered	Covered	Covered	Covered at 50%
Skilled Nursing Facility				
Non-Custodial Care	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year	
Hearing Services¹²				
Examinations	\$30 copay; once every 36 months	\$30 copay; once every 36 months	Covered; once every 36 months	Not covered
Tests	\$30 copay; once every 36 months	\$30 copay; once every 36 months	Covered; once every 36 months	Not covered
Hearing Aids ¹³	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Not covered
Vision Care				
Eye Examinations	Covered. One exam per year. Out-of-network providers covered up to \$40. Dilation not covered	Covered. One exam per year. Out-of-network providers covered up to \$40. Dilation not covered	Covered; one exam per year. Dilation not covered	Covered up to \$40; one exam per year. Dilation not covered.
Eyeglasses	Not covered	Not covered	Not covered	

2 Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a \$2,000 individual, \$4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

11 When billed as a preventive visit.

12 Hearing aid administration guidelines may differ by plan. Contact plan for specific provisions before commencing treatment.

13 Includes ordering and fitting of hearing aids.

Traditional Plan	Consumer-Directed with Health Savings Account	
Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan	
	In-Network	Out-of-Network
Covered	Covered	50% coinsurance after deductible
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
20% coinsurance after deductible. Up to 120 days per calendar year	10% coinsurance after deductible. Up to 120 days per calendar year	
20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months	Not covered
20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months	Not covered
20% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	10% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Not covered
20% coinsurance after deductible; one exam per year. Dilation not covered	10% coinsurance after deductible; one exam per year. Dilation not covered	50% coinsurance after deductible up to \$40; one exam per year. Dilation not covered.
Not covered	Not covered	Not covered

2026 Health Plan Coverage Comparison Chart

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)	
Plan Name	U-M Premier Care Provider Network ²	GradCare Only available to GSIs, GRAs, med students and sponsored grad student groups	BCBSM Community Blue PPO	
			In-Network	Out-of-Network
Home Health Services				
Home Health Care	Covered	\$30 copay	Covered	Covered
Private Duty Nursing	Not covered	Not covered	30% coinsurance	Covered at 50%
Other Services				
Hospice Care	Covered	Covered	Covered	Covered
Durable Medical Equipment, Orthotics, Prosthetic Appliance	Covered when authorized by the plan	Covered when authorized by the plan	Covered when medically necessary	Not covered
Voluntary Sterilization	Covered	Covered	Covered	Covered at 50%
Chiropractic Spinal Manipulation	\$25 copay limited to 24 visits per year	Not covered	\$25 copay limited to 24 visits per year	Covered at 50%; limited to 24 visits per year
Gender Affirming Services	\$30 copay	\$30 copay	\$30 copay	Covered at 50%
Infertility Treatment	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000 across all U-M health plans. Contact plan for details	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000 across all U-M health plans. Contact plan for details	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000 across all U-M health plans. Contact plan for details	Not covered ¹⁴

² Coverage described applies to the U-M Premier Care Provider Network. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a \$2,000 annual deductible for individual, \$4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

¹⁴ Contact the health plan if you live outside of Michigan.

Traditional Plan	Consumer-Directed with Health Savings Account	
Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan	
	In-Network	Out-of-Network
20% coinsurance after deductible	10% coinsurance after deductible	
30% coinsurance after deductible	10% coinsurance after deductible.	50% coinsurance after deductible
Covered	10% coinsurance after deductible	
20% coinsurance after deductible	10% coinsurance after deductible	
Covered	Covered after deductible	50% coinsurance after deductible
20% coinsurance after deductible, limited to 38 visits per calendar year	10% coinsurance after deductible, limited to 24 visits per year	50% coinsurance after deductible, limited to 24 visits per year
20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000 across all U-M health plans. Contact plan for details ¹⁴	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000 across all U-M health plans. Contact plan for details	Not covered ¹⁴

Prescription Drug Plan

Prime Therapeutics Administers This Plan

The university provides a Prescription Drug Plan administered by Prime Therapeutics for everyone enrolled in a U-M health plan. The prescription drug copay varies based on several factors: whether the drug is a generic, a preferred brand, or a non-preferred brand, and whether it is dispensed by a retail pharmacy or the mail-order pharmacy.

For more information on the U-M Prescription Drug Plan and the mail-order pharmacy service, see hr.umich.edu/prescription-drug-plan.

Eligibility and Enrollment

- When you enroll in a university health plan, you will be concurrently enrolled in the U-M Prescription Drug Plan.
- In both your health and prescription drug plans, your coverage will be at the same level (You Only, You + Adult, etc.) and for the same named dependents.
- You cannot elect the U-M Prescription Drug Plan without enrolling in a U-M health plan.

Plan Features

The U-M Prescription Drug Plan provides a consistent benefit and scope of coverage for all members, including:

- **Access to local and national chain pharmacies.** Up to 90-day supplies are available for many medications. Participants can fill prescriptions for one- to 34-day supplies for one copay, 35- to 60-day supplies for two copays, or 61- to 90-day supplies for three copays.
- **Mail-order pharmacy** is an alternative to retail pharmacies for prescriptions filled in 90-day supplies. Use of the mail-order service is optional and may result in savings to you. Orders are mailed to your home in secure packaging. This is particularly convenient for participants who take certain medications on an ongoing basis. Call (877) 269-1160 or visit hr.umich.edu/mailorder.
- **Diabetic insulin, needles, and syringes** are available to all participants in the U-M Prescription Drug Plan. Select insulin products (see the formulary at hr.umich.edu/formulary), needles and syringes are covered at \$0 copay for all members.
- **Coverage of diabetic supplies** (injection devices, alcohol swabs, testing strips, lancets, and blood glucose testing monitors) is determined by your health plan.

U-M Prescription Drug Plan ID Cards

Prescription drug ID cards are the same across all health plans. If you need additional cards for dependents, or a replacement for a lost card, please call Prime Therapeutics at (888) 272-1346. Prescription drug ID cards from Prime Therapeutics are the same across all health plans.

hr.umich.edu/prescription-drug-plan

Terms You Need to Know

Formulary—A formulary is a list of available prescription drugs offered by the plan to serve the pharmaceutical needs of patients requiring self-administered drug therapy on an outpatient basis. In addition, there may be drugs covered but not listed on the formulary. Inclusions (or exclusions) of drugs on the formulary are determined by the clinical judgment of a committee of University of Michigan physicians and pharmacists based on published medical evidence regarding diagnosis and treatment of disease. Drug lists are subject to change. The U-M formulary can be viewed at: hr.umich.edu/formulary.

Generic Drugs (Tier 1)—The generic drug copay level offers the opportunity to take advantage of generic drug savings. Generics cost significantly less on average than their counterpart brand-name drugs. Generic drugs are approved by the U.S. Food and Drug Administration (FDA), contain the same active ingredients as their brand-name equivalents, and must meet the same safety, production and performance standards. Therefore, generic drugs often offer an effective and safe alternative to help reduce prescription drug costs for both you and the University of Michigan. Approximately 77% of all prescriptions under the U-M Prescription Drug Plan are dispensed as generic Tier 1 drugs.

Preferred Brand-Name Drugs (Tier 2)—Brand-name drugs are patent-protected and product-trademarked. After the patent ends, a generic equivalent can be manufactured and made available as a lower-cost alternative. For each drug class (e.g., cardiovascular, depression), there may be several drugs produced by different manufacturers that are equivalent in therapeutic value. Each of these drugs may have a different price.

Preferred brand-name drugs are selected on the basis of therapeutic effectiveness, safety and cost relative to other generic and brand-name drugs used to treat the same conditions. Physicians are encouraged, but not required, to prescribe preferred drugs when appropriate for the patient's condition. Approximately 8% of all prescriptions dispensed are at Tier 2.

Non-Preferred Brand-Name Drugs (Tier 3)—Drugs on the third copay tier are FDA-approved drugs that a committee of university physicians and pharmacists have designated as “non-preferred” and are subject to a higher copay and may have a product selection penalty. These products often are in drug classes that may include several similar alternative brand-name or generic options. Brand-name products with generic equivalents will automatically be placed in Tier 3. Approximately 3% of all medications are dispensed as non-preferred drugs.

Select medications for participants as defined by the Affordable Care Act with a prescription from your doctor are covered at \$0 copay when you use your prescription drug benefit at a network retail pharmacy or mail-order pharmacy. Approximately 11% of all prescriptions under the U-M Prescription Drug Plan are dispensed with a \$0 copay.

Specialty Drugs are processed by the University of Michigan Health Specialty Pharmacy—A “specialty drug” is a prescription drug that is either a self-administered injectable medication, a medication that requires special handling, special administration or monitoring, or is a high-cost oral medication. Up to a 34-day supply per fill may be covered. Prescriptions for immunosuppressive and antiretroviral specialty medications are covered up to a 90-day supply. More information is available at hr.umich.edu/prescription-drug-plan or call the Michigan Medicine Specialty Pharmacy's toll-free number, (855) 276-3002.

hr.umich.edu/prescription-drug-plan

2026 Prescription Drug Plan Copays⁴

Drug Type	Retail Pharmacy Copay ^{1, 2, 3}			Mail Order Copay ^{1, 2, 3}
	1- to 34-day supply	35- to 60-day supply	61- to 90-day supply	
Generic Drugs/Tier 1	\$10	\$20	\$30	Up to 90-day supply (Compare to 61- to 90-day supply at Retail Pharmacy)
Preferred Brand-Name Drugs/Tier 2	\$20	\$40	\$60	\$40
Non-Preferred Brand-Name Drugs/Tier 3	\$75	\$150	\$225	\$150

- 1 If the retail price of a covered medication is less than the tier copay, you pay only the cost of the medication. If the cost of the covered medication is more than the copay, you pay only the copay. The member always pays the full cost for prescriptions that are not covered by the plan.
- 2 Catastrophic coverage for prescription drugs goes into effect after the out-of-pocket maximum of \$2,500 per individual coverage or \$5,000 per family per year is met. Catastrophic coverage applies only to covered prescription drugs and does not include product selection penalties or health plan expenses such as physician office visits.
- 3 Member cost may be higher than the copay if a brand-name drug is selected when a generic equivalent is available.
- 4 Copays for union members may differ based on their collective bargaining agreement.

What's New

Dental Plan Annual Benefit Maximum Increased

- **What is changing?** The Dental Plan annual maximum benefit will increase to \$1,500.
- **What does this mean?** Beginning Jan. 1, 2026, individuals enrolled in Option 2 and Option 3 may have more coverage for dental services requiring more extensive treatment.

For more information review the Dental Plan Comparison Chart on pages 28-29.

Three Dental Plan Options Available

You can choose from three dental plan options. All three options provide coverage for preventive care and orthodontic services. Option 1 does not cover restorative or major services; however, members will pay a discounted rate for these services when they use a Delta PPO or Delta Premier participating dentist.

If you enroll in Options 2 or 3, Delta will pay toward restorative and major services. Even greater savings are reached by using a Delta PPO or Delta Premier participating dentist. Please refer to the benefit comparison chart for information about benefit levels and covered services. For details on coverage and limitations of the plan, see the Delta Dental certificate of coverage that is available for download from hr.umich.edu/dental-plan.

If you select Option 1, there is no monthly dental contribution for coverage for you and your enrolled eligible dependents. The university pays the full cost. You may elect Option 2 or Option 3 for yourself and your dependents; however, you pay the cost difference between the university contribution for Option 1 and the costs for the other plans.

What is Delta Dental PPO (Point-of-Service)?

Delta Dental of Michigan provides dental coverage for eligible University of Michigan faculty, staff, retirees, and graduate students. Delta Dental (Point-of-Service) is a national program that gives members access to two of the largest networks of participating dentists in the country: the Delta Dental PPO network and the Delta Dental Premier network. Members can visit any licensed dentist, but they can save money by choosing a Delta Dental PPO dentist.

How Does the Delta Dental PPO Point-of-Service Work?

The Delta Dental PPO Point-of-Service plan offers two provider networks: Delta Dental PPO and Delta Dental Premier. Your out-of-pocket costs are likely to be lower if you go to a Delta Dental PPO participating dentist. PPO dentists have agreed to accept payment according to a schedule established by Delta Dental, and, in most cases, this results in a reduction of their fees. Delta Dental also pays a higher percentage for most covered services if you go to a PPO dentist.

If your dentist is not a PPO dentist, you will have back-up coverage through Delta Dental Premier. Again, your out-of-pocket expenses will vary depending on the participating status of the dentist. Your coverage levels will be slightly lower in most cases, but you can still save money.

What Are the Advantages of Choosing a Delta Dental PPO Dentist?

- Delta Dental will pay the PPO dentist directly for covered services based on his or her submitted fee or the amount in the local Delta Dental's PPO dentist schedule, whichever is less.
- If the PPO dentist schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a PPO dentist for covered services (see the coverage comparison chart).
- PPO dentists will also fill out and file your claim forms.

What Are the Advantages of Choosing a Delta Dental Premier Dentist?

- Delta Dental will pay the Premier dentist directly for covered services based on his or her submitted fee or the local Delta Dental maximum approved fee, whichever is less.
- If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference. As with PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services (see the coverage comparison chart).
- Like PPO dentists, Premier dentists will fill out and file your claim forms for you.

What if I Go to a Nonparticipating Dentist?

- If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier, you will still be covered (see the coverage comparison chart). However, you could save more of your out-of-pocket expenses if you go to a dentist that participates with Delta Dental.
- Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever they charge.

How Can I Find a Participating Dentist?

- To find the names of participating dentists near you, view a Delta Dental dentist directory on Delta Dental's website at deltadentalmi.com/Member/Using-Your-Benefits/Find-a-Dentist.
- You can call Delta Dental's Customer Service department toll-free at (800) 524-0149.
- Delta's DASI (Delta's Automated Service Inquiry) system is available 24-hours-a-day, seven-days-a-week, and can provide you with a list of participating dentists.
- You can also speak to a customer service representative at any time during normal business hours (Monday through Friday from 8:30 a.m. to 8 p.m. Eastern Time).

Does the University of Michigan School of Dentistry Participate with Delta Dental?

The University of Michigan School of Dentistry's Community Dental Center provides dental services to the general public and participates with Delta Dental for insurance coverage. To confirm the Delta network participation level, contact the Dental School Patient Business Office at (734) 647-8383.

Rates

View your monthly dental plan rates on Wolverine Access at wolverineaccess.umich.edu.

ID Card

Delta Dental does not require ID cards. When visiting a Delta Dental dentist, simply provide your eight-digit UMID number or your Social Security number. The dental office can use that information to verify your eligibility and benefits through Delta Dental's website or toll-free number. If you still would like an ID card, you can print a customized ID card on demand using Delta Dental's online member portal.

How Does Delta Dental Coordinate Coverage with Another Plan When Delta is the Secondary Payer?

Delta Dental bases payment on the amount they approve using the maximum approved fee or PPO dentist schedule according to the dentist's participating status. Delta will pay the balance of that amount after the primary payment or the amount they would pay as primary, whichever is less. The two programs together will not pay more than 100% of covered expenses. A Delta participating dentist cannot bill the patient for any difference between the amount charged and the amount Delta approves.

Preauthorization

Whenever you have a question about whether a dental procedure will be covered, you and/or your dentist should contact your dental plan before you begin treatment. Your dentist should contact Delta Dental and request a pre-authorization of covered benefits any time your dental work is expected to exceed \$200.

Where Can I Find Additional Information Regarding the Dental Plan?

Several resources are available to view what your dental plan covers:

- Refer to the Dental Plan web page at hr.umich.edu/dental-plan.
- Call Delta Dental's Customer Service department at (800) 524-0149.
- Register and log on to Delta Dental's Member Portal. View the next page for instructions about how to access and use the portal.

Manage Your Dental Plan Online With Member Portal

Delta Dental Member Portal gives you easy, secure online access to your benefits information 24/7. Use this free service if you have Delta Dental dental benefits for:

- Eligibility. Review your specific benefits, including eligibility for dependents.
- Up-to-date benefit information. View current information about your benefits, such as how much of your annual maximum has been used to date, how much is still available to use, and levels of coverage for specific dental services.
- Claims information. Review specific claims transactions, reimbursements, payments and pre-treatment estimates. You can also print a copy of your Explanation of Benefits (EOB) statements.
- ID Cards. Print a copy of your ID card to give to your dentist. Please note that ID cards are not required and do not verify eligibility, although many dental offices like to keep a copy on file.
- Paperless EOBs. Sign up for paperless delivery of your EOB statements.
- Dentist search. Search for participating dentists near you.

The site also allows you to find participating providers and print claim forms, as well as your personalized member ID card.

Log in to Member Portal at memberportal.com/mp/delta/

Summary of Dental Plan Benefits

IMPORTANT

This chart is intended to provide basic information about services covered by the University of Michigan Dental Plan. It is not intended to be a full description of the plans offered by the University of Michigan. If you choose a dentist who does not participate in either the PPO or Premier program, you will be responsible for any difference between Delta Dental's allowed fee and the dentist's submitted fee, in addition to any applicable copayment or deductible. Other limitations and exclusions apply. For additional details on how claims are paid, exclusions, and limitations for the dental program, visit hr.umich.edu/dental-plan.

Delta Dental PPO (Point-of-Service) Program									
University of Michigan Group No. 5970	Option 1			Option 2			Option 3		
Sub Group Numbers: Active Employees	1001			2001			3001		
Sub Group Numbers: LTD, COBRA, Retirees & Survivors	1099			2099			3099		
Delta Dental Network Participation Level	PPO	Premier	NonPar	PPO	Premier	NonPar	PPO	Premier	NonPar
CLASS I									
Diagnostic and Preventive Services —Used to diagnose and/or prevent dental abnormalities or disease. Includes prophylaxes, including periodontal prophylaxes, and routine oral examinations/evaluations payable twice in a calendar year. (People with certain high-risk medical conditions or with a documented history of periodontal disease may be eligible for two additional prophylaxes.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Radiographs —Including one set of bitewing x-rays in a calendar year and either a panoramic film or one set of full mouth x-rays once in any five-year period.	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sealants —Sealants are payable on permanent bicuspid and molars once per tooth up to age 16.	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatment —Preventive fluoride treatments are payable twice in a calendar year for people up to age 19. (People over age 19 with certain high-risk medical conditions may be eligible for additional prophylaxes or fluoride treatment.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Space Maintainers —Space maintainers are payable for people up to age 19.	100%	100%	100%	100%	100%	100%	100%	100%	100%
CLASS II									
*Emergency Palliative Treatment —Used to temporarily relieve pain.	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Occlusal Guards —Payable once in a five-year period.	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Periodontal Scaling & Root Planing	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Periodontal Maintenance —Two additional prophylaxes or periodontal maintenance procedures will be covered for individuals with a documented history of periodontal disease. (No more than four prophylaxes [cleanings] and/or periodontal prophylaxes or maintenance procedures will be payable in a calendar year.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
All Other Periodontics —Used to treat diseases of the gums and supporting structures of the teeth.	0%	0%	0%	100%	60%	60%	100%	100%	100%
Oral Surgery —Extractions and dental surgery, including preoperative and postoperative care.	0%	0%	0%	100%	60%	60%	100%	100%	100%
Minor Restorative Services —Used to repair teeth damaged by disease or injury (for example, fillings).	0%	0%	0%	100%	60%	60%	100%	100%	100%
Endodontics —Used to treat teeth with diseased or damaged nerves (for example, root canals).	0%	0%	0%	100%	60%	60%	100%	100%	100%

*Emergency Palliative, Periodontal Maintenance, Scaling & Root Planing, and Occlusal Guard benefits are exempt from the Class II and III calendar year deductible and \$1,500 calendar year maximum.

Summary of Dental Plan Benefits

IMPORTANT

This chart is intended to provide basic information about services covered by the University of Michigan Dental Plan. It is not intended to be a full description of the plans offered by the University of Michigan. If you choose a dentist who does not participate in either the PPO or Premier program, you will be responsible for any difference between Delta Dental's allowed fee and the Dentist's submitted fee, in addition to any applicable copayment or deductible. Other limitations and exclusions apply. For additional details on how claims are paid, exclusions, and limitations for the dental program, visit hr.umich.edu/dental-plan.

Delta Dental PPO (Point-of-Service) Program									
University of Michigan Group No. 5970	Option 1			Option 2			Option 3		
Sub Group Numbers: Active Employees	1001			2001			3001		
Sub Group Numbers: LTD, COBRA, Retirees & Survivors	1099			2099			3099		
Delta Dental Network Participation Level	PPO	Premier	NonPar	PPO	Premier	NonPar	PPO	Premier	NonPar
CLASS III									
Major Restorative Services —Used when teeth can't be restored with another filling material (for example, crowns).	0%	0%	0%	50%	40%	40%	50%	50%	50%
Prosthodontics Services —Used to replace missing natural teeth (for example, bridges, endosteal implants, and dentures).	0%	0%	0%	50%	40%	40%	50%	50%	50%
Relines —Relines and rebase to dentures.	0%	0%	0%	50%	40%	40%	50%	50%	50%
Prosthodontic Repairs —Repairs to bridges and dentures.	0%	0%	0%	50%	40%	40%	50%	50%	50%
TMD Treatment —Used by dentists to relieve oral symptoms associated with malfunctioning of the temporomandibular joint (for example, an occlusal orthotic TMD device).	0%	0%	0%	50%	40%	40%	50%	50%	50%
CLASS IV									
Orthodontic Services (to age 19)	50%	50%	50%	50%	50%	50%	50%	50%	50%
DEDUCTIBLES AND PLAN									
Calendar Year and Lifetime Maximum Payable Benefits	<ul style="list-style-type: none"> There is no calendar year maximum dollar amount applied to covered Class I and II services under Option 1. A \$1,500 per person total lifetime maximum applies to covered orthodontic Class IV Benefits. This is a combined maximum under all plan options, even if you change dental plan options from year to year. 			<ul style="list-style-type: none"> \$1,500 per person total per calendar year for covered Class II and Class III Benefits, except as noted below.* The calendar year maximum does not apply to Class I or Class IV Benefits. A \$1,500 per person total lifetime maximum applies to covered orthodontic Class IV Benefits. This is a combined maximum under all plan options, even if you change dental plan options from year to year. A \$1,000 per person total lifetime maximum applies to covered TMD Benefits. This is a combined maximum under Option 2 and 3, even if you change dental plan options from year to year. 					
Calendar Year Deductible	None			\$50 per person per calendar year limited to a maximum deductible of \$150 per family. Applies to Class II and Class III Benefits, except as noted below.* The deductible does not apply to Class I or Class IV Benefits.					

*Emergency Palliative, Periodontal Maintenance, Scaling & Root Planing, and Occlusal Guard benefits are exempt from the Class II and III calendar year deductible and \$1,500 calendar year maximum.

Dental Care Outside the United States

When you enroll in the U-M Delta Dental plan, you can receive dental care outside the U.S. through Delta's Passport Dental program.

With Passport Dental, Delta Dental enrollees can receive expert dental care when they are outside the U.S. through the AXA Assistance worldwide network of dentists and dental clinics.

How to Find a Dentist

When outside the U.S., call AXA Assistance collect at (312) 356-5971 to receive a referral through an English-speaking operator. The operators are available 24/7. Enrollees must identify themselves as Delta Dental enrollees when they call. When in the U.S., call Delta Dental at (800) 524-0149.

What Dental Services are Covered

Your Delta Dental coverage outside the U.S. is the same as your coverage within the U.S. Please note that AXA Assistance dentists are not Delta Dental participating dentists. If you are enrolled in a dental option that limits your coverage when you see a non-participating dentist, you will have limited coverage when you see an AXA Assistance dentist.

Filing Claims

When you receive dental care outside the U.S., you pay the dentist and file a claim for reimbursement with Delta Dental when you return from your trip. Be sure to get an itemized receipt for all dental services you receive. The receipt should include the dentist's name and address, the services performed, and an indication of which tooth or teeth received treatment. It should also note if the dentist's charges were billed in U.S. dollars or the local currency. Claim forms are available at hr.umich.edu/dental-plan. Make a copy of your receipt and completed claim form, and send the originals to Delta Dental as instructed on the form. Delta Dental will reimburse you subject to the terms and conditions of your existing Delta Dental coverage. The reimbursement may not cover your entire cost.

deltadentalmi.com

How the Vision Plan Works

Davis Vision by MetLife provides benefits under the Vision Plan. You should elect to use in-network services to receive the highest benefit from this plan. In-network means you use a provider in the Davis Vision by MetLife provider directory.

View a participating eye care professional by using the 'Find a Vision Provider' tool:

1. Go to metlife.com/mybenefits.
2. In the Access MyBenefits section, type University of Michigan and hit the Next button.
3. In the Vision box, enter a zip code and select the Find button.

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges, then submit a claim for partial reimbursement.

To use Davis Vision by MetLife, make an appointment with a participating provider when you need vision care services. The provider's office will verify your eligibility for services, and no claim forms or ID cards are required. You will pay a copay (if it applies) when you receive services, and the balance will be paid through the plan.

You may "split" your benefit by receiving your eye examination, frame and spectacle lenses or contact lenses at different time periods or provider locations, if desired. To maintain continuity of care, Davis Vision by MetLife recommends that all available services be obtained at one time from either a network or an out-of-network provider.

Davis Vision by MetLife provides a comprehensive eye exam, including a review of your case history, health status of the visual system, refractive status evaluation, binocular function, diagnosis, treatment, and dilation as professionally indicated. Additional fees attributed to measurements for contact lens fittings are not covered.

Cost of Enhancements

If your prescription requires additional enhancement, a copay will be added; however, the costs are generally at wholesale prices when ordered through a Davis Vision by MetLife provider. The copays are listed in the Davis Vision by MetLife Plan brochure and at hr.umich.edu/vision-plan.

Laser Vision Correction Services

Davis Vision by MetLife provides you and your eligible dependents the opportunity to receive laser vision correction services at discounts of up to 25% off participating providers' normal charge or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Call the participating provider for inquiries about the available discount. For more information, please visit metlife.com/mybenefits or call (833) 393-5433.

Buy a Voucher Program

You can purchase additional pairs of eyeglasses or contact lenses directly from Davis Vision. For more details about the plan, visit davisvision.com/member or call (800) 999-5431. Note this is a separate benefit, not part of the Davis Vision by MetLife plan.

Eye Exams

Your health plan may cover your eye exam. Review the Vision Care section of the Health Plan Coverage Comparison Chart and/or contact your health plan directly to ask if your plan covers eye exams.

Rates

Find your monthly vision plan rates on Wolverine Access at wolverineaccess.umich.edu

ID Card

Go to MetLife's My Benefits website, metlife.com/mybenefits. Register or sign into your existing account for all your benefits needs, including access to a digital ID card.

Warranty

There is a one-year warranty against breakage on all eyeglasses completely supplied by Davis Vision by MetLife.

Summary of Benefits

The Vision Care Plan benefit description from Davis Vision by MetLife is available at hr.umich.edu/vision-plan.

Questions?

If you have questions about the Vision Plan or need a provider directory, call Davis Vision by MetLife at (833) 393-5433.

Legal Services Plan

MetLife Administers This Plan

Low-Cost Help With Legal Matters

For the cost of your monthly premium, you can receive professional legal assistance with matters such as:

- Wills and estate planning, including living wills, powers of attorney, trusts, and codicils (updates to wills)
- Real estate matters, including eviction defense; problems with your landlord; and buying, selling or refinancing your home
- Family law matters, including name change, uncontested adoption and guardianship. (Note that the plan covers advice about divorce but does not cover representation in a divorce case.)
- Debt defense (problems with creditors)
- Defense of civil lawsuits
- Document preparation, including deeds, demand letters, promissory notes and mortgages
- Identify theft defense
- Custody order
- Enforcement or modification of support order

MetLife Legal Plan's identity protection and identity management services, credit monitoring and non-credit monitoring services provide assistance for emerging identity threats, including phishing scams, mobile device attacks, cyberbullying, lost and destroyed documents, and other identity theft issues. This service also includes identity theft defense that provides attorney consultations, services and representation in defense of identity theft.

Identity Management Services

Includes proactive services when you believe your personal data has been compromised and resolution services to assist you in recovering from account takeover or identity theft, with unlimited assistance to correct issues, handle notifications and provide victims with credit and fraud monitoring.

Identity Theft Defense

Provides attorney services for consultations, defense services and representation in defense of identity theft such as foreclosures, repossession or garnishment up to and including trial, if necessary.

Identity & Fraud Protection Services

Provides access to identity restoration services, along with proactively preventing fraud before it happens by protecting identity, assets, privacy, finances, and connecting devices using a virtual private network, in addition to antivirus protection.

One of the most valuable features of the Legal Services Plan is coverage for telephone advice and office consultations. Even if you are not sure you need legal representation, or if you need guidance with a legal matter not covered by the plan, your Legal Services Plan may cover the initial consultation at no cost.

Benefits In or Out of the Network

It is most economical to use a plan attorney, since the plan pays attorney fees for covered services in full—no matter how many times you need assistance. The plan offers benefits, however, even if you choose an attorney outside MetLife’s network. In that case, the plan reimburses you up to a preset dollar amount for each covered service.

If you need representation on a matter not covered by the plan, your MetLife Legal Plan attorney will provide a written fee agreement in advance. That means you will know from the start what those services will cost. To obtain a fee schedule, call MetLife. If you need legal assistance with a family will and estate planning or services where both you and your spouse or other qualified adult are required to sign legal documents (such as in real estate matters), you must enroll at the level of You + Adult or You + Adult + Children in order for these services to be fully paid by the plan.

MetLife Legal Services Plan

(800) 821-6400

Legal Services Plan Book

For more information, view the Legal Services Plan Book at hr.umich.edu/legal-services-plan

After-Tax

Premiums for the Legal Services Plan are deducted after-tax. Once enrolled, the plan requires you to remain enrolled for the balance of the calendar year during which you initially enrolled.

ID Card

There is no ID card for the Legal Services Plan. Check your Confirmation Statement and pay stub to verify your enrollment.

Will Preparation

Simple will preparation services through MetLife Legal Plan attorneys are available to U-M faculty and staff enrolled in the U-M Optional Life Insurance Plan through MetLife.

info.legalplans.com

Health Care Flexible Spending Accounts

Claims Processed by Inspira Financial

Health Care Flexible Spending Accounts (FSAs) allow you to pay for out-of-pocket health care expenses with pre-tax dollars. Your contributions are subtracted from your paycheck before federal, state and FICA taxes are calculated on your pay, so you save money on taxes.

Contributions to FSAs do not reduce your pay for purposes of determining your life insurance, travel accident insurance, long-term disability or retirement benefits provided by the university.

There are two types of Health Care FSAs:

1. Health Care FSA - used to pay for most out-of-pocket medical, vision and dental care expenses for you and your eligible dependents. If you are enrolled in the U-M Consumer-Directed Health Plan (CDHP), you are NOT eligible for this option.
2. Limited Purpose FSA - covers eligible dental, orthodontic and vision expenses. Available only to employees enrolled in the Consumer-Directed Health Plan (CDHP).

Health Care FSA Contribution Limit

From Jan. 1 through Dec. 31, 2026, you can contribute a minimum of \$120, and up to a maximum of \$3,300 per calendar year to your Health Care FSA.

Health Care FSA: Eligible Expenses

Generally, any health care expenses you can deduct on your federal income tax return are eligible for reimbursement from your Health Care FSA. There are some exceptions. For example, a Health Care FSA may not reimburse participants for insurance premiums paid for individual or employer-sponsored coverage.

Eligible expenses include, but are not limited to:

- Physician's office/clinic visit copays
- Dental care, including copays
- Vision care (exams, eyeglasses, contact lenses, contact lens solutions) is not reimbursed by any benefits plan. This includes copays, deductibles and coinsurance, amounts exceeding prevailing fee limits, and amounts exceeding plan dollar maximums.
- Hearing care and hearing aids
- Prescription drug copays

For a list of covered FSA expenses, visit inspirafinancial.com.

Limited Purpose FSA

A Limited Purpose FSA is just like the Health Care FSA, except it can be used only to pay for vision, dental and orthodontic expenses such as dental implants, Invisalign orthodontics, adult braces, prescription sunglasses, and LASIK surgery. It cannot be used to pay for health care expenses.

For a list of covered FSA expenses, visit inspirafinancial.com.

IMPORTANT: Due to IRS regulations, if you elect the Consumer-Directed Health Plan (CDHP) with HSA and have outstanding balances in your 2025 Health Care FSA, you MUST spend down your remaining balance to \$0 and have all claims processed before Dec. 19, 2025 before you can contribute to an HSA. Otherwise, you will NOT be eligible to contribute to your HSA until April 1, 2026.

Claims Processing

An external vendor, Inspira Financial, will process claims for reimbursement from your Health Care FSA account.

If you enroll in a Health Care FSA or Limited Purpose FSA, you'll automatically receive the Inspira Financial Health Spending Account Card. The card works like a debit card, but the funds are deducted from your FSA account. Your account balance and transaction history are updated in real-time. You do not need to file reimbursement claim forms, but you will be asked to provide receipts to verify payments.

- Mail your claims directly to Inspira Financial at:
Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396; or
- Fax to Inspira Financial toll-free at (855) 703-5305.
- Submit claims online
Log in at inspirafinancial.com, enter your claim information and fax or upload your receipts to (866) 932-2567.
- File claims using the Inspira Financial mobile app available from the App Store or Google Play.

View the 2026 Flexible Spending Account book for additional claim filing information at hr.umich.edu/fsa-forms-and-documents.

For helpful FSA information, visit inspirafinancial.com, where you can:

- Check your account balance and view transactions
- View tutorials, worksheets, forms, frequently asked questions and more.

Things to Consider

If you have not previously participated in a Health Care Flexible Spending Account (FSA), review the FSA plan book carefully before you enroll at hr.umich.edu/flexible-spending-accounts.

Be aware of some IRS rules before you decide to participate in an FSA:

- You must enroll each year if you wish to participate. Internal Revenue Service regulations do not allow FSA enrollments to carry over from year to year.
- Your 2026 contributions for a Health Care FSA must be used for eligible expenses you incur between January 1, 2026 and March 15, 2027.
- You incur an expense on the date the service is provided — not when you are billed or when you pay for it.
- By law, any unclaimed money remaining in your 2026 account(s) on June 1, 2027 is forfeited and will not be returned to you. This is known as the “use it or lose it” rule.
- You can enroll in either a Health Care FSA or Limited Purpose FSA, depending on what U-M health plan you have selected.
- The Health Care, Limited Purpose and Dependent Care FSAs are separate accounts. Money cannot be transferred between the accounts, and health care, vision and dental services cannot be reimbursed from a Dependent Care FSA or vice versa.
- Expenses reimbursed through a Health Care FSA cannot be used as a deduction or credit on your federal income taxes.
- With the Health Care and Limited Purpose FSAs, you have access to the total amount you elected for the plan year as soon as eligible expenses are incurred.
- The contribution amount you elect during Open Enrollment is in effect until the end of the plan year. You may change your contribution amount during the plan year only if you experience a qualified family status change.

Annual Enrollment Required to Participate

FSA participation does not carry forward from one year to the next due to IRS regulations. If you have a 2025 Health Care FSA and you wish to participate in 2026, you must re-enroll and designate the amount of money to be withheld.

Services Deadline

For a 2026 Health Care FSA, you can incur expenses until March 15, 2027.

Claims Deadline

To receive reimbursement for 2026 expenses, you must submit your claims to Inspira Financial by May 31, 2027. Money left in your 2026 account on or after June 1, 2027 will be forfeited. In accordance with Internal Revenue Code, the university uses forfeited funds to pay administration costs of the FSA program.

Questions?

For more information, call Inspira Financial at: (877) 343-1346, or visit inspirafinancial.com.

Tax Savings

You can save on federal, state and local taxes; Social Security; and FICA taxes. Your actual savings will depend on your income and tax filing status.

Dependent Care Flexible Spending Account

Claims Processed by Inspira Financial

A Dependent Care Flexible Spending Account (DCFSA) allows you to pay for eligible day care expenses for a dependent child younger than the age of 13, or elder care for a dependent adult, while you and your spouse work (or if your spouse is a full-time student or disabled). Your contributions are subtracted from your paycheck before federal, state and FICA taxes are calculated on your pay, so you save money on taxes.

Contributions to a DCFSA do not reduce your pay for purposes of determining your life insurance, travel accident insurance, long-term disability or retirement benefits provided by the university.

Dependent Care FSA Contribution Limit

You can contribute a minimum of \$120, and up to \$7,500 each year to your Dependent Care FSA. Highly compensated faculty and staff (family gross earnings in 2025 of \$160,000 or more) can contribute \$3,600 per year.

Dependent Care FSA: Eligible Expenses

Eligible dependent care expenses include qualified daycare centers for children and qualified adults, as well as care inside or outside your home.

Eligible expenses include, but are not limited to:

- Care for dependents younger than the age of 13, or dependents regardless of age who are physically or mentally incapable of caring for themselves and whom you claim as a dependent on your federal income tax return. You (and your spouse if you are married) must maintain a home that you live in for more than half the year with your qualifying child or dependent.
- Care when you are at work. If you are married, your spouse must also be at work, school (as a full-time student), searching for a job, or mentally or physically disabled and unable to provide care for a dependent.

To view a list of covered Dependent Care FSA expenses, visit inspirafinancial.com and review the Flexible Spending Account Eligible Expense Guide. Contact Inspira Financial at (877) 343-1346 if you have questions about whether a particular expense is eligible.

Important Information About Enrollment:

You can enroll in a Dependent Care FSA regardless of which U-M health plan you select, or if you opt out of university sponsored health coverage.

Claims Processing

You may file claim(s) for reimbursement after eligible services have been provided for your dependent(s). An external vendor, Inspira Financial, will process claims for reimbursement from your FSA account.

- Mail your claims directly to Inspira Financial at:
Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396; or
- Fax to Inspira Financial toll-free at (855) 703-5305.
- Submit claims online
Log in at inspirafinancial.com, enter your claim information and fax or upload your receipts to (866) 932-2567.
- File claims using the Inspira Financial mobile app available from the App Store or Google Play.

View the 2026 Flexible Spending Account book for additional claim filing information: hr.umich.edu/fsa-forms-and-documents.

For helpful FSA information, visit inspirafinancial.com, where you can:

- Check your account balance and view transactions
- View tutorials, worksheets, forms, frequently asked questions and more.

Things to Consider

If you have not previously participated in a Flexible Spending Account (FSA), review the FSA plan book carefully before you enroll at hr.umich.edu/flexible-spending-accounts.

You should be aware of some IRS rules before you participate in a Dependent Care FSA.

- You must enroll each year if you wish to participate. Internal Revenue Service regulations do not allow FSA enrollments to carry over from year to year.
- Your 2026 contributions for a Dependent Care FSA must be used for eligible expenses you incur between Jan. 1, 2026, and March 15, 2027.
- You incur an expense on the date the service is provided — not when you are billed or when you pay for it.

- By law, any unclaimed money remaining in your 2026 account(s) on June 1, 2027 is forfeited and will not be returned to you. This is known as the “use it or lose it” rule.
- The Health Care, Limited Purpose and Dependent Care FSAs are separate accounts. Money cannot be transferred between the accounts, and health care, vision and dental services cannot be reimbursed from a Dependent Care FSA or vice versa.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.
- For a Dependent Care FSA, you can be reimbursed only up to the amount available in your account. Claims for expenses exceeding that amount will be reimbursed as additional funds accumulate in your account.
- The university reports deduction amounts to Inspira Financial on the first of every month for deductions taken during the preceding month.
- The contribution amount you elect during Open Enrollment is in effect until the end of the plan year. You may change your contribution amount during the plan year only if you experience a qualified family status change.

Annual Enrollment Required to Participate

FSA participation does not carry forward from one year to the next due to IRS regulations. If you have a 2025 FSA and you wish to participate in 2026, you must re-enroll and designate the amount of money to be withheld.

Services Deadline

For a 2026 Health Care FSA, you can incur expenses until March 15, 2027.

Claims Deadline

To receive reimbursement for 2026 expenses, you must submit your claims to Inspira Financial by May 31, 2027. Money left in your 2026 account on or after June 1, 2027 will be forfeited. In accordance with Internal Revenue Code, the university uses forfeited funds to pay administration costs of the FSA program.

Questions?

For more information, call Inspira Financial at (877) 343-1346, or visit [inspirafinancial.com](https://www.inspirafinancial.com).

Tax Savings

You can save on federal, state and local taxes; Social Security; and FICA taxes. Your actual savings will depend on your income and tax filing status.

Resources and Reminders

The following plans are not part of Open Enrollment. You can change or enroll in these plans any time:

- Life Insurance
- Long-Term Disability
- Basic Retirement Savings Plan
- 403(b) Supplemental Retirement Accounts (SRA)
- 457(b) Deferred Compensation Plan

View hr.umich.edu/benefits-wellness for plan details and information about eligibility and enrollment.

Keep Your Beneficiary Up to Date

The Benefits Office encourages you to periodically review your benefits enrollments and update your beneficiary designations if necessary. View hr.umich.edu/beneficiary for details.

Verify Your Covered Dependents' Information

If you have dependents covered under your benefits, it is important to verify that their information on record with the university is accurate. Having the correct information may help avoid delays in receiving health care services and speed claims processing. To view your dependent information:

1. Go to Wolverine Access: wolverineaccess.umich.edu.
2. Click the **Employee Self Service** tile.
3. Log in with your unqname and UMICH password.
4. Click the **Benefits** tile.
5. Click the **Dependent/Beneficiary** tile.
6. Check that names are spelled correctly, birth dates and Social Security numbers are correct, and verify the relationship. If the information is correct, no further action is required.
7. If the information is incorrect, complete the Dependent Information Form available at hr.umich.edu/update-dependent-information, and submit it to SSC - Benefits Transactions as indicated on the form. Please note that submitting this form only corrects the information currently on record with the university and does not change benefits enrollment.

Update Your Address

Keep your address current. Follow these steps to update your address:

1. Go to wolverineaccess.umich.edu.
2. Select the 'Employee Self-Service' tile.
3. Click 'Campus Personal Information.'
4. Click 'Review Addresses.'
5. If a change is needed, click the pencil icon next to the address type you wish to change and make the necessary edit. Once complete, select the 'OK' button.
6. Review 'Current Local' address and edit if needed.

Information

- Benefits information: hr.umich.edu/benefits-wellness
- Call the Shared Services Center - HR Customer Care at (734) 615-2000 locally or (866) 647-7657 toll-free, Monday through Friday from 8 a.m. to 1 p.m. and 2 to 5 p.m.
- Sign up for UHR News, a timely email newsletter for current benefits and helpful employment information. To subscribe, visit myumi.ch/uhr-news-sign-up.

Important Federal Notices

Regarding Your Health Coverage

The notices contained in this section are provided in accordance with the requirements of the federal law.

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under each of the university-sponsored health plans.

Newborns' and Mothers' Health Protection Act

Group health plans and health plan issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the detailed Health Plan Comparison Chart on pages 12-21, a document called a Summary of Benefits and Coverage (SBC), is also available at: hr.umich.edu/health-plans. An SBC is a federally-mandated document

intended to help individuals across the nation compare health plans. Each health plan is required to issue an SBC for every group health plan it offers. An SBC details deductibles, coinsurance and out-of-pocket limits for various services in a prescribed format. A Uniform Glossary of Health Coverage and Medical Terms to accompany the SBC is also available. To view a health plan SBC and/or the Uniform Glossary, you may select the appropriate document from the Summary of Benefits and Coverage page by visiting hr.umich.edu/health-plans.

You may also call the SSC - HR Customer Care at (734) 615-2000 or (866) 647-7657 (toll-free) to request printed copies of a specific plan's SBC and/or the Uniform Glossary at no charge.

Health Care Reform

For the most current information regarding facts about covered services, effective dates, and other important information, visit HealthCare.gov.

Continuation of Benefits (COBRA)

If you or your dependent has a qualifying event in which there is a loss of health care coverage, you have the option to continue group health plans you are already enrolled in under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a limited period of time.

If you need to remove ineligible dependents from your benefits, do not remove them when you make your Open Enrollment elections. If you do, continuation of benefits under the federal COBRA law will not be available to them.

Your dependent children who become ineligible due to age limits will be automatically dropped from your group health coverage and will be sent information on coverage under COBRA provisions at that time. If dependents become ineligible for reasons other than age ineligibility, you must complete and return a Notice of Qualifying Event form to the SSC - Benefits Transactions within 60 days of the loss of eligibility. The form is available at hr.umich.edu or may be obtained by calling the SSC - HR Customer Care at (734) 615-2000 or (866) 647-7657 (toll-free for off-campus long-distance calling within the United States). Failure to submit the notification during the 60-day timeframe will result in forfeiture of your dependent's rights to COBRA continuation coverage.

Special Enrollment Rights

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for health plan coverage may be available if you lose health care coverage under certain conditions, or when you acquire new dependents by marriage, birth, or adoption.

- If during Open Enrollment you decline enrollment for yourself or your dependents (including your spouse) because you have other health care coverage and later you involuntarily lose that coverage, you may be able to enroll yourself or your dependents in health care coverage outside the annual Open Enrollment period, provided you previously declined enrollment due to coverage elsewhere, and you request enrollment within 30 days after your other coverage ends.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for health coverage outside the annual Open Enrollment period, provided you previously declined enrollment due to coverage elsewhere and you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Rules for Gain or Loss of Eligibility for Medicaid/CHIPRA

When you experience a change that results in a gain or loss of eligibility for Medicaid/CHIP,* you may be able to make certain adjustments to your benefits correlating to your status change within 60 days.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") adds two new, special enrollment events. You or your dependent(s) will be permitted to enroll or cancel coverage in the university's sponsored health plan coverage in either of the following circumstances:

1. You or your dependent's Medicaid or state Children's Health Insurance Program ("CHIP") coverage is canceled due to a loss of eligibility. You must request to enroll in U-M's group health plan within sixty (60) days from the date you or your dependent loses coverage.
2. You or your dependent(s) enrolls in Medicaid or the state CHIP. You may cancel coverage in U-M's group health plan within sixty (60) days of your or your dependent's coverage effective date.

To make a change to your university's benefits plans, please complete and submit a Benefits Enrollment/Change Form available on the Benefits Office website, along with your documentation of the change within sixty (60) days after gaining or losing coverage in Medicaid or the state CHIP program. Your change will be effective as of the event date.

For further details about Medicaid or Michigan's CHIP program, visit the Michigan Department of Community Health website or call (888) 988-6300 toll-free.

If you have any questions regarding your eligibility for U-M benefits, call the SSC - HR Customer Care, Monday through Friday from 8 a.m. to 1 p.m. and 2 to 5 p.m. at (734) 615-2000 locally or toll-free at (866) 647-7657.

**The state Children's Health Insurance Program in Michigan is called MICHild.*

Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. (For a list of participating states as of January 31, 2017, visit medicaid.gov/chip).

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, or you may contact 1 (877) KIDS NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled. As of the date of this publication, the state of Michigan does not participate in this program.

HIPAA Privacy and Security

The university is required by law to maintain the privacy of your Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. While the Benefits Office has always treated health information with the utmost care, HIPAA requires that the university issue notification of U-M's compliance with HIPAA privacy rules. The Benefits Office uses PHI for determining benefits eligibility and to enable the general administration of your health and dental benefits. The Benefits Office is committed to continuing to use the utmost care in handling this information to ensure its privacy and security.

Please read U-M's Commitment to HIPAA Compliance and the Privacy Notice, which explains how the Benefits Office and the university use and protect PHI at hr.umich.edu/hipaa.

Read the information carefully and contact the SSC - HR Customer Care, Monday through Friday from 8 a.m. to 1 p.m. and 2 to 5 p.m. at (734) 615-2000 or (866) 647-7657 if you have any questions or would like to request a copy.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the

full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services - If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance-billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance-billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance-bill you and may not ask you to give up your protections against balance billing.

If you get other services at these in-network facilities, out-of-network providers can't balance-bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - » Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - » Cover emergency services by out-of-network providers.
 - » Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - » Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your health plan at the number on the back of your ID card.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Contact Information

Plan Providers	Phone	Web Address
Birdi Rx Mail Order Pharmacy	877-269-1160	umich.birdirx.com
BCBSM Community Blue PPO	855-669-8040	bcbsm.com
BCBSM Comprehensive Major Medical	855-669-8040	bcbsm.com
BCBSM Consumer-Directed Health Plan	855-669-8040	bcbsm.com
Davis Vision by MetLife	833-393-5433	metlife.com/insurance/vision-insurance
Delta Dental Plan Information	800-524-0149	deltadentalmi.com
GradCare	800-658-8878	bcbsm.com
HealthEquity Health Savings Account	877-284-9840	healthequity.com
Prime Therapeutics Member Portal	888-272-1346	umich.primetherapeutics.com
MetLife Legal Plan	800-821-6400	legalplans.com
Inspira Financial	877-343-1346	inspirafinancial.com
U-M Premier Care	800-658-8878	bcbsm.com
University of Michigan Health Specialty Pharmacy	855-276-3002	specialty-pharmacy.uofmhealth.org

Other Helpful Contacts	Phone	Web Address
Benefits Office, UM-Ann Arbor	734-615-2000 866-647-7657	hr.umich.edu
University Human Resources, U-M Dearborn	313-593-5190	umdearborn.edu/human-resources
University Human Resources, UM-Flint	810-762-3150	umflint.edu/hr
Shared Services Center - HR Customer Care	734-615-2000 866-647-7657	ssc.umich.edu
Telecommunications Relay Service	711	

A Final Word

Every effort has been made to ensure the accuracy of this booklet. However, if statements in this booklet differ from applicable contracts, certificates, or riders, then the terms and conditions of those documents prevail. Detailed benefits plan information is available on the University Human Resources website at hr.umich.edu/benefits-wellness. Printed plan descriptions are available upon request. All benefits are subject to change.

Prepared by Benefits Office

University of Michigan
Wolverine Tower—Low Rise G405
3003 South State Street
Ann Arbor, MI 48109-1278

Phone 734-615-2000 or 866-647-7657
(toll-free for off-campus long-distance calling)
Fax 734-763-0363
Web hr.umich.edu/benefits-wellness

Shared Services Center - HR Customer Care

Representatives are available by phone, 8 a.m. to 1 p.m. and 2 to 5 p.m., Monday – Friday, at 734-615-2000 locally, or 866-647-7657 (toll-free for off-campus long-distance calling).



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The Benefits Office is a unit of University Human Resources (UHR).

Richard S. Holcomb, Jr.
Associate Vice President for Human Resources

Brian Vasher
Assistant Vice President for Benefits and Well-being Programs

Kent Seckinger
Senior Director for Benefits

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For other University of Michigan information, call (734) 764-1817.

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Statement of Non-discrimination

The University of Michigan, including the Ann Arbor, Dearborn, Flint campuses as well as Michigan Medicine, as an equal opportunity employer, complies with all applicable federal and state laws regarding nondiscrimination. The University of Michigan is committed to a policy of equal opportunity for all persons and does not discriminate on the basis of race, color, national origin, age, marital status, sex, sexual orientation, gender identity, gender expression, disability, religion, height, weight, or veteran status in employment, educational programs and activities, and admissions.

Inquiries or complaints may be addressed to the Equity, Civil Rights and Title IX Office (ECRT), 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, 734-763-0235, TTY 734-647-1388.



Wolverine Tower—Low Rise G405
3003 South State Street | Ann Arbor, MI 48109-1276