



Your Benefits 2026

benefits.umich.edu

Benefits Information by Phone

The Shared Services Center (SSC) - HR Customer Care can answer many of your benefits questions.

Call the SSC - HR Customer Care at (734) 615-2000 locally, or toll-free at (866) 647-7657, or email shareservices@umich.edu, if you have any questions or need additional assistance. SSC - HR Customer Care is open Monday-Friday from 8 a.m. to 1 p.m. and 2 to 5 p.m. ET.

Benefits Information on the Web

For benefits plan information, visit the [main Human Resources web page](#)

Telecommunications Relay Service

Dial 711 for access to Telecommunications Relay Service (TRS) and ask the operator to connect you to the SSC - HR Customer Care at: (734) 615-2000 or (866) 647-7657 (toll-free). Representatives will be happy to assist you.

Subscribe to UHR News

Sign up for UHR News, a timely email newsletter for current benefits and helpful employment information. To subscribe, visit the [UHR News subscription form](#).

Every effort has been made to ensure the accuracy of this book. However, if statements in this book differ from applicable contracts, certificates, and riders, then the terms of those documents will prevail. All benefits are subject to change.

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, no individual has a vested right to any of the benefits provided or described. 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.

Campus Safety

The [University of Michigan Annual Security & Fire Safety Report](#) is part of U-M's ongoing commitment to transparency and efforts to keep the university community informed of reported crimes and available safety programs and services. It is compiled by the Department of Public Safety and Security (DPSS).

The report includes campus safety information, such as emergency services, safety tips, university policies and state laws, and additional support services. Additionally, it contains the Annual Fire Safety Report regarding fire safety and statistics for on-campus housing.

The publication also includes three-year statistics of reported crime, including bias-motivated crimes, on the Ann Arbor campus, adjoining properties, and remote locations under university control in compliance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act. Additional safety and security information, including crime alerts and daily crime and fire incident logs, can be viewed on this site. If you have any questions or would like to request a copy of the report, please call DPSS at (734) 763-839.

Sign up for U-M Emergency Alerts

Be informed when there is an emergency on campus by signing up for U-M Emergency Alerts. If there is a major emergency, you will receive a text through the U-M Emergency Alert system. Go to Wolverine Access, enter "Emergency Alerts" in the Search box, and then click the **Subscribe to Campus Emergency Alerts** tile.

The university also encourages you to enter your Emergency Contact information under Campus Personal Information.

This information will be used solely for the purpose of notifying the emergency contact(s), beginning with the primary contact you name, of medical emergencies, missing person(s), or other emergency situations.

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1. General Information

Welcome to Your Benefits 2026, a comprehensive resource containing information about the benefits packages offered by the University of Michigan. These benefits packages are some of the most competitive available. Your University of Michigan benefits package is an important part of your total compensation package at the university, adding value and giving you peace of mind.

Each of the plans detailed on these pages have been carefully researched and negotiated. You can enroll in your benefits with the assurance that your benefits needs are priorities at the University of Michigan.

This chapter provides the following information so you may choose the benefits most useful to you and your dependents, and you may manage your benefits to your own advantage.

Paying for Your Benefits contains information about frequency of deductions.

Your Responsibilities highlights the actions you must take to ensure that your enrollment in benefits coverage for you and your dependents is timely and accurate.

Eligibility includes a chart providing comprehensive information about eligibility for you, your spouse or other qualified adult, and your dependent children.

Enrollment contains step-by-step enrollment information for new faculty and staff members and current employees who are newly eligible for benefits.

Benefits Are Subject to Change

The benefits information presented in this book describes only the highlights of the plans and does not constitute official plan documents. Additional terms and conditions apply. If there are any discrepancies between the information contained herein and the official plan documents, the plan documents will govern.

The university reserves the right to change, amend, or terminate the plans at any time. This benefits overview is not intended to give rise to any right to employment, continued employment, or any benefit with or from the University of Michigan. To view official plan documents, go to the [Benefits and Wellness web page](#).

For benefits information, view:
hr.umich.edu/benefits-wellness

To enroll in benefits, go to:
wolverineaccess.umich.edu

Paying for Your Benefits

The university makes a sizable investment in your benefits by paying a significant portion of the cost. You pay any balance through automatic deductions from your pay. You are responsible for making sure that your pay can cover the cost of the benefits you choose.

Cost of Your Benefit Plans

You can view your benefit costs in [Wolverine Access](#): search for **Employee Self-Service**, select **Benefits**, then **Display Benefit Plan Rates**. Costs are also shown in Wolverine Access Self-Service when you enroll online. Each plan has its own rates.

Frequency of Deductions

Bi-weekly

If you are paid bi-weekly:

- Benefit deductions are taken equally from your first two paychecks each month.
- For months with a third paycheck, only retirement savings contributions are deducted.
- The rates in this guide are monthly amounts.

Monthly

If you are paid monthly:

- Payroll deductions will be taken in one equal installment from each monthly paycheck.
- The rates shown in this book are for monthly deductions.

Payroll Deductions for Faculty and Staff

Certain benefits are paid for by payroll deductions from your salary on a pre-tax basis (before taxes are calculated). The benefits plans with pre-tax deductions are:

- Health Plan
- Dental Plan
- Vision Plan
- Health Care Flexible Spending Account (including Limited Purpose FSA)
- Dependent Care Flexible Spending Account
- Health Savings Account
- Basic Retirement Savings Plan
- Pre-tax 403(b) SRA and pre-tax 457(b)

The plans with after-tax deductions are:

- Legal Services Plan
- Optional Group Life Insurance
- Spouse Group Life Insurance
- Dependent Child(ren) Life Insurance
- Long-Term Disability
- Roth 403(b) SRA and Roth 457(b)

Questions about your benefits?

Call the SSC - HR Customer Care at (734) 615-2000 locally, or toll-free at (866) 647-7657, or email sharingservices@umich.edu, if you have any questions or need additional assistance.

Your Responsibilities

Review Benefit Information and Enroll Within Your Deadline

It is important that you review benefit plan information, make your benefits selections, and enroll within 30 days or as specified by your collective bargaining agreement.

Enrollment is online for most benefits. Electronic forms or paper forms are used to enroll in Health Care and Dependent Care Flexible Spending Accounts.

Check Your Confirmation Statement

After making an online election, you can view or print your submitted confirmation statement immediately after your elections are submitted. Final and submitted confirmation statements are available in [Wolverine Access](#): search for **Employee Self-Service**, select the **Benefits** tile, then the **Benefits Statement** tile.

Check Your Deductions

Verify your benefit deductions on your pay stub to be sure they match the coverage you requested. You can view your pay stub online through Wolverine Access. Log into [Wolverine Access](#), search for **Payroll and Compensation**, and click the **View Paycheck** tile. If you find an error in your deductions, call the SSC - HR Customer Care immediately.

Keep Your Address and Phone Number Updated

It is important to maintain up-to-date contact information (e.g., address and phone number) to ensure that the university can contact you if necessary.

It is your responsibility to notify the university immediately if your home address changes. You may update your address and phone number online using Wolverine Access.

Go to [Wolverine Access](#), search for **Employee Self Service**, select the **Campus Personal Information** tile, then **Addresses**. Edit your "Current Local" address.

Keep Your Beneficiary Designations Updated

It is important to name your beneficiaries and update your beneficiary designations as needed when your circumstances change. You may change your beneficiary designations at any time. It is important to note that there are four separate companies that require you to name your beneficiary to receive funds in the event of your death. You must complete a separate beneficiary designation for each plan in which you are enrolled.

MetLife administers the U-M Life Insurance plan, TIAA and Fidelity are the U-M Retirement Savings plan investment companies, and HealthEquity administers the Health Savings Account (HSA). Go to hr.umich.edu/yourbeneficiary for more information.

Fidelity Investments: netbenefits.com/uofm

HealthEquity: healthequity.com

MetLife: metlife.com/mybenefits

TIAA: tiaa.org/beneficiaries

Emergency Contact Information

The university also encourages you to provide emergency contact information. Log into [Wolverine Access](#), search for **Campus Personal Information**, and select **Emergency Contact**. Once a year, you will receive a prompt from Wolverine Access to review your addresses, emergency contacts, and U-M Emergency Alert notification preferences.

Know Your Rights and Responsibilities Under Federal Law

The Benefits Office is required to provide you with important information and notices about federal laws and acts that affect your coverage. These notices are on [page 78](#). While the notices do not cover all the details of these laws, they do give you and your family information about your rights and protections under the law. You are encouraged to carefully review them.

Make Dependent Coverage Changes Promptly

Every year, changes affect the personal status of faculty and staff members who are enrolled in any of the university sponsored benefits plans. Marriages, births, adoptions, divorces, and loss of coverage from another source are examples of qualified family status changes that may allow enrolled employees the opportunity to make mid-year changes to their current benefits enrollments. If any of these changes have affected or will affect you this year, **you must act within 30 days of the family status change**. Otherwise, you will have to wait for the next Open Enrollment period and have the change(s) become effective Jan. 1 of the following year. View Chapter 4, Changes to Your Benefits, for more information, or visit the [Life Events web page](#).

It is especially important to delete any ineligible dependents within the 30-day period to avoid overpaying premiums, because the university will not refund payment for coverage of ineligible dependents. In addition, failure to notify the SSC - HR Customer Care or complete and return a COBRA Notice of Qualifying Event form within 60 days of your dependent's loss of eligibility will result in forfeiture of COBRA continuation rights. See [page 78](#) for more information.

Download change forms on the [Benefits and Wellness web page](#).

Questions should be directed to the SSC - HR Customer Care at (734) 615-2000 locally, or toll free at (866) 647-7657, or email sharedservices@umich.edu.

Watch for Communications from U-M

Watch for emails and mailings from the Benefits Office and the University of Michigan. Dated and time-sensitive materials may require your prompt attention. Please note that emails go to "@umich.edu" addresses only. If you have an email address with a prefix (such as "@med.umich.edu"), edit your personal profile in mcommunity.umich.edu to set up forwarding to @umich.edu. If you need help, contact the Information and Technology Services help desk. Visit the [Information Technology Services "get help" web page](#) or call (734) 764-4357.

U-M Information and Technology Services uses spam blocking filters so that email from known spam sources is prevented from appearing in your mailbox. Each email program has its own means of detecting spam and diverting it to the spam or junk folder. Sometimes legitimate emails from the university are falsely identified as spam. Be sure to check your email spam or junk folder regularly to look for emails from the university and mark them as "not spam."

Protect Your Personal Information and the University

Be on the lookout for spam, phishing, and other malicious email. Criminals can use them to gain access to your personal and financial information, as well as sensitive university information and access. To learn about how to recognize and avoid phishing emails and protect the university and your personal information, visit the [Safe Computing web page](#).



Your Way to Well-Being

[MHealthy](#), U-M's health and well-being service, offers faculty and staff members a variety of programs and services that encourage you to move more, stress less, eat smarter, manage weight, be tobacco-free, manage chronic conditions, drink less, and more. Our programs reflect the university's philosophy that many factors affect your quality of life and play a part in achieving balance, purpose, and vitality in your career and at home.

MHEALTHY

YOUR WAY TO WELL-BEING

Well-being is a life-long journey.

Many factors play a part in achieving balance, purpose, and vitality in your career and at home.

Our programs and services allow you the flexibility to choose your own way to well-being, focusing on the goals that are most important to you.

- Feel connected
- Improve your mood
- Solve ergonomic issues
- Eat well
- Be active
- Drink less alcohol
- Be tobacco-free
- Boost your financial well-being
- And much more!



MHealthy supports U-M's philosophy of well-being.



mhealthy.umich.edu

Eligibility

Your eligibility for benefits at the University of Michigan is based on your career/job family, your appointment percentage, and the duration of your appointment.

New Hire/Newly Eligible

If you are a new hire or newly eligible for benefits, your specific benefits options will be shown when you log onto [Wolverine Access](#), search for **Employee Self-Service**, and click the **Benefits** tile. The eligibility charts also show the benefits for which you are eligible and the eligible dependents you can cover under your benefits.

If You Return to U-M

Continuous Appointments

If you are reappointed to a position without a break in service/eligibility, it is considered a continuous appointment and your benefits enrollments will continue. This primarily affects supplemental faculty and graduate student career/job families who are appointed on an academic term basis. In these positions, benefits are active only for the duration of the term.

- Benefits may lapse if the reappointment is processed after the beginning of the next term; however, your benefits will be reinstated retroactively.
- If your first appointment is for the fall term and your reappointment is for the winter term, you will need to re-enroll in your Health Care and/or Dependent Care Flexible Spending Account(s). If both appointment terms are in the same calendar year, your FSA account(s) will continue.

To confirm your reappointment and your benefits enrollments, including retirement savings plans, call the SSC - HR Customer Care at the beginning of the new term.

Break in Service/Rehire

If you are rehired at the university after a break in service, you must re-enroll in benefits. A break in service is defined as a period when you did not work for the university. For example, if you are a lecturer who teaches the fall term, does not teach the winter term, but returns the following fall term, you must re-enroll in benefits when you are rehired.

Enrollment information will be sent to you after your personnel record is created.

You will also need to re-enroll in the [Basic Retirement Plan](#), [403\(b\) Supplemental Retirement Account \(SRA\)](#), and/or [457\(b\) Deferred Compensation Plan](#).

Research Fellows

There are specific guidelines in the university's [Standard Practice Guide](#) (SPG) regarding the benefits that must be provided for Research Fellows (see SPG 201.19 and 203.02). For example, the university requires that Research Fellows enroll themselves and their dependents, if any, in a University Group Health plan at the same costs charged to staff. This requirement can be waived only if the Research Fellow provides proof of comparable coverage elsewhere.

Research Fellows who fail to make a health plan election within 30 days of becoming newly eligible for coverage will be automatically defaulted to the Comprehensive Major Medical plan for "you only" coverage.

Eligibility for University of Michigan Benefits by Career/Group

Group	Eligibility Criteria ^{1,5}	Eligible	Not Eligible
AFSCME COAM Faculty and Staff IUOE LEO-GLAM LEO Lecturers I/II/ III/IV LEO Intermittent MNA POAM SEIU Trades UM-Flint AFT-AAUP UMMAP UPAMM	<p>You are a regular faculty or staff member, including primary and instructional staff;</p> <p>You have at least a 50% appointment lasting four continuous months or longer and funding for four continuous months or longer (exception: for Long-Term Disability, your appointment must last eight months or longer);</p> <p>Basic Retirement Plan 403(b) SRA and 457(b) eligibility requires only a 1% or greater appointment and funding.</p>	<ul style="list-style-type: none"> • Health Plan² • Dental Plan (Option 1, 2, or 3) • Vision Plan • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Basic Long-Term Disability (AFSCME members only) • Expanded Long-Term Disability (Supplemental Faculty appointments and AFSCME members are not eligible) • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Flexible Spending Accounts • Business Travel Accident Insurance • Basic Retirement Savings Plan, 403(b) SRA, and 457(b) • MHealthy Rewards program³ • MHealthy wellness programs⁴ 	
Supplemental (LEO Adjunct, Adjunct, Visiting and Clinical I titles)	<p>You have a 50% or greater appointment and funding for four continuous months or longer.</p>	<ul style="list-style-type: none"> • Health Plan² • Dental Plan (Option 1, 2, or 3) • Vision Plan • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Expanded Long-Term Disability (LEO Lecturers I only with two years of service) • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Flexible Spending Accounts • Business Travel Accident Insurance • Basic Retirement Savings Plan • 403(b) SRA and 457(b) with a 1% or greater appointment for four consecutive months or longer • MHealthy Rewards program³ • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Basic Retirement Savings Plan if less than a 50% appointment • Supplemental Faculty appointments are not eligible for Expanded Long-Term Disability
GSI GSSA	<p>You have less than a 25% appointment and funding for one full term.</p>	<ul style="list-style-type: none"> • Health Plan² (GradCare only) • Dental (Option 1, 2, or 3) • Business Travel Accident Insurance • 403(b) SRA and 457(b) with a 1% or greater appointment for four consecutive months or longer • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Vision Plan • Long-Term Disability • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Legal Services Plan • Basic Retirement Savings Plan • MHealthy Rewards program
	<p>You have a 25% or greater appointment and funding for a minimum of four continuous months for fall and winter terms or 25% appointment and two months continuous appointment in the spring/summer term.</p>	<ul style="list-style-type: none"> • Health Plan (GradCare only)² • Dental Plan (Option 1, 2, or 3) • Legal Services Plan • Flexible Spending Accounts • Business Travel Accident Insurance • University Life, Optional Life, and Dependent Life Insurance • Vision Plan • 403(b) SRA and 457(b) with a 1% or greater appointment for four consecutive months or longer • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Long-Term Disability • Basic Retirement Savings Plan • MHealthy Rewards program
GSRA	<p>You have a 25% or greater appointment and funding for a minimum of four continuous months at all times.</p>	<ul style="list-style-type: none"> • Health Plan (GradCare only)² • Dental Plan (Option 1, 2, or 3) • Legal Services Plan • Flexible Spending Accounts • Business Travel Accident Insurance • University Life, Optional Life, and Dependent Life Insurance • Vision Plan • 403(b) SRA and 457(b) with a 1% or greater appointment for four consecutive months or longer • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Long-Term Disability • Basic Retirement Savings Plan • MHealthy Rewards program

¹ Employees with dual career/job families are eligible for the Basic Retirement Plan if effort and funding are present in the appropriate combination. For example, if you are a Research Fellow who is also appointed as a Lecturer, you are eligible for the Basic Retirement Plan if the Lecturer job has at least a 1% appointment, regardless of which position has funding.

² Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan.

³ For more information about the MHealthy Rewards program, view the [MHealthy Rewards web page](#).

⁴ For more information about MHealthy wellness, view the [MHealthy web page](#).

⁵ You could become eligible to continue medical benefits at a different monthly cost if you move to a temporary position, reduce your effort below 50% or return after a break in service of less than 26 weeks. For more information, view the [Employer Shared Responsibility web page](#).

Eligibility for University of Michigan Benefits by Career/Group

Group	Eligibility Criteria ^{1,5}	Eligible	Not Eligible
HOA	You receive U-M or outside funding and have a 0% or greater appointment lasting four continuous months or longer.	<ul style="list-style-type: none"> • Health Plan² • Dental Plan (Option 1, 2, or 3) • Vision Plan • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Long-Term Disability (provided through the House Officers Association) • University Life, Optional Life, and Dependant Life Insurance • Legal Services Plan • Flexible Spending Accounts (stipends are not eligible) • Business Travel Accident Insurance • 403(b) SRA and 457(b) with a 1% or greater appointment for four consecutive months or longer • MHealthy Rewards program³ • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Expanded/Basic Long-Term Disability • Basic Retirement Savings Plan
Research Fellows	<p>For health plan coverage, you must have a 0% or greater appointment and funding (stipend, Special Purpose Funds) or salary for a minimum of four continuous months.</p> <p>For life insurance, 403(b) SRA and 457(b) plans, you must have a 1% or greater appointment and university funding. Stipend money is not eligible.</p> <p>For dental, you must have 0% or greater appointment.</p> <p>Research Fellows must provide proof of comparable coverage to waive health plan and prescription drug plan coverage (SPG 201.19).</p>	<ul style="list-style-type: none"> • Health Plan² • Dental Plan (Option 1, 2, and 3) • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • University Life, Optional Life, and Dependent Life Insurance (0% or greater appointment. Stipend funds not eligible) • Legal Services Plan • Flexible Spending Accounts (0% or greater appointment. Stipend funds or temporary hourly wages are not eligible) • 403(b) SRA and 457(b); 1% or greater appointment. (Stipend funds are not eligible) • Business Travel Accident Insurance • Vision Plan • MHealthy Rewards program³ • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Long-Term Disability • Basic Retirement Savings Plan
Professional Specialists	You have a 0% or greater appointment and U-M funding (stipend, Special Purpose Funds) or salary for a minimum of four continuous months.	<ul style="list-style-type: none"> • Health Plan² • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Flexible Spending Accounts (50% or greater appointment. Stipend funds or temporary hourly wages are not eligible) • 403(b) SRA and 457(b); 1% or greater appointment. (Stipend funds are not eligible) • Business Travel Accident Insurance • MHealthy Rewards program³ • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • Dental Plan • Vision Plan • Long-Term Disability • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Basic Retirement Savings Plan
Benefit-Eligible Fellowship Holders	<p>Holders of designated fellowship</p> <p>Michigan Science Training Program fellows</p> <p>Check with your department if you do not know if you are sponsored for GradCare under this provision</p>	<ul style="list-style-type: none"> • Health Plan² (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan • MHealthy wellness programs⁴ 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
Medical School Students	Health plan coverage is mandatory for all University of Michigan medical school students. Medical school students are required to either enroll in GradCare or provide verification that they have comparable health plan coverage elsewhere.	<ul style="list-style-type: none"> • Health Plan² (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program • Dependent Life Insurance

1 To be eligible for the Basic Retirement Plan, all career/job families, except Supplemental, must have at least a 1% appointment for four continuous months or longer. Supplemental must have a 50% or greater appointment and funding for one full term.

2 Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan. Enrollment in the Consumer-Directed Health Plan will also include enrollment in the Health Savings Account.

3 For more information about the MHealthy Rewards program, view the [MHealthy Rewards web page](#).

4 For more information, view the [MHealthy web page](#).

5 You could become eligible to continue medical benefits at a different monthly cost if you move to a temporary position, reduce your effort below 50% or return after a break in service of less than 26 weeks. For more information, view the [Employer Shared Responsibility web page](#).

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Spouse A person who:</p> <ul style="list-style-type: none"> • Is legally married to you, and • Is not already covered through the university as an employee.¹ <p>OR</p> <p>Other Qualified Adult (OQA) A person who:</p> <ul style="list-style-type: none"> • Is not already covered through the university as an employee • Shares a primary residency with the employee for 6 continuous months prior to enrollment, other than as your tenant or employee • Maintains shared residency while enrolled <p>The following are not eligible as an OQA: The employee's or OQA's:</p> <ul style="list-style-type: none"> • Parents • Parents' other descendants (siblings, nieces, nephews) • Grandparents and their descendants (aunts, uncles, cousins) • Renters, boarders, tenants, employees • Children or their descendants (children, grandchildren) <p>See page 14 for eligibility details, imputed tax information and instructions in the event and your OQA marry.</p>	<p>AFSCME COAM Faculty and Staff GSI GSSA GSSRA IUOE LEO-GLAM LEO Lecturers I/II/ III/IV LEO Intermittent MNA POAM Research Fellows SEIU Trades UM-Flint AFT-AAUP UMMAP UPAMM</p>	<ul style="list-style-type: none"> • Health Plan³ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance if employee is enrolled in the University Life plan • Legal Services Plan • MHealthy Tobacco Independence Program³ (if enrolled in a U-M health plan) • MHealthy Rewards program⁴ (if enrolled in a U-M health plan) 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Health Savings Account (if enrolled in Consumer-Directed Health Plan)
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan² • MHealthy Tobacco Independence Program³ (if enrolled in a U-M health plan) • MHealthy Rewards program⁴ (if enrolled in a U-M health plan) 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Vision Plan • Long-Term Disability • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan³ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
	<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan² (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program

1 If you and your spouse or OQA are both employees of the university, you cannot be covered as both an employee and as a dependent on U-M Health, Prescription Drug, Dental, or Vision Plans.

2 Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan.

3 For more information about the MHealthy Tobacco Independence Program (MTIP), please call: (734) 998-2193 or view the [MHealthy Tobacco Consultation Services web page](#).

4 For more information, view the [MHealthy web page](#).

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Your Children by Birth or Adoption, Children of Your Spouse or Other Qualified Adult, from Birth to Age 26</p> <p>Eligible from birth through end of the month children turn age 26 and are not already covered through the university as an employee or as a dependent on another university employee's coverage.</p> <p>Your Child under Legal Guardianship</p> <p>Eligible from the date the court order is effective, or on the date the child moves into your home, whichever is later, and is not already covered through the university as an employee or as a dependent on another university employee's coverage. Coverage under your benefits can continue through the end of the year in which the child turns age 18, or until the expiration date stipulated by the court within the Letters of Guardianship, but in no event beyond the end of the month the child reaches age 26.</p>	<p>AFSCME COAM Faculty and Staff GSI GSSA GSRA IUOE LEO-GLAM LEO Lecturers I/II/ III/IV LEO Intermittent MNA POAM Research Fellows SEIU Trades UM-Flint AFT-AAUP UMMAP UPAMM</p>	<ul style="list-style-type: none"> • Health Plan¹ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance (eligible from 15 days to age 26)² if employee is enrolled in the University Life plan • Legal Services Plan 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • MHealthy Rewards program • Health Savings Account (if enrolled in Consumer-Directed Health Plan)
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan¹ 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Vision Plan • University Life, Optional Life, and Dependent Life Insurance • Long-Term Disability • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance • MHealthy Rewards program
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
	<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program

¹ Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan.

² Only unmarried dependent children are eligible for Dependent Life Insurance.

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Never Married Principally Supported Children, to Age 19²</p> <p>Children through the end of the year in which they reach age 19 who:</p> <ul style="list-style-type: none"> • Are not your own children by birth or marriage; • Are related to you by blood or marriage; • Live with you on a permanent basis; • Are not eligible for coverage through the university as an employee; • Are not already covered through the university as a dependent on another university employee's coverage; • Will be claimed as a dependent on your income tax return for the current year; • Have been principally supported by you for at least six consecutive months before you apply for coverage. <p>Coverage will go into effect the first day of the month following 90 days after the application is received.</p>	<p>AFSCME COAM Faculty and Staff GSI GSSA GSRA IUOE LEO-GLAM LEO Lecturers I/II/ III/IV LEO Intermittent MNA POAM Research Fellows SEIU Trades UM-Flint AFT-AAUP UMMAP UPAMM</p>	<ul style="list-style-type: none"> • Health Plan¹ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance (eligible from 15 days to age 26)² if employee is enrolled in the University Life plan • Legal Services Plan 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • MHealthy Rewards program • Health Savings Account (if enrolled in Consumer-Directed Health Plan)
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan¹ 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Vision Plan • University Life, Optional Life, and Dependent Life Insurance • Long-Term Disability • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance • MHealthy Rewards program
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
	<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program

¹ Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan.

³ Only unmarried dependent children are eligible for Dependent Life Insurance.

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Disabled Dependent, Age 26 or Older</p> <p>Your unmarried children by birth, adoption, or children of your spouse or other qualified adult who:</p> <ul style="list-style-type: none"> • Are not classified as principally supported children; • Have reached the end of the month in which they turn age 26 and are covered as your dependent under a U-M health plan; • Are incapable of self-support due to a mental or physical disability incurred prior to age 26; • Are chiefly dependent upon you, your spouse or eligible other qualified adult for support and maintenance (50%+ support); • Are not eligible for coverage as an employee or are not already covered through the university as the dependent on another university employee's coverage; • Are not eligible for any other health coverage (such as employer group plans, Medicaid, Medicare, other government plan, etc.) • Application for extended coverage due to dependent's disability must be submitted within 31 days of the date the dependent reaches age 26. • Once your disabled child has reached age 26, the child must be continuously covered under a University of Michigan group health plan in order to maintain eligibility. If removed, the child cannot be re-enrolled except under commercial transfer rules. • A new hire or newly eligible employee with a disabled child over age 26 may also apply for coverage for that child when first enrolling for coverage, provided that: the child's disability began before the child turned age 26, the child has had continuous employer group medical coverage since age 26 and such proof of coverage is provided when application is made. 	<p>AFSCME COAM Faculty and Staff GSI GSSA GSSA IUOE LEO-GLAM LEO Lecturers I/II/ III/IV LEO Intermittent MNA POAM Research Fellows SEIU Trades UM-Flint AFT-AAUP UMMAP UPAMM</p>	<ul style="list-style-type: none"> • Health Plan¹ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance (eligible from 15 days to age 26)² if employee is enrolled in the University Life plan • Legal Services Plan 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • MHealthy Rewards program • Health Savings Account (if enrolled in Consumer-Directed Health Plan)
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan¹ 	<ul style="list-style-type: none"> • Health Savings Account (if enrolled in Consumer-Directed Health Plan) • Vision Plan • Long-Term Disability • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance • MHealthy Rewards program
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program 	

¹ Enrollment in any U-M health plan automatically includes enrollment in the U-M Prescription Drug Plan.

² Only unmarried dependent children are eligible for Dependent Life Insurance.

Tax Information for Coverage of Other Qualified Adults

You will 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 health, dental, and vision 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 any amount representing the fair market value of providing the coverage in enrolled health, dental, and/or vision coverage for your other qualified adult less your after-tax contribution. This is referred to as “imputed income,” and you will pay taxes on it: it is also subject to applicable income taxes, as well as FICA/FUTA.

For information about imputed income, refer to the [Other Qualified Adult web page](#). If you marry your OQA, you will need to complete and submit a [Dependent Information Form](#) within 30 days of your marriage to report your change in relationship. 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.

Call the SSC - HR Customer Care at (734) 615-2000 locally, or toll-free at (866) 647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance.

“Other Qualified Adult” Eligibility Criteria

Under the Other Qualified Adult (OQA) program, a U-M employee who does not enroll a spouse in the health or other benefit plans may enroll one adult individual for benefit coverage if all of the following eligibility criteria are met:

- The employee is eligible for U-M benefits.
- The Other Qualified Adult, at the time of proposed enrollment, shares a primary residence with the employee and has done so for the previous 6 continuous months, other than as an employee or tenant.
- You have 30 days from the date shared residency has been established to add your OQA to your benefits coverage. If you do not enroll your OQA within the 30-day deadline, you must wait until the next Open Enrollment period to do so.
- To remain eligible for coverage, you and your OQA must continuously share the same primary residence. If your OQA no longer resides with you, you must notify the SSC - HR Customer Care within 30 days of the date your OQA moved from your residence. Coverage for your OQA and your OQA's children will terminate at the end of the month of their move. Failure to provide notification of the loss of eligibility within 30 days may result in additional and unwanted imputed income, in addition to claims and premium costs to you.

Eligible children of an Other Qualified Adult may also be enrolled.

The following individuals are not eligible for participation in the OQA program if they are the employee's or the spouse/OQA of the employee's:

- Parents
- Parents' other descendants (siblings, nieces, nephews)
- Grandparents and their descendants (aunts, uncles, cousins)
- Renters, boarders, tenants, employees
- Children* or their descendants (children, grandchildren)

* Eligibility for children is defined by the eligibility criteria for dependent children.

Enrollment

When to Enroll

Generally, there are four times when you can enroll or may be able to change your benefits at the university:

- As a newly hired/rehired or newly eligible faculty or staff member;
- After experiencing a qualifying job status change;
- After experiencing a qualifying family status change; or
- During Open Enrollment, usually in October, with benefits effective Jan. 1.

It is to your advantage to enroll in benefits as soon as you are eligible. However, if you are eligible, you may enroll at any time during the year in the following plans:

- Basic Retirement Plan
- 403(b) Supplemental Retirement Account (SRA)
- 457(b) Deferred Compensation Plan
- Optional and Dependent Spouse/Other Qualified Adult Group Term Life Insurance (by providing proof of insurability)
- Child Life
- Expanded Long-Term Disability (health statement may be required)

If you do not enroll in the life insurance or Expanded LTD plans when you are first eligible, you will be required to complete appropriate health statements and prove insurability before you can enroll. Enrollment information for each of the benefits plans is available from the [Benefits and Wellness web page](#).

Effective Date of Benefits Elections

For the following benefits plans, coverage begins on your service date or newly eligible date if you enroll by the deadline stated on your enrollment materials.

- Health, Prescription Drug, Dental, Vision, and Legal plans
- Life Insurance (if a health statement is required, coverage will not begin until the date the health statement is approved by MetLife; this may take 2-4 weeks)
- Expanded Long-Term Disability

If you do not enroll within the deadline, you will not have health plan coverage. Members of the AFSCME, COAM, HOA, IUOE, MNA, POAM, SEIU, UMMAP, UPAMM, and GEO unions, GSRAs, and benefits eligible fellowship and medical school students who do not enroll will be enrolled by default into single-person health plan coverage. Research Fellows' default coverage will be determined by university policy. View the [U-M Standard Practice Guide](#).

Your participation in Flexible Spending Accounts (Health Care and/or Dependent Care accounts) will begin on the first day of the month after the SSC - Benefits Transaction team receives your enrollment form.

If you enroll in the Consumer-Directed Health Plan (CDHP), you are eligible to enroll in the Health Savings Account (HSA). With an HSA, you can put away money for future health care costs while saving on taxes. Additional information about the HSA is available on the [Consumer-Directed Health Plan web page](#).

You are automatically covered for [Business Travel Accident Insurance](#) and [Travel Assistance](#) beginning your first day of service with the university.

University Life Insurance coverage is automatic on the date of eligibility for faculty and staff newly hired or newly eligible after Jan. 1, 2001.

Job or Family Status Change

If you have a job status change that impacts your eligibility for benefits, you will receive a notification.

If you have a qualified family status change, you must act within 30 days of the qualifying event for the change to be accepted by the university. Otherwise you will have to wait for the next Open Enrollment period to make the change to your benefits. See [page 71](#).

Questions about mid-year changes affecting your University of Michigan benefits should be directed to the SSC - HR Customer Care. Change forms are available from the [Benefits and Wellness web page](#).

During Open Enrollment

Open Enrollment is an annual event (usually in October) during which you can enroll in new benefits or change your current benefits enrollments for the upcoming year, effective Jan. 1. The Benefits Office will send benefits updates, rate changes, and enrollment information to you before Open Enrollment begins.

When Two Members of a Household Work at U-M and/or a Family Member Has U-M Benefits as a Retiree

If you and your spouse or other qualified adult (OQA) are both employed by the university, or one of you has benefits as a U-M retiree, when you enroll in benefits, keep in mind:

- You and your spouse or OQA cannot be covered as both an employee or retiree and a dependent for any university benefit program except employee and dependent life insurance benefits.
- Each parent can enroll in different benefits plans or options, and each of them can enroll a different child under his or her coverage, but both cannot enroll the same child.

Under your University of Michigan benefits plans, you cannot cover:

- Anyone who works for the university and has his or her own coverage as an employee of the university;
- Any eligible dependents who are already covered by another employee of the university, unless you are court-ordered to provide such coverage;
- Anyone who is not your legal spouse or eligible dependent;
- Yourself if you are covered by another University of Michigan employee in the same plan.

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

Use Benefits Self-Service on Wolverine Access

To enroll online, log onto [Wolverine Access](#), search for **Employee Self Service**, and click the **Benefits** tile. Supported browsers are Chrome, Firefox, Edge, and Safari.

Your Uniqname and UMICH Password

A University of Michigan unqname and a UMICH password are required to login to Wolverine Access. Contact your supervisor if you do not have a unqname or UMICH password.

Accessing Benefits Self-Service

If you can view your job appointment on Wolverine Access, your benefits enrollment information will also be available. You must have internet access on your computer to use Benefits Self-Service. Visit [Browser and Operating System Support](#) on the U-M Information and Technology Services website for information on supported browsers.

Follow these instructions to enroll in benefits:

1. Log on to [Wolverine Access](#).
2. Search for ‘**Benefits**,’ then select **Benefits Self-Service**.
3. Complete two-factor authentication to continue the login process.
4. Click the **U-M New Benefits Eligibility** tile.
5. Follow the prompts to make your elections.

If you are unable to enroll online, call the SSC - HR Customer Care at (734) 615-2000 locally, or toll-free at (866) 647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance.

When you make a benefit election, you confirm that you understand and agree that to claim coverage for an ineligible dependent is misconduct, and you agree to reimburse the university for any additional costs incurred as a result of that misconduct. The university reserves the right to request documentation to verify eligibility of your enrolled dependents. When you enroll a dependent, you agree to provide such documentation upon request.

Flexible Spending Account Enrollment Forms

Separate forms are required to enroll in the Health Care or Dependent Care Flexible Spending Account. Electronic enrollment forms, as well as downloadable forms, are available on the [Flexible Spending Accounts Forms and Documents web page](#).

Confirmation Statement

Your confirmation statement will be available in the system for you to view. After making an online election, you can view or print your submitted confirmation statement immediately after your elections are submitted. Final and submitted confirmation statements are available in Wolverine Access. You will also receive a confirmation statement when you do the following:

- Enroll in or change your elections for the Basic Retirement Plan, 403(b) SRA, or 457(b) Deferred Compensation Plan.
- Enroll in a Health Care or Dependent Care Flexible Spending Account (FSA).
- Enroll in Life Insurance and your application is approved by MetLife.

Questions about Your Benefits or Benefits Enrollment

If you have questions or need assistance completing your benefits enrollment, call the SSC - HR Customer Care at (734) 615-2000 locally, or toll-free at (866) 647-7657, or email sharedservices@umich.edu.

Protect Your Personal Information

U-M uses two-factor authentication for login security to protect you and the university. Two-factor means that when you log in, you provide two proofs of your identity. Two-factor is required for access to many U-M systems and departmental services.

Two-factor authentication is required for Weblogin to add protection to your information in Wolverine Access, U M Google accounts, and more.

To learn more about two-factor authentication, visit the [U-M Safe Computing web page](#).

**For benefits information, go to the
University Human Resources Benefits and Wellness website**

**To enroll in benefits, go to
Wolverine Access**

2. Benefit Plans

This section provides information on benefit plans offered by the university to eligible faculty, staff, and graduate students. The plans and options available to you and your dependents depend upon your career/job family, your appointment duration and percentage effort (regular hours worked per week), and your funding type. See the Eligibility Charts on [pages 8-13](#).

Retirement Savings Plans

The [Basic Retirement Plan](#) is a tax-deferred 403(b) and 401(a) plan with a 2-for-1 matching contribution. You may enroll at any time, and all contributions are immediately vested. Individuals newly hired or newly eligible to participate in the plan must complete a waiting period of 12 consecutive months of eligible service in order to become eligible to receive the university contribution. In addition to the Basic Retirement Plan, you may also contribute to the 403(b) Supplemental Retirement Account (SRA) and the 457(b) Deferred Compensation Plan. See [page 19](#).

Health Plan Coverage

A number of [health plan coverage options](#) are available. Choose the plan that covers you and your dependents' health needs in ways that are most advantageous to you. See [page 28](#).

Prescription Drug Plan

If you are enrolled in a university health plan, you are automatically enrolled in the U-M [Prescription Drug Plan](#). See [page 46](#).

Dental Plan

The [Dental Plan](#) offers three coverage choices with differing features: Option 1, Option 2, and Option 3. If you are eligible, you may select the option most suited to your needs. See [page 48](#).

Vision Plan

Each person enrolled in the [Vision Plan](#) may receive an eye exam, lenses, and frames once each calendar year. See [page 53](#).

Health Care Flexible Spending Account

Enrolling in the [Health Care Flexible Spending Account](#) allows you to pay certain health care and dental expenses with tax-free money. See [page 55](#).

Dependent Care Flexible Spending Account

Enrolling in the [Dependent Care Flexible Spending Account](#) allows you to pay certain child care and elder care expenses with tax-free money. See [page 58](#).

Expanded Long-Term Disability

The [Expanded Long-Term Disability plan](#) pays up to 65% of your covered pre-disability base salary in the event you should become totally disabled. The plan also pays the cost to continue most of the benefits you have at the time of disability. (House Officers and AFSCME members have separate plans.) See [page 60](#).

Basic Long-Term Disability

The [Basic Long-Term Disability plan](#) is available to AFSCME members only. It pays up to \$1,200 per month. The plan also pays the cost to continue most of the benefits you have at the time of disability. See [page 62](#).

Group Term Life Insurance

The university offers three [Group Term Life insurance](#) plans to eligible faculty and staff.

- **University Plan**—\$30,000 of coverage for you paid for by the university;
- **Optional Plan**—Your choice of coverage of \$10,000, \$50,000, or 1 to 8 times your annual salary to a maximum of \$1.7 million, paid for by you;
- **Dependent Plan**—Coverage for your spouse or other qualified adult (OQA) or your dependent children, paid for by you.

See [page 63](#).

Legal Services Plan

For a low monthly fee, you can obtain help for a personal legal matter from a local attorney in private practice who participates with [MetLife Legal Services](#). Your plan attorney will maintain strict confidentiality. See [page 67](#).

Travel Accident Insurance and Travel Assistance

While traveling on business for the university, all active faculty and staff members are covered by [travel accident insurance and the Secure Travel Plan](#), the entire cost of which is paid by the university. See [page 69](#).

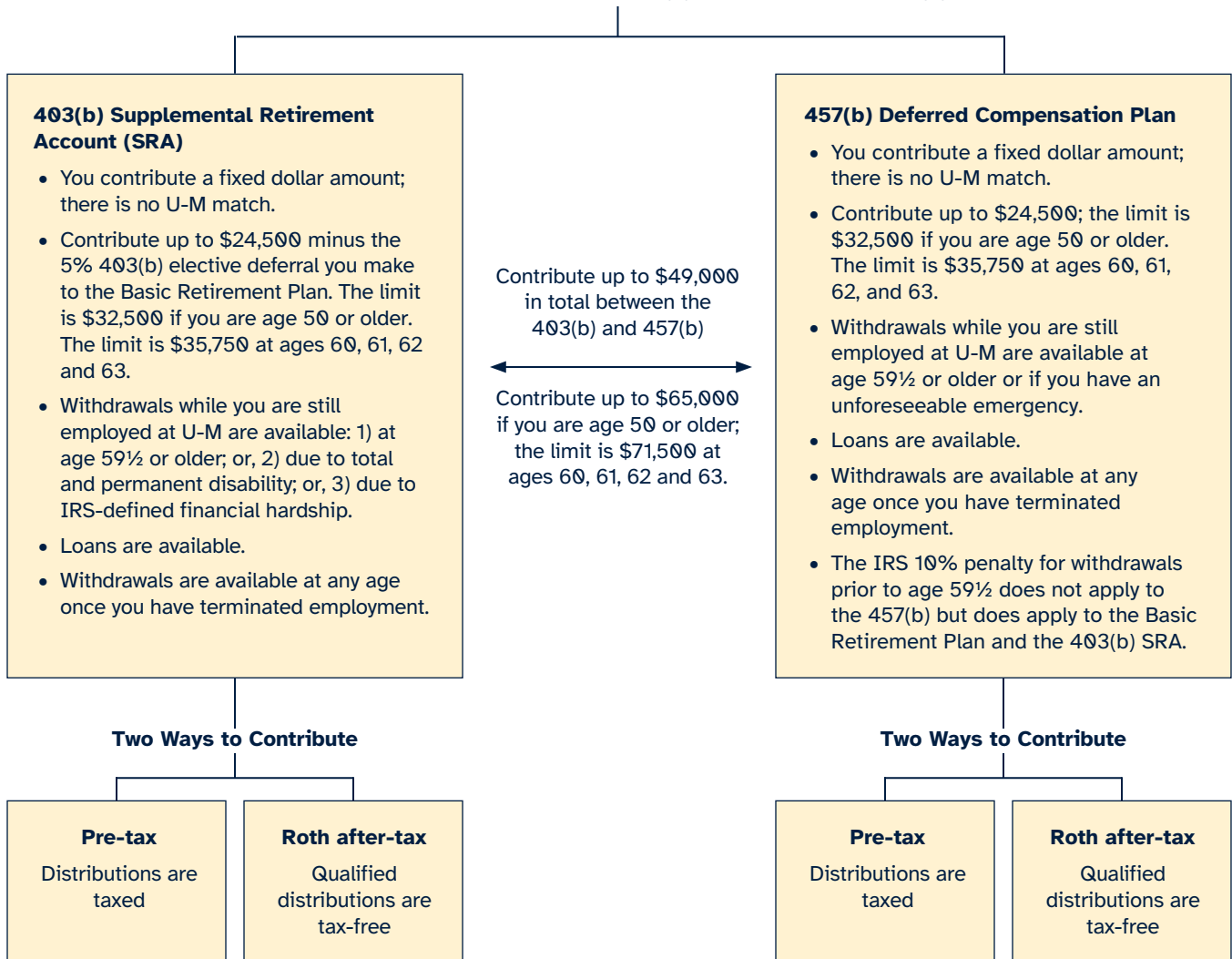
U-M Retirement Savings Plans Overview

Basic Retirement Savings Plan, 403(b) SRA and 457(b)

Basic Retirement Savings Plan

- The U-M Basic Retirement Savings Plan is a 403(b) and 401(a) plan with immediate vesting.
- You contribute 5% of your pre-tax salary and U-M contributes 10% after 1 year of service once you are enrolled in the Basic Plan. If you are subject to a collective bargaining agreement, consult with the terms of the agreement to confirm the contribution rate.
- The Basic Retirement Plan does not offer loans, although cash withdrawals of your 5% 403(b) contribution are available while employed due to total and permanent disability, if you have an IRS-defined financial hardship, or at age 59 1/2 or older.
- You may cash out all contributions and earnings at any age after you have terminated employment.

Save More with the 403(b) SRA and 457(b)



U-M Retirement Savings Plans

Basic Retirement Plan

The University of Michigan [Basic Retirement Plan](#) is a tax-deferred defined contribution retirement savings plan with a 2-for-1 match on earnings up to \$360,000. It is a combination 403(b) plan for employee contributions and a 401(a) plan for university contributions.

Participation and Eligibility

Regular faculty and staff, including LEO I-IV and LEO Intermittent, can participate with as little as a 1% appointment lasting for at least four continuous months funded by the university. Supplemental instructional staff (Adjunct, LEO Adjunct, Visiting and Clinical I titles) with a 50% or greater appointment funded for at least four continuous months are also eligible.

The following titles are not eligible for the Basic Retirement Plan but may contribute to the 403(b) Supplemental Retirement Account (SRA) and the 457(b) Deferred Compensation Plan: Supplemental instructional staff below 50% effort, House Officers, Research Fellows, Graduate Students, Professional Specialists, and emeritus/a titles. Temporary staff may also contribute to the 403(b) SRA.

Stipends, scholarships, and fellowships are not eligible to be contributed to any type of plan.

Contribution Rate

Eligible faculty and staff contribute 5% of salary and receive a 10% U-M match after one year of service once enrolled.

Individuals subject to a collective bargaining agreement should consult the terms of their agreement to confirm the contribution rate.

Eligible Compensation

Both the employee and university contribution for the Basic Retirement Plan are provided on base salary for faculty and staff eligible to enroll. Incentive payments (risk pay) under the Medical Service Plan and summer salary for university-year appointees are also eligible. Contributions are not provided on the following types of compensation:

- Overtime
- Salary supplement
- Payout of unused vacation or Paid Time Off (PTO) at termination or retirement
- Annual PTO sell back
- Shift differential
- Administrative differential
- Added duties differential
- Faculty honor

Individuals subject to a collective bargaining agreement should consult with the terms of the agreement to determine if additional forms of compensation are not eligible for contributions.

Immediate Vesting

All retirement savings plan contributions and earnings are vested immediately. This means that the accumulations are yours for retirement or to be paid to your designated beneficiary in the event of death. Please note that restrictions apply to cash withdrawals and rollovers.

Learn More about U-M Retirement Savings Plans

[Web Page](#)

[Plan Book](#)

[IRS Limits](#)

Waiting Period for U-M Contributions to the Basic Retirement Plan

What is the waiting period?

The waiting period means a new hire or newly eligible faculty or staff member must complete 12 consecutive months of eligible service in order to become eligible for the U-M contribution to the Basic Retirement Plan.

Does the waiting period apply to individuals who belong to a union or bargaining unit?

Check with the terms of the collective bargaining agreement to see if you are subject to the waiting period.

How is the waiting period measured?

You must complete 12 consecutive months of service in a job title eligible to enroll in the plan. The waiting period is measured from the date you are first eligible to enroll in the plan, which is typically your date of hire. If you were hired into a job not eligible for the plan (example: temp, House Officer, Research Fellow, etc.) but later become eligible due to a change in effort or job title, the waiting period is measured from the effective date of your job change.

Can I get credit toward meeting the waiting period based on time I worked at my previous employer?

No; the waiting period is based solely on eligible service completed at the University of Michigan.

Do I have to fulfill the waiting period if I lose eligibility for the plan or am rehired?

- If your gap in employment or eligibility is one year or greater, you will need to complete the waiting period to become eligible to receive university contributions.
- If your gap in employment or eligibility was less than one year, and you were eligible for university contributions prior to the gap, you do not need to fulfill the waiting period and you will receive university contributions upon enrollment.
- If your gap in employment or eligibility was less than one year, but you were not eligible for university contributions prior to the gap, you will need to complete the waiting period.
- University retirees who are rehired into a title eligible for the Basic Retirement Plan do not need to complete the waiting period if they were eligible for university contributions prior to retirement and will receive university contributions upon enrollment.

Does the waiting period mean I cannot enroll until after I complete 12 months of service?

No. You may enroll in the plan and contribute. However, university contribution begins after you have completed the 12-month waiting period. The waiting period refers to becoming eligible for university contributions, not whether you may enroll.

When will the U-M matching contribution begin?

The university contribution will be provided with respect to compensation earned after you have completed the 12-month waiting period and you are enrolled in the Basic Retirement Plan. If you are not enrolled after completing the waiting period, you must affirmatively enroll in order to receive the university contribution.

Enrollment in the Basic Retirement Plan and university contributions do not automatically begin due to completing the waiting period.

Can I wait until after completing the waiting period to enroll in the Basic Retirement Plan?

Yes. Participation is optional and you may enroll any time throughout the year.

Basic Retirement Plan Contribution Rate Once Enrolled

During first 12 months of eligible service

- You contribute
- U-M does not contribute

After 12 months of eligible service

- You contribute
- U-M provides its matching contribution

Do You Have Another Retirement Plan?

Elective deferrals you make to another retirement plan in the same calendar year will reduce how much you may contribute to the Basic Retirement Plan and the 403(b) SRA.

These plan types include:

- Federal Thrift Savings Plan (example: as a VA Rotator)
- 403(b)
- 401(k)
- 408(k)(6) SARSEP
- SIMPLE (Savings Incentive Match Plans for Employees)

If you have already made significant contributions to these plan types during the calendar year, you may have limited ability to save through the U-M 403(b) SRA and the Basic Retirement Plan. If this is the case, consider the 457(b) as an option to make additional contributions to save for retirement. Also, 457(b) elective deferrals you make at another employer will reduce how much you contribute to the 457(b) at U-M.

Contributions made to certain plans also reduce the amount you may contribute to the U-M plans. These include certain plans with respect to self-employment income, another 403(b) plan outside the U-M plans, or certain types of plans sponsored by a corporation, partnership, or sole proprietorship in which you have more than a 50% ownership interest.

For information, view the [Retirement Savings Plan Contribution Limits web page](#).

Consult with a Tax Advisor

Consult with a tax advisor to ensure you do not exceed the IRS limits. Call the SSC - HR Customer Care if you have questions about the IRS contribution limits or to report contributions made to another plan that may affect the amount contributed to the U-M plans.

Save More with the 403(b) SRA and 457(b)

You may save more for retirement through the [403\(b\) SRA](#) and [457\(b\) Deferred Compensation](#) plans by making contributions as traditional pre-tax, Roth after-tax, or any combination of both at any time. These amounts are separate from the amount you contribute to the Basic Retirement Plan and are not matched by U-M.

Roth 403(b) SRA and Roth 457(b)

Roth contributions are taxed when taken from your paycheck but offer the incentive that qualified distributions are tax-free when made after a 5-taxable-year period of participation and are either made on or after the date you attain age 59½, made after your death, or attributable to your being disabled. In contrast, pre-tax contributions are not subject to income tax when deducted from your paycheck, but are taxed when you take a distribution.

Another incentive to the after-tax Roth 403(b) SRA and Roth 457(b) plans is that you may postpone distributions indefinitely during your lifetime, and you can even pass assets tax-free to your heirs.

Who may benefit from a Roth 403(b) or Roth 457(b)?

- Those not eligible for a Roth IRA due to IRS income restrictions which do not apply to the U-M Roth plans.
- Young faculty and staff who have a long retirement horizon that will allow time to amass significant tax free assets.
- Those who believe their income tax rates will rise in the future.
- Those who want tax diversification of having both after-tax and tax-deferred assets as a hedge against potential tax increases.

403(b) and 457(b) Contribution Limits

You may contribute up to \$24,500 into each plan per year if you are younger than age 50; if you are age 50 or older, the limit is \$32,500. At ages 60, 61, 62, and 63 you may contribute up to \$35,750. This allows you to contribute up to \$49,000 to both plans combined if you are younger than age 50 and up to \$65,000 if you are older than 50. At age 60, 61, 62, and 63, you may contribute up to \$71,500 to both plans combined.

SECURE 2.0 Act Roth Mandate

In addition to the annual limit on 403(b) and 457(b) contributions, the SECURE 2.0 Act Roth mandate applies to individuals who are age 50 or older and have more than \$150,000 in Social Security FICA tax wages (reported in Box 3 on the W-2) for the prior year. If you are subject to the Roth mandate, age 50 catch-up contributions (those in excess of the \$24,500 general limit) can be made only as Roth and cannot be pre-tax. For more information, view the [SECURE 2.0 Act Roth Mandate web page](#).

Limits on Cash Withdrawals and Rollovers

Basic Retirement Plan:

- Your 5% 403(b) contributions are available for cash withdrawals while you are an active faculty or staff member:
 1. At age 59½ or older;
 2. In the event of total and permanent disability;
 3. If you have an IRS-defined financial hardship.
- Cash withdrawals and rollovers of employee and university contributions are available at any age once you have terminated employment.
- Loans are not available under any circumstance.

403(b) SRA: Cash withdrawals and rollovers are available upon termination of employment at any age and at 59½ while still working at U-M. Withdrawals due to disability and hardship that meet IRS qualifications are also available.

457(b): Cash withdrawals and rollovers are available upon termination of employment at any age, and at age 59½ or due to an unforeseeable emergency while you are still working at U-M.

Loans: Available for both the 403(b) SRA and the 457(b) Deferred Compensation Plan.

For more information, view the [Cash Withdrawals and Loans web page](#).

Rollovers into U-M

You can roll over assets from another employer's retirement plan or from an IRA into the U-M Retirement Plans with TIAA and/or Fidelity Investments to consolidate your assets alongside your U-M retirement plan accounts, and it provides you with a single quarterly statement. Assets you roll into any of the U-M plans are available for withdrawal while you are working for the university or after you terminate employment. In addition, the 403(b) SRA and 457(b) Deferred Compensation plans also offer the option to take a loan on your account. For more information, view the [Rollovers web page](#).

Compulsory Participation

You may enroll in the Basic Retirement Plan at any time. Participation is compulsory for regular faculty and staff who are age 35 or older, work a 100% appointment, and have at least two years of eligible service. If you are not participating in the Basic Retirement Plan once you meet all three criteria, you will be enrolled and the contribution rate will be the Reduced Benefit Option. Under the Reduced Benefit Option on earnings below the FICA wage base, you do not contribute and the U-M contribution is half the normal match rate. On earnings exceeding FICA, the 2-for-1 contribution rate applies. You may change between participating at the Reduced Benefit Option and the full matching rate throughout the year as a compulsory participant.

Direct Transfers

You may transfer accumulations between TIAA and Fidelity Investments at any time, but you must have an account at the company that will receive the transfer. The transfer application does not create your account, which you must do as a separate action. A transfer only moves existing balances. You will need to direct future contributions to the newly chosen investment company or they will continue to be deposited with your current company. For more information, view the [Rollovers web page](#).

Military Leave of Absence

When you return from a military leave of absence, you are allowed to make extra contributions to the Basic Retirement, SRA, and 457(b) plans to make up for those you missed. Call the [SSC - HR Customer Care](#) for information.

1. Enroll in the Basic Retirement Plan

You may select the Basic Retirement Plan enrollment option while you are choosing other benefits like medical and dental as part of the new hire enrollment event. Be sure to also indicate how much of your contribution and the U-M contribution (when you are eligible) to invest with TIAA and/or Fidelity. You may change how much you allocate to either investment company or enroll in the Basic Retirement Plan throughout the year by creating an enrollment event.

2. Enroll in the 403(b) SRA and/or 457(b) Deferred Compensation Plan

You contribute a fixed dollar amount to the 403(b) SRA and/or 457(b) Deferred Compensation Plan; you may choose to contribute as traditional pre-tax, Roth after-tax, or a combination of both. You need to create a separate enrollment event to enroll in the 403(b) SRA and/or 457(b) since they are not part of the new hire event that you use to enroll in the Basic Retirement Plan.

You may also enroll in, or make changes to, any retirement plan throughout the year by creating an enrollment event as follows:

3. Select Your Funds and Designate Your Beneficiary

Your beneficiary and investment fund for the Basic Retirement Plan, 403(b) SRA, and 457(b) Deferred Compensation Plan will be a default. You may change these at any time after your account has been created; for example, after you receive the welcome packet from the company. You may also create your account online through the TIAA and Fidelity websites.

Default Investment Fund – The fund default is an age appropriate Lifecycle Index Fund if you select TIAA and a Freedom Index Fund if you select Fidelity Investments. If you do not have a U.S. street mailing address, the default investment fund for TIAA will be CREF Money Market.

Default Beneficiary – For both TIAA and Fidelity, the default beneficiary will be according to the person or persons surviving you in the following order: a) spouse, b) children, c) parents, d) brothers or sisters, e) personal representative (executor or administrator).

IMPORTANT – You need to make your fund and beneficiary designations for each type of plan in which you enroll and for each investment company you select. For example, if you enroll in the Basic Retirement Plan and the 403(b) SRA with TIAA, you need to designate your fund choices and beneficiary for each plan even though both are with the same company.

How to Enroll as a New Hire

You may enroll in the Basic Retirement Plan using Wolverine Access when you select your other benefits, such as medical and dental, as a new hire.

403(b) SRA and 457(b) Enrollment

The 403(b) SRA and 457(b) enrollment elections are not available as part of the online new hire enrollment process. You need to create a separate enrollment event to enroll in the 403(b) SRA and the 457(b).

Therefore, you will need two separate events to enroll in all three plans. Each enrollment is processed overnight after you finalize your elections; allow up to 24 hours between enrollment elections.

Your U.S. Social Security number must be on file with Wolverine Access or your contributions will be rejected.

When you complete the online enrollment process, a notice will be sent to TIAA and/or Fidelity to create your account(s) for the Basic Retirement Plan, 403(b) SRA, and/or 457(b). You will need to follow up with TIAA and/or Fidelity to select your investment funds and designate your beneficiary.

Effective Date – The Basic Retirement Plan, 403(b) SRA, and 457(b) can all take effect in the current month if your enrollment is completed by certain deadlines. For information about deadlines, synchronizing your plan enrollments to take effect with a specific paycheck, and enrollment instructions, view the [Enrollment or Making Changes Throughout the Year web page](#).

If you are a rehire – If you have an existing U-M account for the type of plan in which you are enrolling, it will continue to be used and a new account will not be created. Be sure your name, address, beneficiary, and investment funds with TIAA and/or Fidelity Investments are correct; they may have become outdated since your previous employment with the university.

TIAA Online

You can create your account, select your investment funds, and designate your beneficiary online at any time instead of waiting for your welcome packet by using the [U-M/TIAA log-in web page](#).

- Select “**Enroll Now.**”
- Click on the type of plan for which you are creating an account: Basic Retirement Plan, 403(b) SRA, 457(b) Deferred Compensation Plan.
- Follow the online prompts and enter your selections.

By Phone: Call TIAA at (800) 842-2252, Monday through Friday from 7 a.m. to 9 p.m. and Saturday from 8 a.m. to 5 p.m. (Central Time). A consultant will help you make the appropriate beneficiary designations for your retirement planning needs and record your investment fund selections.

Fidelity Investments Online

You can create your account, select your investment funds, and designate your beneficiary online at any time instead of waiting for your welcome packet by using the [U-M/Fidelity log-in web page](#).

- Select “Enroll.”
- Click on the type of plan for which you are creating an account: Basic Retirement Plan, 403(b) SRA or 457(b) Deferred Compensation Plan.

NOTE: You will need to open an account under two different plans for the Basic Retirement Plan. Open an account under **401(a) Base Plan 86503** for the U-M contribution and open an account under **403(b) Base Plan 72104** for your contribution.

- Follow the online prompts and enter your selections.

By Phone: Contact a Fidelity retirement services specialist by calling (800) 343-0860, Monday through Friday from 8 a.m. to midnight, Eastern Time, if you have questions or need assistance.

The Default Investment Fund

A TIAA Lifecycle Index Fund or Fidelity Investments Freedom Index Fund is a mutual fund that is a diversified portfolio of other mutual funds offered by that company; essentially it is a fund of other funds. This includes domestic and international stock funds, bond funds, and money market funds. Each Lifecycle Index or Freedom Index Fund automatically selects the allocation of stock, bond, and money market funds that are appropriate for a target retirement date of approximately age 65.

The Lifecycle Index and Freedom Index Funds gradually adjust over time to become more conservative by decreasing the underlying equity holdings and increasing the fixed income holdings as the fund’s target retirement date nears. The gradual shift into fixed income from equities provides the potential for growth, while reducing volatility as the retirement date approaches.

TIAA Lifecycle Index and Fidelity Freedom Index funds are actively managed; however, the underlying mutual funds within each portfolio are index mutual funds. An index fund is a passive investment strategy that aims to replicate the movements of a specific benchmark that are held constant, regardless of market conditions. Using underlying index funds is a lower cost option to meet your retirement savings goals.

Your date of birth will be included in the enrollment notice sent to your chosen investment company. This will determine the specific Lifecycle Index or Freedom Index Fund into which you will be enrolled.

Lifecycle Index and Freedom Index funds provide a simple solution if you lack the time, confidence, or investment knowledge to create and manage a well-diversified portfolio. Each fund is professionally managed and provides you with a simple, single investment fund.

Investment Company Profiles

TIAA

What is TIAA?

TIAA is the nationwide retirement and financial services system for people who work at more than 15,000 colleges, universities, independent schools, and other nonprofit education, hospital and health care, and research institutions throughout the U.S. In fact, the University of Michigan was the first in the nation to offer TIAA in 1919.

What are my investment choices?

The investment fund is automatically defaulted to an age-appropriate TIAA Lifecycle Index Fund. You may change this at any time. TIAA offers more than 40 fund choices, including mutual funds, and fixed and variable annuities.

Domestic and international stock funds, bond funds, money market funds, and real estate funds are available, along with a guaranteed fixed annuity and socially responsible funds.

Several Vanguard funds are also available through TIAA.

For a complete list of available investment funds, view the [U-M/TIAA log-in web page](#).

TIAA Institutional Class Mutual Funds

All TIAA mutual funds available through University of Michigan plans are offered under the Institutional Share Class. The institutional class is the share class with the lowest management fees and expenses TIAA offers and charges 25 basis point ($\frac{1}{4}$ of a percent) less in expenses than the retirement share class that is typically offered through most employers. The low fees mean more of your money remains in your account, working toward your financial future, and your retirement account balances have more earnings potential.

Where can I get more information?

You can meet with a TIAA investment professional by calling (800) 732-8353.

TIAA Telephone Counseling Center: (800) 842-2252

Fidelity Investments

What is Fidelity Investments?

Fidelity Investments was founded in 1946 by Edward C. Johnson II and today is the largest mutual fund company in the world. Fidelity is one of the nation's top providers of 403(b) retirement savings plans for not-for-profit organizations, including colleges and universities, health care institutions, foundations, and charitable organizations.

What are my investment choices with Fidelity?

The investment fund is automatically defaulted to an age-appropriate Freedom Index Fund. You may change this at any time. Fidelity Investments offers more than 200 mutual funds, including domestic and international stock funds, bond funds, money market funds, and real estate funds. In addition, the Select Portfolio Funds allow you to invest in highly specialized sectors of the economy.

Several Vanguard funds are also available through Fidelity.

For a complete list of available investment funds, view the [U-M/Fidelity log-in web page](#).

Fidelity Freedom Index Funds: Class W

The Fidelity Freedom Index Funds available through the University of Michigan plans are offered at the lowest-cost share class Fidelity offers for the Freedom Funds. The low fees mean that more of your money goes to purchasing investments and you keep a higher percentage of the potential returns generated, which can help you reach your retirement goals faster.

Where can I get more information?

You can meet with a Fidelity Investments professional by calling (800) 642-7131.

Fidelity Retirement Specialists: (800) 343-0860

Fund Management Fees and the U-M Plans

Investment carriers pay for operational expenses, portfolio management, recordkeeping, quarterly statements, general administration, and customer service by assessing fees on its investment funds. The fees are subtracted from the investment returns or earnings of those funds, with the net return being credited to participant accounts. The prospectus of each fund summarizes its various fees. The combination of these fees will generally equal a fund's expense ratio. The expense ratio is reported as a percent of assets under management.

There are no sales charges or loads on any fund offered by TIAA or Fidelity Investments through the U-M plans. All transaction fees (example: for taking a loan, cash withdrawals, etc.) have been waived and there are no account maintenance fees. In addition, U-M does not pay any fees to TIAA or Fidelity.

All TIAA mutual funds and the Fidelity Freedom Index Funds available through the University of Michigan plans are offered at the lowest cost share class available. Low fees mean more of your money remains in your account, working toward your financial future, and your retirement account balances have more earnings potential.

Where to Get More Information

Information and a breakdown of the fees assessed by TIAA and Fidelity Investments for its funds may be found in each fund's prospectus. A fund prospectus may be requested by phone or downloaded from each carrier's website.

You can view an explanation of the types of fund management fees on the [Fund Fees and Expenses web page](#).

Information on a fund's current and historical investment performance, as well as benchmarks, may also be found online at TIAA and Fidelity Investments.

In addition, you may also get direction on your investment choices by calling [TIAA](#) and [Fidelity Investments](#) at the phone numbers listed on [page 83](#) or through their secure websites.

Health Plan Coverage

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

Enrollment Deadlines

To ensure that you and your eligible dependents have health coverage, you must enroll within 30 days of your service date (first day on the U-M payroll) or newly eligible date, or as specified by your collective bargaining agreement.

Members of the AFSCME, COAM, HOA, IUOE, MNA, POAM, SEIU, UMMAP, UPAMM, and GEO unions, GSRAs, and benefits-eligible fellowship and medical school students who do not enroll will be enrolled by default into single-person health plan coverage. Research Fellows' default coverage will be determined by university policy. See the [University Standard Practice Guide](#) for more information.

Effective Date

If you enroll within the 30 days allowed, coverage is effective on your service date. Any applicable retroactive employee contribution amounts will be deducted from your paycheck. Deductions are retroactive to the event date if the event date is the first of the month. If the event date is after the first of the month, deductions begin on the first full pay period after the event date. To minimize the impact of retroactive deductions, it is recommended that you make your benefits elections as soon as possible.

Services Before You Get Your ID Card

Contact your health plan company to find out how to receive services before your health plan ID cards arrive. Phone numbers for plan companies are listed on [page 83](#). Your ID card will be mailed to you directly from your health plan company in a nondescript white envelope. If you have not received an ID card within two weeks of enrolling, contact the health plan to order a card and find out how to receive services until your new card arrives.

Prescription Drug Coverage

Prescription drug coverage through Prime Therapeutics is automatically included for everyone who enrolls in a U-M health plan. See [page 46](#) for details.

Provider and Hospital Plan Participation

Participating providers and participating hospitals are always subject to change. Contract renewal dates between medical plans and their providers and hospitals vary, and renewal is optional for either party. In the event your provider's affiliation ends midway through the calendar year, you will need to select another provider within your plan's service area. You will not be able to change plans midyear due to a provider'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 provider 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.

View the [Health Plans web page](#) for more information.

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.

Understanding Your U-M Health Plan Choices

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

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. The U-M Premier Care provider 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.

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 providers that includes Michigan Medicine providers.
- Understand that you need a referral from your 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 of Michigan. **If you plan to use providers and hospitals outside of 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.

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

Dollar-Savings Tip

You can use a Health Care Flexible Spending Account (FSA) for yourself and your dependents for health care expenses beyond what your plan covers. See the Health Care Flexible Spending Account section ([page 55](#)) for details.

BCBSM Community Blue PPO

The Community Blue PPO plan offers members the flexibility to see any provider throughout the U.S. without a referral, 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 provider 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.

BCBSM 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 of Michigan (BCBSM) provider.

Consider the Comprehensive Major Medical plan if you:

- Want a plan with a lower rate, and less financial risk than the Consumer-Directed Health Plan.
- 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 contracted providers within Blue Cross Blue Shield of Michigan (BCBSM) 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.

BCBSM Consumer-Directed Health Plan

The university offers a Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA). The HSA is available ONLY to those enrolled in the CDHP.

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 monthly 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 may 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 and HSA limits are adjusted annually based on IRS requirements.

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 can 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 by any other health plan unless it is a Health Savings Account qualified High Deductible Health Plan.
- You have NOT received any medical benefits (excluding dental, vision, or preventive) during the previous three months from:
 - » The Indian Health Service (IHS)
 - » The U.S. 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](#) starting on [page 36](#) for plan options.

The HSA is managed by HealthEquity, a health savings company. For more information about the CDHP and eligibility requirements, view the [Consumer-Directed Health Plan web page](#).

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. 20, 2026. Otherwise, you will not be eligible for HSA contributions until April 1, 2027.

Not sure if the CDHP is right for you? Visit [Benefits Mentor](#) to help you decide.

GradCare

GradCare, an HMO with low out-of-pocket costs, is exclusively available to benefit-eligible graduate students, including Graduate Student Instructors (GSIs), Graduate Student Staff Assistants (GSSAs), Graduate Student Research Assistants (GSRAs), benefits-eligible fellowship holders, medical school students, and their eligible dependents. GradCare is administered by Blue Care Network (BCN).

Consider GradCare if:

- You want a health plan with low out-of-pocket costs.
- You want to use U-M Premier Care network 1 providers.
- You 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.
- You understand that out-of-network, non-emergency services will not be available to you unless you receive special permission from the plan.

Health Plan Rates

Your individualized health plan rates are available on [Wolverine Access](#) through Employee Self Service. The page displays rates for all benefits plans for which you are eligible—not just the health plan rates. Rates are updated annually prior to Open Enrollment.

To view your benefits plan rates:

1. Go to [Wolverine Access](#).
2. Enter “Benefits” in the Search bar.
3. Click the Benefits Self-Service tile.
4. Click the Display Benefits Plan Rates tile.

A username and UMICH password are required to log in to Wolverine Access. If you do not have a username and UMICH password, contact your supervisor.

If you need login help, contact Information and Technology Services by calling (734) 764-HELP (764-4357), or send an email to 4Help@umich.edu.

Health Plan Resources

Tools and resources are available to help you find the health plan that offers the most advantages to you and your family. To access these resources, visit the [Health Plan Resources web page](#).

Coordination of Benefits with Michigan No-Fault Auto Insurance

Michigan law requires no-fault auto insurance. Every registered automobile must be insured. Every automobile owner must buy basic coverage in order to get license plates.

The basic no-fault auto policy has three parts: Personal Injury Protection (PIP), Property Protection Insurance (PPI), and residual bodily injury and property damage liability. The PIP portion of your no-fault policy pays for medical costs if you are injured. PIP provides a higher level of medical coverage and services not covered under your medical benefits such as lost wages, in-home attendant care, replacement services, and funeral expenses.

There are two types of PIP medical coverage: “excess or coordinated coverage” and “primary or uncoordinated coverage.”

Excess or Coordinated Medical Coverage on Auto Insurance Policies

Most people have what’s called “coordinated” or “excess” medical benefits on their auto insurance policies. This means that in the event the person is injured in an automobile accident, his or her health insurance is supposed to pay related medical bills first, then the auto insurer is responsible for the balance under the Michigan No-Fault law. Coordinated or excess coverage is generally less expensive than primary coverage, as your auto insurance company expects it will not have to pay medical bills first in the event of a motor vehicle crash.

Benefits under the U-M Health plans will not be reduced because of the existence of coverage under an employee’s coordinated or excess no-fault automobile policy.

The university health plan will assume primary responsibility to provide benefits available under your plan in accordance with the benefit plan’s terms and conditions if you have purchased a coordinated no-fault policy.

Primary or Uncoordinated Medical Coverage on Auto Insurance Policies

There is also an option to have primary medical benefits on your no-fault auto insurance policy. Another term for this is “uncoordinated” medical PIP. This means that in the event of an auto accident injury, the injured person receives medical benefits from their auto insurance company. If you have coverage through a non-coordinated no-fault policy, your U-M Health Plan will not assume primary liability and will pay as a secondary plan. If the university plan makes payment in error, claims are subject to recovery.

No-Fault and HMO or “Network” Plans

Employees covered under an HMO or any plan that restricts covered benefits to services or treatment available within a “network” who seeks services or treatment outside of the network without following proper procedures to obtain prior plan approval are cautioned to consult with their automobile insurance carrier prior to seeking such services. In some cases, the no-fault insurer may not be obligated to pay any of the cost for services denied by your university plan for treatment obtained outside the network or due to your failure to follow the plan’s proper procedures.

U-M Medicare Advantage Plans Coordination with Auto Insurance

University-sponsored Medicare Advantage plans typically do not coordinate with auto insurance for accident-related injuries. This is due to the Medicare Secondary Payer law requiring Medicare to serve as secondary coverage to other insurers for accident-related medical expenses, including those covered by auto insurance.

Coordination of benefits letters are available on your Medicare Advantage health plan’s webpage, or contact customer services using the phone number on the back of your health plan ID card.

Questions?

Please consult with your automobile insurance carrier if you have any questions about the terms of your no-fault policy. The university is unable to answer or respond to any questions you may have regarding your no-fault policy.

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	BCBSM 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.
Prior authorization 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	
BCBSM 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	
BCBSM 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 annual deductible for 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	
BCBSM 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
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
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	
BCBSM 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 ¹²	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	
BCBSM 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 for everyone enrolled in a U-M health plan. The plan is administered by Prime Therapeutics.

The prescription copay for a covered drug varies based on several factors: whether the drug is a generic, a preferred brand, or a non-preferred brand; and whether the drug is dispensed by a retail pharmacy or a mail-order pharmacy.

For more information about U-M Prescription Drug Plan coverage and the mail-order pharmacy service, visit the [Prescription Drug Plan web page](#).

Eligibility and Enrollment

- When you enroll in a university health plan, you will be concurrently enrolled in the 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 most medications. Participants can fill prescriptions for 1- 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.** Use of the mail-order service results in member savings. You will receive delivery of your maintenance medications right to your mailbox. This is particularly convenient for those who take certain medications on an ongoing basis. Participants save a third of their out-of-pocket copay for a 90-day supply of medication through mail order. Visit the [Mail Order Pharmacy web page](#) to learn more.

Note: Certain drugs may not be available through mail order. Contact Birdi at (877) 269-1160 if you have any questions about drugs available through the mail order program. Prescription drugs cannot be mailed outside the U.S. when using the U-M Prescription Drug Plan.

- **Diabetic insulin, needles, and syringes** are available to all participants in the U-M Prescription Drug Plan. Select insulin products (view the [Formulary web page](#)), needles, and syringes are covered at \$0 copay for all members.
- **Coverage of diabetic supplies** (injection devices, alcohol swabs, testing strips, lancets, and non-continuous blood glucose testing monitors) is determined by your health 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 is 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. View the [Formulary Updates web page](#).

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.

For copay amounts for generic drugs, see the Prescription Drug Plan Copays chart on [page 47](#).

Brand-Name Drugs/Tier 2 and Tier 3 – 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 with different prices that are equivalent in therapeutic value. Each of these drugs may have a different price.

Generics are always preferred and are your lowest cost option. Preferred brand-name drugs are selected on the basis of therapeutic effectiveness, safety, and cost relative to other 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.

For copay amounts for preferred brand-name drugs, see the Prescription Drug Plan Copays chart below.

Non-Preferred Drugs (Brand-Name)/Tier 3 – Drugs on the third copay tier are FDA-approved drugs that university physicians and pharmacists have not designated as “preferred”; they are subject to a higher copay and may have a product selection penalty. These products often are in drug classes that include several similar alternative brand-name or generic options. Brand-name products with generic equivalents will automatically be placed in Tier 3.

For copay amounts for non-preferred brand-name drugs, see the Prescription Drug Plan Copays chart below.

Select medications as defined by the Affordable Care Act with a prescription from your doctor are covered at \$0 copay for drug plan participants when you use your prescription drug benefit at a network retail pharmacy or a mail-order pharmacy.

Specialty Drugs are processed by the Michigan Medicine 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 a high-cost oral medication. Up to a 34-day supply per fill may be covered for most specialty products. More information is available on the [Specialty Drugs web page](#), or call the Michigan Medicine specialty pharmacy’s toll-free number, (855) 276-3002.

Dollar-Saver Tip

You can use a [Health Care Flexible Spending Account \(FSA\)](#) for yourself and your dependents to pay for prescription drug expenses. See [pages 55-57](#) for more information on the Health Care FSA.

This section is not intended to be a full description of the U-M Prescription Drug Plan coverage. The complete plan description is available on the University of Michigan HR website. Every effort has been made to ensure the accuracy of this information. If statements in this section differ from the website, then the terms and conditions of the website prevail. All benefits are subject to change.

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.

Dental Plan

Delta Dental of Michigan Administers This Plan

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 about coverage and limitations of the plan, view the [Dental Plan web page](#).

If you select Option 1, there is no monthly 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..

To view benefit levels and covered services, please refer to the benefit comparison chart on [pages 50-51](#).

For the [Dental Plan Rates web page](#) for more information about monthly contributions and dental plan rates.

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 will 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 their submitted fee or the amount in the local Delta Dental's PPO dentist fee schedule, whichever is less.
- If the PPO dentist fee 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 use 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 their 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 have coverage (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 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 participating dentists near you, view a [Delta Dental dentist directory](#).
- 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, 7 days a week, and can provide a list of participating dentists.
- Speak to a customer service representative 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 U-M School of Dentistry and Community Dental Center provides dental services to the general public and participates with Delta Dental for insurance coverage. To confirm the Delta Dental network participation level, call the Dental School Patient Business Office at (734) 647-8383, and visit the [School of Dentistry website](#).

ID Card

Delta Dental does not require ID cards. When visiting a Delta Dental dentist, simply provide your eight-digit UMID 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 card using Delta Dental's online consumer toolkit.

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

Delta Dental bases payment on the amount it approves 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 it 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 preauthorization 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 determine what your dental plan covers:

- View the [Dental Plan web page](#).
- Call Delta Dental Customer Service at: (800) 524-0149.
- Register and log on to Delta Dental's Member Portal. See below for instructions on how to access and use the toolkit.

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 pretreatment 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.

Log in to the [Delta Dental Member Portal](#) for more information.

Summary of Dental Plan Benefits

Please note: The column “NonPar” is coverage for services by dentists who do not participate in the Delta Dental PPO or the Delta Dental Premier network.

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. For additional details about how claims are paid, exclusions and limitations, view the [Dental Plan web page](#).

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.

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 U.S.

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

With Passport Dental, enrollees receive dental care outside the U.S. through the AXA Assistance worldwide network of dentists and dental clinics.

How to Find a Dentist

Call AXA Assistance at 312-356-5971 to receive a referral through an English-speaking operator. The operators are available 24/7. Callers must identify themselves as Delta Dental enrollees. When inside 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 in-country coverage. 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 nonparticipating dentist, you will have limited coverage when you use 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. 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.

Vision Plan

Davis Vision by MetLife Administers This Plan

How the Vision Plan Works

Davis Vision by MetLife provides benefits under the Vision Plan. You can receive benefits in-network or out-of-network. If you choose this benefit, you should elect to use in-network services to receive the highest benefit. In-network means you use a provider who is in the Davis Vision by MetLife provider directory.

View a participating eye care professional by using the “Find a Vision Provider” tool. To access plan information and find a provider:

1. Select “Find a Vision Provider”
2. Choose “Davis Vision by Metlife”
3. Complete the information requested, then select the “Search Now” 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 and then submit a claim for partial reimbursement. Complete the [reimbursement form](#) to start the process.

To use Davis Vision by MetLife, make an appointment with a participating doctor. The provider’s office will verify your eligibility for services, and no claim forms or ID cards are required. You will be responsible for 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, eyeglass frames, 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 services be obtained at one time from either an in-network or an out-of-network provider.

Davis Vision by MetLife provides coverage for 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. Coverage also includes a materials benefit, providing you access to eyeglasses or contact lenses. Additional fees 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 received through a Davis Vision by MetLife provider. The copays are listed on the [Vision Plan web page](#).

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 a participating provider’s normal charges, or 5% off advertised specials (please note that some providers have flat fees equivalent to these discounts). Call the participating provider for more information, view the [U-M/MetLife web page](#) or call (833) 393-5433 for an overview of benefits.

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 vision exam. Review the Vision Care section of the [Health Plan Coverage Comparison Chart](#) and/or contact your health plan office directly to ask if your plan covers eye exams.

\$ Saver Tip

Use a Health Care Flexible Spending Account (FSA) for yourself and your dependents for vision care expenses beyond what the Vision Plan option covers or for vision services if you do not wish to enroll in the Vision Plan.

No Vision Plan ID Card

No ID card is needed for the Vision Plan. Davis Vision by MetLife will automatically send you a welcome kit and plan brochure when you enroll.

Go to [MetLife’s My Benefits website](#). Register or sign into your existing account for all your benefits needs, including access to a digital ID card.

Warranty

Davis Vision by MetLife provides a one-year warranty against breakage on eyeglasses.

Summary of Benefits

The Vision Care Plan benefits description is available on the [Vision Plan web page](#).

Questions?

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

The Vision Plan covers the following services once each calendar year

Service/Supply Plan Benefits¹	Davis Vision Provider Maximum Benefit Payment	Non-Davis Vision Provider Maximum Benefit Payment
Comprehensive eye exam²	Covered in full	\$30
Single-vision lenses	Covered in full	\$25
Bifocal lenses	Covered in full	\$35
Trifocal lenses	Covered in full	\$45
Eyeglass frames	<ul style="list-style-type: none"> • Exclusive Collection allowance: \$200 retail allowance. • Additional allowance of \$50 at Visionworks locations. You will receive an additional 20% savings on the amount over the allowance. • Frame copay (in lieu of allowance): fashion, designer and premier have \$0 copay 	\$30
Scratch-resistant coating	Covered in full	N/A
Blended invisible bifocals	Covered in full	N/A
Ultraviolet (UV) coating	Covered in full	N/A
Contact lenses in lieu of eyeglasses^{3,4}	Covered in full	\$75
Davis Vision Contact Lens Collection (Includes evaluation, fitting, follow-up): <ul style="list-style-type: none"> • Standard/Daily: one pack of lenses • Disposable: Four boxes/ multi pack • Non-Plan contact lenses 	In lieu of Davis Vision Contact lenses, a \$200 retail credit will be applied toward contact lenses from the provider's own supply of contact lenses, evaluation, fitting and follow-up care	N/A

1 Benefits include oversize lenses, blended invisible bifocals, certain fashion frames and sun tinting of plastic lenses, gradient tints, glass gray #3 prescription sunglasses, and initial lenses following cataract surgery. Materials carry a one-year warranty against breakage. Discounts are available for additional prescription glasses. Ask your provider if they are willing to extend a discount on non-prescription eyewear.

2 Your health plan may cover your vision exam. See Vision Care on the chart on [page 42](#) and/or contact your health plan office directly.

3 Contact Davis Vision to verify the applicable copay and that your brand of contacts is covered before you enroll.

4 Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. Routine eye examinations may not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

Health Care Flexible Spending Accounts

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.

U-M offers two types of Health Care FSAs:

1. **Health Care FSA** – used to pay for most out-of-pocket medical, dental, orthodontic and vision 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 for you and your eligible dependents. Available only to employees enrolled in the Consumer-Directed Health Plan (CDHP).

Health Care FSA Contribution Limit

For 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 expense you can deduct on your federal income tax return is 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. Necessary medical, dental, and vision plan expenses not reimbursed by any benefits plan. This includes copays, deductibles, coinsurance, amounts above prevailing fee limits, and amounts exceeding plan dollar maximums.
- Dental care, including copays.
- Vision care (exams, eyeglasses, contact lenses, contact lens solutions) not reimbursed by any benefit plan. This includes copays, deductibles, coinsurance, amounts above prevailing fee limits, and amounts exceeding plan dollar maximums.
- Hearing exams and hearing aids.
- Services and equipment for the disabled.
- Prescription drug copays.
- Eligible over-the-counter medications.

For a list of covered FSA expenses, review the Flexible Spending Account Eligible Expense Guide section on the [Inspira Financial web page](#).

Limited Purpose FSA

For 2026, you can contribute a minimum of \$120, and up to a maximum of \$3,300 per calendar year.

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, review the Flexible Spending Account Eligible Expense Guide section on the [Inspira Financial web page](#).

Important Information About Enrollment:

- If you enroll in the Consumer-Directed Health Plan (CDHP) you can ONLY enroll in the Limited Purpose FSA.
- If you enroll in any other U-M health plan you can enroll in the Health Care FSA.
- You can enroll in the Dependent Care FSA regardless of which U-M health plan you select.

IMPORTANT:

If you enroll in the Consumer-Directed Health Plan (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. 20, 2026. Otherwise, you will not be eligible for HSA contributions until April 1, 2027.

How to Set Up an FSA

- You decide what FSA account(s) you would like to participate in.
- You decide how much you want to deposit during the calendar year.
- The university's claims processor, Inspira Financial, provides an online FSA calculator to help you determine how much to contribute to your FSA account, and lets you know how much you can save by using pre-tax dollars to pay for eligible health care, dental/vision, and/or dependent care expenses.
- The money you allocate to each account is automatically deducted from your pay each pay period, before taxes are taken out. Contributions cannot be taken from fellowship, stipend, or temporary hourly pay.

Claims Processing

Inspira Financial processes 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, only 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 may 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 upload your receipts.
- File claims using the Inspira Financial Mobile app available from the App Store or Google Play.

See the [2026 Flexible Spending Account book](#) for additional information about filing a claim.

For helpful FSA information, visit inspirafinancial.com.

- Inspira Financial pays claims on a daily basis.
- Check your account balance, and view transactions and claim histories at inspirafinancial.com.
- Inspira Financial can directly deposit your reimbursements to your bank account.

Things to Consider

You should be aware of some Internal Revenue Service (IRS) rules before you decide to participate in an FSA.

- You must enroll each year if you wish to participate. IRS 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 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. This is known as the "use it or lose it" rule. Planning carefully with the Inspira Financial FSA calculator at [Inspira Financial](#) and filing your claims promptly will help ensure that you can maximize the benefits of your account.
- You can enroll in either a Health Care FSA or Limited Purpose FSA, depending on which 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.

Plan Booklet

If you have not previously participated in a Flexible Spending Account (FSA), review the FSA plan book carefully before you enroll. View the book and plan information on the [Flexible Spending Accounts web page](#).

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 or Limited Purpose 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, visit the [Inspira Financial web page](#) or call (877) 343-1346.

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 Accounts

Dependent Care Flexible Spending Accounts (DCFSA) allow 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 a maximum of 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 day care 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 of 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.

For a list of covered Dependent Care FSA expenses, visit the [Inspira Financial website](#) 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.

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. The mailing address is:
Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396

- Fax to Inspira Financial toll-free at (855) 703-5305
- Submit claims online:
Log in at inspirafinancial.com, enter your claim information, and upload your receipts.
- 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 information about filing claims.

For helpful FSA information, visit the [Inspira Financial website](#), where you can:

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

Things to Consider

You should be aware of some IRS rules before you decide to 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. 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 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](#).

Plan Booklet

If you have not previously participated in a Flexible Spending Account (FSA), review the FSA plan book carefully before you enroll. View the book and plan information on the [Flexible Spending Accounts web page](#).

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 Dependent Care FSA, you can incur expenses until March 15, 2027.

Claims Deadline

To receive reimbursement for 2026 expenses, you must submit your claims by May 31, 2027. Any 2026 money left in your 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, visit the [Inspira Financial website](#) or call (877) 343-1346.

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.

Expanded Long-Term Disability

The University of Michigan Expanded Long-Term Disability (LTD) Plan is designed to provide you with up to 65% income replacement benefits, fringe benefit continuation, and Basic Retirement Plan contributions should you become totally disabled and can no longer work. If an illness or injury is going to keep you out of work for at least twelve months, LTD insurance coverage can protect yourself and your family financially.

Some important questions to ask yourself:

- Do you already have disability insurance that protects both your salary and benefits?
- How would you pay your bills?
- Do you have other options for medical insurance and prescription drug coverage?
- Do you have other life insurance coverage?
- Do you have another means of saving for retirement?

The maximum covered annual base salary is \$424,615. The Expanded LTD plan pays up to 65% of your covered, pre-disability base salary. Income benefits from the plan are coordinated with income from public programs, such as Social Security. The plan pays the cost to continue most of the benefits you have at the time of disability and provides a Basic Retirement Plan contribution for those enrolled.

Eligibility

You are eligible to enroll immediately in this plan if you have at least a 50% appointment for eight continuous months.

Refer to the information starting on [page 7](#) of this book for individual eligibility.

Enrollment

You can enroll in this plan within 30 days of your service date or newly eligible appointment. If you miss the 30-day deadline, you can still enroll if you are actively at work and submit the Expanded LTD Health Statement Application for Maximum Coverage. The form is available on the [Long-Term Disability Forms and Documents web page](#) or from the SSC - HR Customer Care. The application will be reviewed for evidence of insurability (medical underwriting) by the external LTD Claims Administrator. Coverage will take effect on the date your application is adjudicated as approved by the external LTD Claims Administrator.

Your Years of Service Count

- You pay for coverage on your full salary the first two years of service at the university. You must have at least a 50% appointment for eight continuous months.
- If your appointment drops below 50% or below eight continuous months during the first two years of service, you are no longer eligible for the benefit, but you do not lose your current benefit eligibility date. When your appointment again reaches 50% and the expected duration is for eight months or more, you are newly eligible to enroll.
- At two years of service in an eligible career/job family with at least a 50%, eight-month continuous appointment or more, you are automatically enrolled provided you are actively at work. The university pays for your coverage on up to \$77,000 of annual salary. If you enrolled in coverage on your full salary during your first two years of service, you will pay for coverage only on a salary more than \$77,000.
- At three years of service in an eligible career/job family with less than a 50%, eight-month continuous appointment or more, you are automatically enrolled provided you are actively at work. The university pays for your coverage up to \$77,000 of annual salary. You can elect to pay for coverage above that amount. If you do not enroll within 30 days of eligibility, you must submit the Expanded LTD Health Statement Application for Maximum Coverage. The form is available on the [Long-Term Disability Forms and Documents web page](#) or by request from the SSC - HR Customer Care. The application will be reviewed for evidence of insurability (medical underwriting) by the external LTD Claims Administrator. Coverage will take effect on the date your application is adjudicated as approved by the Claims Administrator.

Cost of Expanded LTD Coverage

Faculty and staff members pay for coverage on their entire salary for the first two years of employment at the university. The current cost is \$7.14 per month for each \$1,000 of monthly base salary. Rates may change annually.

For information on the cost of coverage after you have two years of service, refer to the section “Your Years of Service Count” above. To calculate your monthly cost for the Expanded LTD Plan, view the [Expanded Long-Term Disability Monthly Cost Calculator web page](#).

Leaves Affect Coverage

You must be actively at work in order for automatic enrollment to occur. Actively at work means you are present in the workplace at your regular appointment. You are not considered “actively at work” if you are absent from the workplace for medical, child care, personal leaves, any other type of leave without salary, or while using extended sick time pay. For example:

- During a family medical leave of absence (FMLA), your coverage continues until the leave ends provided you pay the monthly premium. Automatic enrollment does not occur during a paid or unpaid family medical leave of absence (FMLA). Automatic enrollment does not occur during a child care, personal, or any other type of leave of absence without salary.
- During a child care, personal, or any other type of leave of absence without salary, coverage continues for up to one year provided you pay the monthly premium, unless another employer provides coverage.
- During a personal medical leave of absence, your coverage continues for up to two years provided you pay the monthly premium, unless another employer provides coverage. Automatic enrollment does not occur during a personal medical leave of absence.
- During a military leave, educational leave, or Reduction in Force (RIF layoff), you are not eligible for Expanded LTD coverage and automatic enrollment does not occur.

Definition of Disability

University disability plans define disability as a time when you are completely unable, except during periods of rehabilitative employment, by reason of any medically determinable physical or mental impairment, to engage in any occupation or employment for wages or profit for which you are reasonably suited by education, training, or experience. The impairment must be expected to result in death or to have lasted or be expected to last for a continuous period of not less than 12 months from your last day of work. If you are a practicing physician, the Expanded Long-Term Disability plan, under a special provision, will provide partial disability coverage. Please refer to the University of Michigan HR website at hr.umich.edu/ltd physicians for more information on the special provision for practicing physicians.

A full description of plan provisions are available in the [Expanded Long-Term Disability Plan book](#).

Expanded Long-Term Disability Benefits

Participants who qualify for LTD benefits receive:

- 65% salary replacement of covered annual base salary less income from any public programs, such as Social Security.
- Basic Retirement Plan contributions, if enrolled immediately preceding the date LTD benefits begin.
- Payment of premiums for the following benefits in which you and your dependents are actively enrolled immediately preceding the date LTD benefits begin, such as:
 - » Health Plan
 - » Prescription Drug Plan
 - » Dental Plan Option 1
 - » Group Life Insurance (employee only)

How to Apply for Expanded LTD Benefits

If you believe you may need to apply for Expanded LTD benefits, you should contact Work Connections at: (734) 615-0643. Work Connections will work with you to obtain the necessary information. If it appears you may qualify for Expanded LTD benefits, Work Connections will coordinate the application process with the Benefits Office and the external LTD Claims Administrator. The external LTD Claims Administrator makes claim determinations at their sole discretion. For more information about Work Connections, view [page 82](#).

Basic Long-Term Disability

The University of Michigan Basic Long-Term Disability (LTD) Plan is designed to provide you with income replacement and fringe benefit continuation should you become totally disabled and no longer able to work. If an illness or injury is going to keep you out of work for at least twelve months, LTD insurance coverage can protect yourself and your family financially.

The Basic LTD plan pays up to \$1,200 per month. Income benefits from the plan are coordinated with income from public programs, such as Social Security. The maximum combined benefit you can receive from the Basic LTD plan and a public program is the greater of 75% of your pre-disability base salary or your pre-disability net income. In any case, the maximum payable income benefit under the provisions of the Basic LTD plan is \$1,200 per month. The plan also pays the cost to continue most of the benefits you have at the time of disability and provides a Basic Retirement Plan contribution for those enrolled.

Eligibility

You are eligible for enrollment in this plan if you are an AFSCME member with any percent appointment greater than 0% and have at least four continuous years of service.

Enrollment

At four years of service, AFSCME members will be automatically enrolled in the Basic LTD plan provided they are actively at work.

Cost of Basic LTD Coverage

The university pays the cost of this plan. There is no cost to you.

Leaves Affect Coverage

You must be actively at work in order for automatic enrollment to occur. Actively at work means you are present in the workplace at your regular appointment. You are not considered “actively at work” if you are absent from the workplace for medical, child care, personal leaves, any other type of leave without salary, or while using extended sick time pay. For example:

- During a family medical leave of absence (FMLA), your coverage continues until the leave ends provided you pay the monthly premium. Automatic enrollment does not occur during a paid or unpaid family medical leave of absence (FMLA). Automatic enrollment does not occur during a child care, personal, or any other type of leave of absence without salary.
- During a child care, personal, or any other type of leave of absence without salary, coverage continues for up to one year provided you pay the monthly premium, unless another employer provides coverage.
- During a personal medical leave of absence, your coverage continues for up to two years provided you

pay the monthly premium, unless another employer provides coverage. Automatic enrollment does not occur during a personal medical leave of absence.

- During a military leave, educational leave, or Reduction in Force (RIF layoff), you are not eligible for Basic LTD coverage and automatic enrollment does not occur.

Definition of Disability

University disability plans define disability as a time when you are completely unable, except during periods of rehabilitative employment, by reason of any medically determinable physical or mental impairment, to engage in any occupation or employment for wages or profit for which you are reasonably suited by education, training, or experience. The impairment must be expected to result in death or to have lasted or be expected to last for a continuous period of not less than 12 months from your last day of work.

For more information, a full description of plan provisions are available in the [Basic Long-Term Disability Plan book](#).

Basic Long-Term Disability Benefits

Participants who qualify for LTD benefits receive:

- 50% salary replacement up to \$1,200 per month, or
- 75% salary replacement coordinated with income from a public program up to the monthly \$1,200 maximum. For AFSCME staff members, the pre-disability net monthly base income is used for coordination if it is more than 75% of your gross monthly pre-disability base salary. For example, if your pre-disability net monthly income is \$2,000 and you receive monthly Social Security disability income in the amount of \$800, the Basic LTD plan will pay \$1,200 per month ($\$2,000 - \$800 = \$1,200$), and
- Basic Retirement Plan contributions, if enrolled immediately preceding the date LTD benefits begin
- Payment of premiums for the following benefits in which you and your dependents are actively enrolled immediately preceding the date LTD benefits begin, such as:
 - » Health Plan
 - » Prescription Drug Plan
 - » Dental Plan Option 1
 - » Group Life Insurance (employee only)

How to Apply for Basic LTD Benefits

If you believe you may need to apply for Basic LTD benefits, you should contact Work Connections at (734) 615-0643. Work Connections will work with you to obtain the necessary information. If it appears you may qualify for Basic LTD benefits, Work Connections will coordinate the application process with the Benefits Office and the external Claims Administrator. The external LTD Claims Administrator makes claim determinations at their sole discretion. For more information on Work Connections, see [page 82](#).

Group Term Life Insurance

MetLife Administers These Plans

The university offers [three group term life insurance plans](#) to eligible faculty and staff:

- **University Plan**—\$30,000 of coverage for you paid for by the university;
- [Optional Life Insurance Plan](#)—your choice of coverage paid for by you;
- [Dependent Life Insurance Plan](#)—coverage for your spouse, other qualified adult, and/or your dependent children, paid for by you.

Plan Highlights

- The University Plan and the Optional Plan offer coverage for you only. The Dependent Plan offers coverage for your spouse or other qualified adult and/or dependent children.
- Both the University Plan and the Optional Plan have a “Living Needs Benefit” option—or accelerated payment of death benefits—which is an advance payment of life insurance proceeds when you are terminally ill and have a life expectancy of 12 months or less.
- These term life plans have neither cash value nor provisions for loans, which means you must be enrolled when you die in order for your beneficiary to receive benefits.

University Life Insurance Plan

The University Life Insurance Plan provides \$30,000 of life insurance coverage for benefits-eligible faculty and staff. It covers you only and is paid by the university at no cost to you. If your hire date or new eligibility is after Jan. 1, 2001, you will be automatically enrolled in the plan.

Optional Life Insurance Plan

If you are enrolled in the University Plan and want additional life insurance coverage, you can enroll in the Optional Life Insurance Plan. The Optional Plan covers you only.

- If you are a nonsmoker, you receive a discount on the Optional Plan premium. A nonsmoker is defined as a person who has not smoked for 12 months.
- You will be defaulted to the higher standard (e.g. smoker) rate unless you update your smoker status.
- To find your smoker status and monthly premiums, visit [Wolverine Access](#), search for **Employee Self-Service**, select the **Benefits** tile, select the **Display Benefits Plan Rates** tile, then click the **Life Plan Rates** tab.
- If your coverage is based on your salary, under the Optional Plan, the amount of coverage you choose and its cost may increase when your salary increases. Your cost will increase when you move into a higher age bracket.
- If you are enrolled in the Optional Plan, you are eligible for simple will preparation services provided by attorneys who participate in the MetLife Legal Plan Network.
- You may cancel at any time, but if you wish to re-enroll you will be required to furnish evidence of insurability (a health statement) that is satisfactory to MetLife Insurance Company of America. MetLife may also require a physical examination.

How to Enroll in the Optional Plan

There are three ways you can enroll in the Optional Plan:

1. As a new hire to the university. You have 30 days (or as specified by your collective bargaining agreement) to enroll. If you enroll as a new hire, you will not be required to provide evidence of insurability (a health statement) as long as optional coverage is less than \$650,000. Therefore, it is to your advantage to enroll in Optional Life at the time you become eligible.
2. As a newly eligible faculty or staff member. As you become newly eligible for life insurance due to a promotion or job change that qualifies you for life insurance benefits, you will receive an application form. If you enroll within the 30 days allowed, you will not be required to provide evidence of insurability (a health statement) as long as coverage is less than \$650,000.
3. At any time. After the 30-day period provided for (1) and (2) above expires, you can apply to enroll at any time you choose, but you will be required to furnish evidence of insurability (a health statement) that is satisfactory to the MetLife Insurance Company of America. MetLife may also require a physical examination.

Application Form

The application form is available on the [Life Insurance Forms and Documents web page](#) or by request from the SSC - HR Customer Care.

What You Pay for Your Optional Life Insurance Plan Coverage

The cost of your Optional Life Insurance Plan depends on the coverage you select, your age, your smoking status, and your annual salary. The amount of coverage you choose and its cost will increase when your salary increases, if your coverage is based on your salary. Your cost will increase when you move into the next-higher age bracket. Your premiums will be deducted from your pay on an after-tax basis.

Calculate your monthly rate using the rate table.

- If you choose a flat dollar amount of coverage, your rate—based on your age and smoking status—will be multiplied by the amount of coverage you choose, and then divided by 1,000 to get your monthly rate.

Example:

Age 30-34, Smoker, \$50,000 of coverage ($\$0.023 \times \$50,000$)/1,000 = \$1.15 monthly rate

- If you choose coverage based on a multiple of salary, your rate — based on your age and smoking status — will be multiplied by your annual salary that you enter, then multiplied by the level of coverage you choose (1 to 8 times your annual salary), and then divided by 1,000 to get your monthly rate.

Example:

Age 30-34, Smoker, \$20,000 salary, 4x salary coverage ($\$0.023 \times \$20,000 \times 4$)/1,000 = \$1.84 monthly rate

2026 Monthly Rate Per \$1,000 of Coverage		
AGE	STANDARD	NON-SMOKER RATE
<30	\$0.021	\$0.010
30 - 34	\$0.023	\$0.021
35 - 39	\$0.028	\$0.025
40 - 44	\$0.043	\$0.037
45 - 49	\$0.074	\$0.063
50 - 54	\$0.122	\$0.104
55 - 59	\$0.191	\$0.162
60 - 64	\$0.296	\$0.269
65 - 69	\$0.531	\$0.448
70 & older	\$0.952	\$0.620

You will be defaulted to the higher standard (i.e. smoker) rate unless you update your smoker status.

Health Statement

If you enroll within 30 days of the date you become eligible and choose less than \$650,000 of coverage, you will not need to provide a satisfactory health statement as proof of insurability. Therefore, it is to your advantage to enroll in Optional Life at the time you become eligible.

The amount of coverage you elect and when you enroll determines whether you need to submit a health statement. You will need to submit a health statement if you:

- Enroll in or increase Optional Plan coverage above \$650,000 more than 30 days after you become eligible.
- Elect Optional Plan coverage above \$650,000.
- Request increased Optional Plan coverage above \$650,000, or your salary increases, raising your coverage above \$650,000.
- Enroll in the University Plan after the 30-day deadline.

Effective Date

If you are newly eligible, your insurance will become effective on your service date or the first day you are newly eligible if you enroll within 30 days. If you are not actively at work on the day your insurance would otherwise become effective, you will become insured on the day you return to active work. If proof of insurability is required, your insurance will become effective on the day the health statement is approved by MetLife, the Benefits Office has been notified, and you are actively at work.

Your Beneficiary

When you elect life insurance coverage of any kind for the first time, you must complete the beneficiary designation on the [U-M/MetLife My Benefits web page](#).

You are automatically the beneficiary for any dependent life insurance for your spouse, other qualified adult (OQA), or eligible children.

You may choose any beneficiary you wish, such as a family member, a friend, a trust, or an organization. You can name a single beneficiary or you can name two or more joint beneficiaries to receive the insurance payment. You may change your beneficiary at any time.

You can choose different beneficiaries for each of the life insurance plans; you will need to fill out and return a “Beneficiary for Group Life Insurance” form for each additional plan. If you enroll in the Optional Plan, for example, and you change the amount of your coverage at a future date, the beneficiary you designate now will remain your beneficiary unless you make a change.

If you do not designate a beneficiary, or if none of the beneficiaries you name survives you, death benefits will be paid to the first of the following:

- Your surviving spouse/OQA
- Surviving children in equal shares
- Surviving parents in equal shares
- Surviving siblings in equal shares
- Estate

Beneficiary Changes

You may change your beneficiary at any time. When you experience family status changes, you may want to review your beneficiary. If you are not sure whom you have named as your beneficiary, you may want to update your designation by submitting a beneficiary change on the [U-M/MetLife My Benefits web page](#).

Please note that your life insurance beneficiary designation is separate from your Retirement Savings Plan beneficiary designation. Designate and update your Retirement Savings Plan beneficiaries online on the TIAA and Fidelity websites.

Beneficiary Confidentiality

To protect your privacy, the Benefits Office, the SSC - HR Customer Care, and MetLife cannot tell you the names of your beneficiary designations over the phone.

Your Coverage in Retirement

When you retire, you will be covered under the university's Retiree Group Term Life Insurance Plan. Your amount will be the lesser of:

- The amount for which you were insured on your date of retirement from the university, or
- The amount applicable to your age in the "Amounts of Insurance" chart to the right.

In any event, during retirement, the amount of insurance will decrease as your age increases until you reach age 66, at which time coverage of \$2,000 becomes effective and will remain in effect for the rest of your life. Dependent life insurance plans end at retirement.

Under present policy, which is subject to change, the university pays the entire cost of the continued life insurance protection during retirement for persons with a date of service prior to July 1, 1988. If your date of service is July 1, 1988 or later, you pay the full cost of retiree life insurance until you reach age 62; the university pays the full cost at age 62 and older.

Amounts of Insurance	
Your Age On or After Retirement	Amount of Insurance
50 Years or Less	\$15,000
51 years but less than 52 years	\$15,000
52 years but less than 53 years	\$15,000
53 years but less than 54 years	\$15,000
54 years but less than 55 years	\$15,000
55 years but less than 56 years	\$15,000
56 years but less than 57 years	\$14,000
57 years but less than 58 years	\$13,000
58 years but less than 59 years	\$12,000
59 years but less than 60 years	\$11,000
60 years but less than 61 years	\$10,000
61 years but less than 62 years	\$8,000
62 years but less than 63 years	\$6,000
63 years but less than 64 years	\$5,000
64 years but less than 65 years	\$4,000
65 years but less than 66 years	\$3,000
66 years and over	\$2,000

Dependent Life Insurance Plan

The Dependent Life Insurance Plan offers life insurance coverage for your spouse or other qualified adult and any eligible children. You must be enrolled in the University Plan in order to enroll in the Dependent Life Insurance Plan.

Spouse or Other Qualified Adult

Your spouse or other qualified adult can enroll in the Dependent Life Insurance Plan at any time. He or she will need to provide satisfactory evidence of insurability (a health statement). Coverage will go into effect when (1) the Dependent Life Insurance Plan application is received in the Benefits Office and (2) satisfactory evidence of insurability has been received and approved. You will be notified by Confirmation Statement when coverage begins.

Dependent Children

No health statement is required to enroll children in the Dependent Life Insurance Plan. Children may be enrolled in the Dependent Life Insurance Plan at any time.

Dependent Life Insurance Plan coverage for newborns will go into effect at age 15 days or when the Dependent Life Insurance Plan application is received, whichever is later.

Your dependent child may remain enrolled in the Dependent Life Insurance Plan as long as they are younger than age 26, unmarried, and supported by you.

Beneficiary

When you enroll in the Dependent Life Insurance Plan, you do not need to designate a beneficiary. You are automatically the beneficiary. If you and any dependent die within a 24-hour period, death benefits will be paid to the beneficiary of your life insurance policy or to your estate. If a beneficiary is a minor or incompetent to receive payment, benefits will be paid to that person's guardian.

Continuation of Coverage

When your insurance coverage ends, and your dependent has been enrolled in the Dependent Life Insurance Plan, you have the option to convert all or part to an individual policy.

Terminating Coverage

You can terminate dependent coverage at any time. To do so, complete a [Group Life Insurance Withdrawal Form](#) available from the university's HR website or the SSC - HR Customer Care.

Dependent Spouse or other qualified adult plan coverage terminates when the faculty or staff member retires, terminates employment with the university for any reason, or dies. In case of a divorce, Dependent Spouse Plan coverage terminates the date the faculty or staff member's divorce is final.

Coverage for your eligible dependent child ends at the end of the month in which the child turns age 26.

You must complete a form to notify the Benefits Office to stop deducting premiums from your paycheck when you no longer have a child eligible for benefits.

Dependent Life Insurance Coverage Options and Monthly Rates		
COVERED DEPENDENT	COVERAGE AMOUNT	2026 COST PER MONTH
Spouse/OQA	\$10,000	\$1.56
Spouse/OQA	\$25,000	\$3.90
Spouse/OQA	\$50,000	\$7.80
Spouse/OQA	\$100,000	\$15.60
Children	\$2,000 per child	\$0.10
Children	\$5,000 per child	\$0.26

The cost of coverage for children covers all eligible children in the household age 15 days through the end of the month they turn age 26.

Legal Services Plan

MetLife Legal Services Administers This Plan

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

- Wills and estate planning, including living wills, powers of attorney, trusts, and codicils (updates to wills)
- Real estate, including eviction defense; tenant problems; and buying, selling, or refinancing your principal home
- Family law matters, including name change, uncontested adoption, guardianship, and divorce, dissolution and annulment (contested or uncontested), custody order, and enforcement or modification of support order
- Debt defense (problems with creditors)
- Defense of civil lawsuits
- Document preparation, including deeds, demand letters, promissory notes, and mortgages
- Credit monitoring at a single credit bureau (for the enrolled employee only)
- Identity monitoring services and identity theft defense
- Social Security Disability (for enrolled employee or employee's spouse only), including preparing initial forms, request for reconsideration, hearing requests, attendance at hearings, and review of decision order
- Reproductive assistance (for enrolled employee or employee's spouse only), first 20 hours of legal services and court work related to reproductive assistance matters.

For a complete list of covered legal services, view the [Legal Services Plan web page](#).

One of the most valuable features of the Legal Services Plan is that it covers 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 to you.

Benefits In or Out of the Network

To use the Legal Services Plan after you have enrolled, call the MetLife Legal Plans Client Service Center directly at (800) 821-6400, Monday - Friday from 8 a.m. to 8 p.m., Eastern Time. The client representative who answers your call will:

- Verify your eligibility for services (have your MetLife Legal Plans membership number on hand);
- Make an initial determination of whether and to what extent your case is covered (the plan attorney will make the final determination of coverage);
- Give you the telephone number of the participating attorney near you; and
- Answer any questions you have about the Legal Services Plan.

You also may find a participating attorney in your area by viewing the [Legal Plans Members web page](#). From there, you will have immediate access to plan details, attorneys in your area and case numbers.

MetLife Legal offers an attorney scheduler who finds specific attorneys and will schedule an initial appointment with an attorney on your behalf. The MetLife Legal representative will call you back to provide attorney information and appointment details, and to answer questions.

If you choose, you may use a non-participating attorney by advising the MetLife Legal Plans representative during your call for authorization. In a few areas where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans will reimburse you for these non-participating attorney's fees in accordance with a set fee schedule.

You may need legal help with a problem involving your spouse, other qualified adult or your children. In some cases, both you and your dependent may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. Your dependent will not be covered under the plan.

If you or your dependents are involved in a dispute with another eligible plan member or that member's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

MetLife Legal Plan

You can enroll in the Legal Services Plan within 30 days, or as specified by your bargaining agreement, on the date your appointment begins or during Open Enrollment. For additional information, call MetLife directly at: (800) 821-6400.

Legal Plan Book

For more information, view the [Legal Services Plan book](#).

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 Services are Covered through U-M Optional Life Insurance

Simple will preparation services from MetLife attorneys are available to U-M faculty and staff enrolled in the U-M Optional Life Insurance Plan, without having to enroll in the Legal Services Plan. Call MetLife at: (800) 821-6400.

Business Travel Accident Insurance & Travel Assistance

All active faculty and staff members traveling domestically and internationally while on official U-M business (excluding everyday travel to and from work) are provided coverage for accidental death or permanent total disability. The university pays the full premium; you do not have to enroll in this coverage.

Plan Summary

- [Business Travel Accident Insurance](#) is administered by MetLife.
- Coverage begins on your first day of work and continues until your last day of work at the University of Michigan.
- If you die while traveling on university business, the plan provides a minimum benefit of \$50,000 or 10 times your annual salary, whichever is more, with a maximum of \$500,000. The plan also pays benefits for dismemberment and disability.
- The maximum benefit for any one covered accident is \$10 million.

Travel Assistance

In addition to business travel insurance, the [travel assistance program](#) from AXA Assistance USA, Inc., provides travel services to you and your family anytime you are 100 or more miles from home.

Filing a Claim

Your department representative or a family member should contact the SSC - HR Customer Care to file a claim by calling (734) 615-2000 or (866) 647-7657 (toll-free).

Travel Registry

The University of Michigan provides a secure website within Wolverine Access for faculty and staff to record travel plans and contact information. The registry is a convenient, one-stop service that supports emergency communications and access to university-approved travel abroad health insurance. According to U-M's International Travel Policy, SPG 601.31, faculty and staff are required to register their international travel plans when traveling for university-related business.

Visit the [Global Michigan web page](#) for more information.

3. Graduate Student Benefits

Review the charts on [pages 8-13](#) to identify the benefits available to your graduate student group and for details on dependent benefits eligibility.

For all eligible graduate students, application for benefits must be made within 30 days of your date of hire or newly eligible status. If you do not elect to enroll or do not waive medical and/or dental, you will be automatically enrolled in the [GradCare health plan](#) and the [Dental Option 1](#) plan at single person coverage. You will be notified by email when you are eligible to enroll. You will enroll using [Wolverine Access](#) as instructed in the student new hire email message.

A Change in Appointment

Job changes can affect your benefits eligibility. For example, you may become eligible for other benefits if you change career/job families or if you change from a Fellowship holder or a Graduate Student Research Assistant (GSRA) to a Graduate Student Instructor (GSI). If this occurs, you will receive an email notification. Call the SSC - HR Customer Care if you experience a job change and have questions regarding your benefit eligibility.

If you are a GEO member or a GSRA and were enrolled in GradCare, dental, or life insurance during the previous fall and the current winter terms, you are eligible for university contributions during the spring/summer terms.

If you are a GEO member or a GSRA and if you are participating in GradCare, dental, or life insurance during the winter term (Term II), and you will be re-employed for the following fall term (Term I) with a one-quarter or greater employment fraction, benefits may continue during spring/summer term (Term III).

To ensure continuation of your benefits, your department must confirm your eligible Term I appointment with the Benefits Office by April 10.

Review your April pay stub to see if benefits premiums have been deducted for the summer.

To learn about continuation of GradCare through the summer, view the [GradCare web page](#) or call the SSC - HR Customer Care.

Effects of Changes on Health Care Eligibility

If you are a graduate student and your job status changes, your health care eligibility may change.

Graduate Student Instructors (GSIs), Graduate Student Staff Assistants (GSSAs), and Graduate Student Research Assistants (GSRAs) who become Fellowship holders and are no longer university employees may be eligible for GradCare under the fellowship. Check with your department to determine whether your fellowship includes GradCare sponsorship.

Assignments Outside the GradCare Service Area

If your assignment takes you off campus, download the [GradCare off-site registration form](#) or call to request a form from the SSC - HR Customer Care. Your department must authorize and submit the form to the Blue Care Network.

Visit [the Blue Care Network website](#) to designate or change your primary care provider, update your address or request a replacement ID card.

Continuation of Coverage for Benefit-eligible Fellowship or Medical School Students

See the Benefit-Eligible Fellowship Holder section on the [Benefits Eligibility web page](#) for information on continuing your GradCare health plan coverage.

4. Changes to Your Benefits

Qualified Family Status Change

Your benefits elections will remain in effect through Dec. 31 as long as you remain eligible. Once you have enrolled, you may not change coverage until the annual benefits Open Enrollment, usually in October, with changes taking effect Jan. 1. Mid-year changes may be allowed when you have a change in status as defined by Section 125 of the IRS. Changes that qualify typically include:

- Marriage, divorce, birth, adoption, or death of a spouse or child
- Change in eligibility status for a covered dependent
- Your spouse starts or stops working
- You or your spouse take an unpaid leave of absence
- Elimination of your spouse's coverage due to an employment change
- You move out of the managed care plan's service area

Different qualifying events allow different benefit changes. Any change you make mid-year must be consistent with your change in status, and the event must affect eligibility for coverage under the plan. For example, if you get married, you can add your new spouse to your health coverage, but you cannot drop your children from your health coverage. For more information, visit the [Life Events web page](#).

Moving Out of a Managed Care Plan Service Area

If you are covered by a managed care plan and move outside the service area for more than 60 days, you can change your health plan mid-year by completing a [Moving Out of a Managed Care Service Area](#) form and submitting it to the SSC Benefits Transaction team within 30 days after your move date. Your new health plan coverage will become effective the first of the month following the date your form is received, or the first of the month after the date of your move, whichever is later. Your next opportunity to make a change will be the next Open Enrollment period.

Dependents of International Students/Scholars Entering the Country

If you are an F-1 or J-1 student or J-1 scholar and your Form I-20 or Form DS-2019 was issued by the University of Michigan (Ann Arbor), you must have health insurance that meets U-M requirements for yourself and any accompanying F-2 or J-2 dependents during the entire time you are a F-1 or J-1 student or scholar at the University of Michigan. If your F-2 or J-2 dependents accompany you, they should be enrolled in health coverage at the same time you enroll upon your entry into the country.

If your F-2 or J-2 dependents intend to join you later, you must add them to your health coverage within 30 days of their arrival in the U.S. Remember that they must have health insurance, too. You will be asked to provide a copy of your F-2 or J-2 spouse and dependents' flight ticket/confirmation or their admission stamp, or paper or printout of electronic Form I-94 as documentation of their arrival date. Call the SSC - HR Customer Care at (734) 615-2000 locally, or (866) 647-7657 (toll-free for off-campus long distance calling within the U.S.) for assistance.

View more information on the [Dependent Entering the Country](#) page.

Deadline for Reporting Changes in Family Status

If you have a family status change, you must act within 30 days of the qualifying event to make a corresponding mid-year change to your benefits. Otherwise, you will have to wait for the next Open Enrollment period and have the change(s) become effective Jan. 1 of the following year. In order to make such changes, call the SSC - HR Customer Care at (734) 615-2000 locally, or (866) 647-7657 (toll-free for off-campus long-distance calling within the U.S.) before the 30-day deadline.

Exception: 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.

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

Removing Dependents Who Lose Eligibility

If your covered dependent loses eligibility under your U-M benefit plan coverage due to an event occurring midway through the year, it is your responsibility to remove your dependent from your coverage within 30 days of ineligibility. It is especially important to delete any ineligible dependents within that time frame to avoid overpaying premiums that will not be refunded by the university.

Further, failure to notify the SSC Benefits Transaction team within 60 days of the dependent's loss of eligibility will result in forfeiture of that dependent's COBRA continuation rights. In providing this notice, you must use the form entitled "Notice of COBRA Qualifying Event." You may obtain a copy of this form by calling the SSC - HR Customer Care, or by downloading the form on the [Health Plan Forms and Documents web page](#).

Refer to [page 78](#) for information concerning COBRA. In addition, information regarding your rights under COBRA are available on the [COBRA web page](#).

Ex-Spouse

If you are ordered to continue coverage for a former spouse by the terms of a divorce judgment, that coverage can be provided for a limited time under COBRA. Your ex spouse (and your stepchildren) cannot be continued on your university benefits coverage. If COBRA is selected, the ex-spouse will have his/her own account and will be responsible for paying premiums directly.

Age 26 Dependent Child

Children who turn age 26 will be automatically removed from coverage at the end of the month they turn 26, and offered COBRA.

Questions?

If you have any questions about your dependent's eligibility for benefits or making changes to your coverage, call the SSC - HR Customer Care at: (734) 615-2000 locally, or (866) 647-7657 (toll-free for off-campus long-distance calling within the U.S.).

Change in Your Appointment

If at any time your hours decrease to less than 50%, you become ineligible for health, life insurance, dental, and prescription drug benefits (does not apply to House Officers, Research Fellows, GSIs, GSSAs, and GSRAs). Expanded Long-Term Disability ceases if you have less than five years of service.

However, you could become eligible to continue medical benefits at a different monthly cost under the Employer Shared Responsibility (ESR) provision of the Affordable Care Act if you move to a temporary position, reduce your effort below 50% or return after a break in service of less than 26 weeks. For more information, view the [Employer Shared Responsibility web page](#).

Leaves of Absence

Questions about leaves should be directed to the SSC - HR Customer Care or Michigan Medicine Human Resources. Leaves of absence are approved by your department and staff HR rep. There are several kinds of leaves, and the effect on your benefits may vary. When your leave is approved, you will receive information about benefits continuation at your current address on file with the university.

All leave of absence premiums are due on the first of each month for that month's coverage (i.e., the premium for the month of June is due June 1). Any late or partial payments will be processed and refunded.

Address Update

As a U-M employee, it is your responsibility to keep your address updated with the university. See "Update Your Address and Phone Number," View [page 4](#) for more information.

COBRA information will be mailed to you at your last known current address on file with the university.

If your employment terminates for any reason, contact the SSC - HR Customer Care before you leave to make sure your address is correct.

Change Forms

Forms for making changes to your benefits are available on the [Health Plan Forms and Documents page](#).

5. When You Leave the University

Your Benefits When Your Employment Ends

If your employment terminates, for whatever reason, you need to know what happens to your benefits.

Health, Dental, and Vision Plans

University coverage for health care, including health plan, dental plan, vision plan, and prescription drug coverage, ends on the last day of the month in which your employment terminates. For example, if you terminate employment on Aug. 15, your health care coverage will end on Aug. 31. You are covered up to and including Aug. 31.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you to continue coverage under these plans at your own cost for up to 18 months.

Following your termination, COBRA enrollment materials will be sent to your last known home address. Update your address with the university before your employment end date. See “Update Your Address and Phone Number” on [page 4](#).

Long-Term Disability

Long-Term Disability coverage ends on your last day of employment.

Group Life Insurance

University Life, Optional Life, and Dependent Life Insurance end on the last day of the month in which your employment terminates; however, if you or your dependent die within 31 days after insurance ends (during the 31-day conversion period), benefits will be paid.

If you or your dependents were enrolled in Group Life Insurance with the university, you may convert all or part of your life insurance to an individual policy. Call the SSC - HR Customer Care for a conversion form. The premium payment must be made within 31 days after the last day of the month that you terminate. For example, if your termination date is Aug. 15, you must make the premium payment by Oct. 1. No evidence of insurability is required to convert your insurance coverage to an individual policy.

Basic Retirement Plan

The money that you have invested in TIAA and Fidelity under the Basic Retirement Plan remains invested with those companies until you become eligible to withdraw the money.

You may withdraw or roll over your employee contributions and earnings, as well as the university contributions and earnings at any age after you have terminated your employment. Contact TIAA and Fidelity when you wish to make a withdrawal.

It is important to update your address with your investment companies every time you move so you will continue receiving your quarterly statements.

403(b) SRA and 457(b) Deferred Compensation Plan

If you have contributed to a 403(b) SRA or 457(b) Deferred Compensation Plan with either TIAA or Fidelity, you can cash out or roll over the funds at any age after your university employment terminates.

Legal Services Plan

Legal Services Plan enrollment ends on the last day of the month in which your employment terminates. You can convert to an individual plan. Contact MetLife Legal Services at: (800) 638-5433.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account can be continued for up to 18 months on an after-tax basis under the provisions of COBRA. To continue coverage, you must complete and return the COBRA Election Form within 60 days of the date stamped on the form.

If you have a balance in your account after you terminate, payment of claims will be based on eligible expenses incurred on or prior to the last day of the month in which you terminated. Call Inspira Financial at (877) 343-1346.

Dependent Care Flexible Spending Account

Dependent Care Flexible Spending Account participants may continue to submit reimbursement requests for eligible expenses incurred before the end of the calendar year.

If you have a balance in your account after you terminate, payment of claims will be based on eligible expenses incurred on or prior to the last day of the month in which you terminated. Call Inspira Financial at: (877) 343-1346.

Health Savings Account

Any balance remaining in your Health Savings Account when you leave the university is yours to keep. The university will no longer contribute to your HSA, and you will be responsible for all account maintenance fees. Contact Health Equity at (866) 346-5800 for more information.

Important Deadline

You have only 60 days following your loss of eligibility for benefits to elect COBRA coverage. If you do not receive your COBRA information within 14 days from your last day of benefits coverage, call SSC - HR Customer Care immediately.

Update Your Address

If you move, be sure to update your address with the university.

- Change it online in [Wolverine Access](#)
- Call the SSC - HR Customer Care at: (734) 615-2000 or (866) 647-7657 (toll free).

Remember that you also need to update your address directly with TIAA and/or Fidelity for your retirement savings accounts.

- Call TIAA at (800) 842-2252
- Call Fidelity at (800) 343-0860

Your Benefits When You Retire

Your eligibility to retire is determined by several factors including your age, your service date, your appointment, and the number of years you have worked for the university.

“Retirement” is defined as a voluntary termination from the university based on meeting age and eligible service requirements. In addition to other eligibility, there is also a 10-year minimum service requirement to retire with benefits (including health, prescription drug, dental, vision, legal, and life insurance coverage, if eligible).

Retirement Eligibility Point System

Retirement eligibility is determined by a point system. The number of points you have at a given time is equal to your age plus your years of continuous eligible service at the university. Eighty points are required to retire. For example, if Robert is age 65 in 2025 and has worked at U-M for 15 continuous years, he will have 80 points and will be eligible to retire ($65 + 15 = 80$).

Visit the [Planning for Retirement web page](#) for more information about service requirements to retire and associated benefits. Individuals who belong to a union or bargaining unit should check with the terms of the collective bargaining agreement regarding eligibility to retire.

Determination of Years of Service

Years of eligible service to retire with health, dental, and life insurance benefits are determined by counting the continuous years employed in a status that was eligible for participation in both the Basic Retirement Plan and health plan benefits. This is a 50% or greater appointment as a regular or supplemental faculty or staff member. Each appointment must be at least four continuous months in duration with university funding.

Eligible part-time regular and supplemental faculty and staff (appointments of 50% - 79.9%) will accrue 0.8 years of credit toward retirement eligibility per calendar year worked starting on or after Jan. 1, 2013.

For more information on eligibility to retire and accrual of service to retire, see [SPG 201.83](#).

If You Retire Under Age 62

The university contribution for retiree health care will be set by the year in which retirement occurs. However, if your date of service is on or after July 1, 1988 and you retire under age 62, you will pay the full cost of all benefits plans through the month you turn age 62.

Date of Service Prior to Jan. 1, 2013 and Retire on or After Jan. 1, 2021

The university contribution toward retiree health benefits for faculty and staff with a date of service prior to Jan. 1, 2013 who retire on or after Jan. 1, 2021 will be based on years of service at retirement (see table below). This service requirement is in addition to the points system used to determine eligibility to retire. For example, faculty and staff will need 80 points to be eligible to retire by 2021 and will need 20 or more years of eligible service in order to receive the maximum 80% university contribution for the retiree and 50% for dependents. In addition, faculty and staff with a date of service on or after July 1, 1988 will pay the full cost of benefits through the month of turning age 62.

University Contribution for Health Care*		Years of Service at Retirement	
Retiree Portion	Dependent Portion	Minimum	Less Than
40%	25%	10	12
48%	30%	12	14
56%	35%	14	16
64%	40%	16	18
72%	45%	18	20
80%	50%	20+	N/A

* The university contribution for health care is calculated to be a percentage of the enrollment weighted average premium of the two lowest cost comprehensive health plans. This calculation yields a fixed amount that is the maximum university contribution toward the health plan you have selected.

Date of Service on or After Jan. 1, 2013 and Retire on or After Jan. 1, 2021

The maximum university contribution for health care benefits for faculty and staff with a date of service on or after Jan. 1, 2013 who retire on or after Jan. 1, 2021 will be 68% for the retiree and 26% for the dependent. In addition, retirees pay 100% of the premium for all benefits plans through the month they turn age 62.

University Contribution for Health Care*		Years of Service at Retirement	
Retiree Portion	Dependent Portion	Minimum	Less Than
34%	13%	10	12
40.8%	15.6%	12	14
47.6%	18.2%	14	16
54.4%	20.8%	16	18
61.2%	23.4%	18	20
68%	26%	20+	N/A

* The university contribution for health care is calculated to be a percentage of the enrollment weighted average premium of the two lowest cost comprehensive health plans. This calculation yields a fixed amount that is the maximum university contribution toward the health plan you have selected.

Your Benefits After You Retire

Currently, retirees who have continually maintained their eligibility for benefits during all the continuous years of service needed to retire will receive:

- Health care coverage (retiree pays a monthly premium)
- University-paid Dental Option 1 coverage (Options 2 or 3 with some cost to the retiree)
- University-paid retiree Group Life Insurance, if participating at retirement. The amount of coverage will be the lesser amount in effect on your date of retirement or the retiree amount applicable to your age. The amount of coverage in retirement will gradually decrease to \$2,000 at age 66 and remain at that level. If you retire before age 62, you will pay the full cost of the Retiree Life Insurance plan through the month you turn age 62. The cost of the plan is \$1.423 per thousand in coverage. University contributions resume at age 62, provided you have maintained the Retiree Life Insurance plan since your retirement.
- Vision Plan (retiree pays full cost)
- Legal Services Plan (retiree pays full cost)

The amount of university and retiree contributions toward retiree benefit plans will vary based on hire date, age, retirement date, eligibility for Medicare, coverage level, and health plan selected.

For any other retiree privileges, contact the facilities you wish to use.

Under specific conditions, these benefits, except Group Life Insurance, can continue for a surviving spouse and eligible dependents.

The university reserves the right to change these benefit plans or discontinue its contribution to these programs at any time.

Covering Your Dependents in Retirement

Only eligible dependents covered on your benefits at the time you retire may continue to be covered during retirement. Review the Eligibility for University of Michigan Benefits for Dependents charts on [pages 10-13](#) for additional details.

Medicare

Medicare Advantage becomes the primary coverage for you and any covered dependents age 65 years of age or older once you have retired, or disabled.

The University of Michigan's policy is that individuals enrolled in a university-sponsored retiree medical plan must enroll in both Medicare Part A and Part B when first eligible.

Failure to enroll in Medicare Part A and Part B will result in disenrollment from your University of Michigan retiree health plan. In addition, Medicare may add a penalty to your Medicare premium.

When to Enroll in Medicare

- Retiring at Age 65 or Older...
 - » If you and/or your spouse are 65 or older at the time of retirement, Medicare must start on the first of the month following the date of your retirement. Unless your retirement date is the first of a month, Medicare must begin the day you retire.
 - » It is recommended that you apply for Medicare approximately 120 days before your retirement. Refer to your Retirement Packet for more information on enrolling in Medicare.
- Retiring Before Age 65...
 - » If you and/or your covered dependents are receiving Social Security income benefits before age 65, you will automatically be notified and enrolled in Medicare parts A and B by the U.S. Social Security Administration. Coverage will begin on the first day of the month in which the 65th birthday occurs.
 - » If you and/or your covered dependents are not receiving Social Security Income benefits before age 65, you must complete an application to enroll in Medicare.
 - » Plan to complete an enrollment form approximately 120 days before your 65th birthday. On the first day of the month that you turn 65 (or the first of the previous month, if your birthday falls on the first of the month).
 - » Call (800) 772-1213 or (800) 325-0778 (TTY/TTD) to schedule an appointment with a Social Security counselor at an office near you, or to request enrollment forms by mail.

Notifying the University of Your Medicare Enrollment

- Provide the university with the Medicare enrollment information for you and any covered dependents via the Medicare Information Form or this [SSC-HR-Medicare Information Form](#).
- You and/or your covered dependents will transition to the Medicare Advantage plan associated with your current health plan vendor.
- View details on the [Medicare Advantage Plans](#) web page.

Waiving Coverage Under Age 62 at Retirement

Retirees with a date of service on or after July 1, 1988, and are under age 62 have to pay the full cost of benefits because they retire before age 62 may choose to waive U-M coverage at retirement. Such individuals who choose to waive coverage are eligible for re-enrollment in U-M medical and/or dental coverage at age 62, provided the retiree maintains continuous comparable medical and/or dental coverage through another source and requests re-enrollment by contacting SSC - HR Customer Care within 30 days of turning 62 years of age. Certification that comparable coverage has been maintained will be required. Effective the first of the month after reaching age 62, the university will provide its contribution toward the cost of benefits.

Retirees who choose to waive life insurance cannot re-enroll.

Loss of Comparable Coverage

Individuals may choose to maintain comparable coverage through another source until they are eligible for re-enrollment in U-M medical and/or dental coverage at age 62. Such individuals may be eligible to request re enrollment in U-M medical and/or dental coverage at their own cost before age 62 if the other corresponding comparable coverage is involuntarily lost. The following conditions must be met:

- The retiree and/or dependents were enrolled under U-M medical and/or dental coverage at the time of retirement, or if not enrolled, were eligible for enrollment but were covered under another group health and/or dental plan;
- A completed and signed Request to Waive has been sent to the SSC - HR Customer Care
- A Retiree Coverage form has been submitted to the SSC Benefits Transaction team within 30 days of the date you request waiver of your retiree benefits;
- Comparable coverage has been continuously maintained in another medical and/or dental plan; that is, there has been no lapse in coverage between the time university coverage was waived and later applied for;
- Enrollment must be requested within 30 days after the other medical and/or dental coverage is involuntarily lost and satisfactory evidence is provided as requested by the Benefits Office that all requirements for re enrollment have been satisfied.
- Age 65 or older:
Medicare-enrolled retirees and covered dependents may re-enroll in a university-sponsored Medicare Advantage plan, provided that you have maintained continuous coverage with a Medicare supplemental plan and a prescription drug plan. Certification that comparable coverage has been maintained will be required. The opportunity to re-enroll in a U-M Medicare Advantage plan occurs during the U-M Open Enrollment period annually each October, with your enrollment choices effective the following Jan. 1.

Maintaining Comparable Medical and Dental Coverage

Comparable medical coverage is health coverage that is at least as comprehensive as the university-sponsored Blue Cross Blue Shield of Michigan Comprehensive Major Medical (CMM) plan. The health plan must offer the same scope of benefits and equivalent cost sharing for medical and prescription drug benefits as CMM, but benefits do not have to be exactly the same. The plan must include basic coverage for:

- Primary and preventive care
- Mental health services
- Hospitalization
- Office calls
- Surgical services
- Prescription drugs
- Emergency care services
- Diagnostic tests (x-ray and lab work)

A plan that places a lifetime limit on the dollar value of the above services does not qualify.

Retirees who are Eligible to Receive a University Contribution for Their Benefits

You may waive (opt out of) enrollment in a retiree U-M medical plan for yourself and/or your eligible spouse or dependent because you have other medical coverage through another employer. If you waive medical coverage and you subsequently lose that coverage involuntarily, you may be eligible to enroll yourself and/or your eligible spouse or dependent in a U-M plan, provided all of the following conditions are met:

1. You and/or your spouse or dependents were eligible for medical insurance at the time of your retirement from the university;
2. Coverage has been continuously maintained in another group medical plan; that is, there has been no lapse in coverage between the time you waived university coverage and later apply for coverage;
3. You must request enrollment within 30 days after the other medical coverage is involuntarily lost and provide satisfactory evidence as requested by the Benefits Office that all requirements for re-enrollment have been satisfied. Coverage will go into effect the day following the termination of the other coverage.

6. Important Federal Notices

The notices contained in this section are provided in accordance with the requirements of 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 (or 96) hours.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the detailed Health Plan Comparison Chart on [pages 36-45](#), a document called a Summary of Benefits and Coverage (SBC) is also available on the University of Michigan HR website.

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, visit the [Health Plan Forms and Documents web page](#).

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 details about covered services, effective dates and other information, view the [federal Health Care website](#).

Continuation of Benefits (COBRA)

If you or your dependent has/have a qualifying event in which there is a loss of health care coverage, you have the option to continue medical and/or dental benefits 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 SSC Benefits Transactions within 60 days of the loss of eligibility. The form is available on the [COBRA web page](#) 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 U.S.). 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 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 60 days of your or your dependent's coverage effective date.

To make a change to your university benefits plans, please complete and submit a Benefits Enrollment/Change Form found on the [Benefit Plan Forms and Documents web page](#), along with your documentation of the change within 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 on Medicaid or Michigan's CHIP program, visit the Michigan Department of Community Health website at michigan.gov/mdhhs 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 at (734) 615-2000 locally, or toll-free (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. (For a list of participating states, visit the [federal Health Care website](#).) 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 (877) KIDSNOW or visit the [Insure Kids Now website](#) 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, on the [HIPAA Compliance and Other Important Federal Notices web page](#).

Read the information carefully and call the SSC - HR Customer Care 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 not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot 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.

7. Workplace Resources

Faculty and Staff Counseling and Consultation Office (FASCCO)

The [Faculty and Staff Counseling and Consultation Office \(FASCCO\)](#) provides support and assistance to university staff and faculty in resolving personal or work-related concerns. The goal is to help you develop and foster strengths and resiliency to enhance your emotional health, well-being, and job performance. Your support includes confidential and professional counseling, coaching, training, and consultation services for supervisors.

FASCCO offers a number of services designed to help active or retired staff and faculty members and their immediate, benefits-eligible adult family members with personal difficulties encountered at work or at home. All FASCCO services are free of charge.

Services include:

- Counseling
- Supervisory consultations
- Ongoing support groups
- Mental and emotional health presentations
- Personalized coaching services

What to Expect When Contacting FASCCO

Since the FASCCO counseling staff are licensed mental health professionals, you will be required to complete brief intake forms and review and complete a “Statement of Understanding” that provides an overview of confidentiality policies and guidelines.

The initial assessment session with a FASCCO counselor will include the following:

- A counselor will gather information from you to aid in the development of a course of action and, if appropriate, an action plan.
- You and the counselor will discuss the issues you’re concerned about.
- You and the counselor will review relevant history and background to help best support you.
- At the end of your assessment, the counselor will review options with you and make recommendations about the most appropriate steps that you can take to address your concern or issue.

Phone: (734) 936-8660

Email: fascco@umich.edu

Michigan Medicine Office of Counseling and Workplace Resilience

The [Office of Counseling and Workplace Resilience](#) is an assessment, referral, consultation, and short-term counseling service for employees of Michigan Medicine.

All active faculty, staff, and temporary employees and their immediate families are eligible. The primary purpose of the Office of Counseling and Workplace Resilience is to assist in the identification and resolution of personal or work-related issues that may affect productivity and overall satisfaction in the work environment, as well as the employee’s personal well-being.

Office of Counseling and Workplace Resilience counselors will help you explore personal problem areas and workplace issues, such as:

- Mental health concerns
- Crisis resolution
- Marital/family/partner issues
- Grief/loss
- Financial concerns
- Alcohol and other drugs use
- Work relationships
- Unit or department reorganization or change
- Job stress

Individual and work group consultation and education/training is available. Any faculty or staff member who voluntarily requests assistance from the Office of Counseling and Workplace Resilience is assured that confidentiality is carefully maintained.

Services are provided at no cost to faculty/staff members. If a referral is made to a provider outside of the Office of Counseling and Workplace Resilience, the cost of the service is the responsibility of the faculty/staff member. Costs incurred for such outside services may be covered in part or fully by the faculty/staff members health insurance.

Phone: (734) 763-5409

Email: counseling@med.umich.edu

Mediation Services for Faculty and Staff

Mediation is an informal but structured process when people work together with the help of a mediator to prevent or resolve a misunderstanding or conflict. At [Mediation Services](#), we provide mediation to help faculty and staff solve work-related problems.

Services are completely confidential, available to faculty and staff, provided by professionally trained and experienced mediators, and free of charge.

A mediator/consultant at Mediation Services will be glad to talk to you by phone or in person about whether mediation might be helpful for you.

Phone: (734) 763-0235

Email: mediation.services@umich.edu

Work Connections

[Work Connections](#) is an integrated disability management program developed by the University of Michigan to help employees and supervisors when an employee experiences an injury or illness that prevents working. We work with other programs at the university to ensure that employees and supervisors have convenient and centralized access to a wide variety of resources and support.

The program will:

- Provide confidentiality of medical information for employees.
- Provide assistance through an employee's recovery.
- Facilitate appropriate and necessary communication among involved individuals and departments.
- Coordinate the services of nurses, therapists, physicians and other health care professionals.
- Provide return-to-work support (e.g., job analysis, vocational rehabilitation, ergonomic consultations).
- Help facilitate a safe return to work.

Phone: (734) 615-0643

Toll-Free: (877) 869-5266

Fax: (734) 936-1913

Email: work.connections@umich.edu

Child and Family Care

[Child and Family Care](#) (formerly Work-Life) provides resources to support your personal life while maintaining your professional responsibilities. Resources for currently-affiliated U-M faculty, staff, and students include:

- Child care resources including [databases of all state-licensed centers and homes](#)
- [U-M Children's Centers](#) information and apply to the Ann Arbor [waitlist](#) online
- [Campus Child Care Homes](#) weekday licensed care in the Ann Arbor area
- [Backup Child, Adult, and In-home Care Resources](#) for faculty, staff, and students
- [Additional child care options](#) including in-your-home and summer care resources
- [Family Helpers Posting Board](#) of U-M students and U-M retirees available to hire
- [Ann Arbor Campus and Michigan Medicine lactation rooms and lactation resources](#)
- [Elder care resources and adults and children with disabilities resources](#)
- [Connecting the Dots annual virtual conference](#)

UHR is committed to the ongoing development of a workplace culture supportive of personal and family life. By advocating for enlightened policies, practices, and services, [Child and Family Care](#) contributes to the recruitment and retention of the highest-quality faculty, staff, and students.

Contact Child and Family Care by email, or by leaving a message at (734) 763-9379 for resource information, or at (734) 936-8677 for general inquiries.

Phone: (734) 936-8677

Email: worklife@umich.edu

Emergency Hardship Program

Sometimes, unforeseen and unavoidable circumstances such as sudden illness, family crises, or natural disasters can result in a traumatic or emergency financial crisis for U-M employees. The [Emergency Hardship Program](#) provides financial support to employees who are experiencing a qualifying financial hardship.

Examples of eligible expenses may include rent assistance to prevent eviction, utility assistance to prevent utility shutoff, funeral expenses, home repairs, or car repairs due to catastrophic events such as flood, fire, or major accident.

Email: MHealthyResourceCoach@med.umich.edu

8. Contact Information

Plan Providers	Phone	Web Address
Health Plans		
Blue Cross Blue Shield of Michigan Community Blue PPO	(855) 669-8040	bcbsm.com
Blue Cross Blue Shield of Michigan Comprehensive Major Medical	(855) 669-8040	bcbsm.com
Blue Cross Blue Shield of Michigan Consumer-Directed Health Plan	(855) 669-8040	bcbsm.com
GradCare	(800) 658-8878	bcbsm.com
U-M Premier Care	(800) 658-8878	bcbsm.com
Prescription Drug Plan		
Birdi Rx Mail Order Pharmacy	(877) 269-1160	umich.birdirx.com
Michigan Medicine Specialty Pharmacy	(855) 276-3002	uofmhealth.org/conditions-treatments/specialty-pharmacy-services
Prime Therapeutics Rx Customer Support	(855) 457-0007	primetherapeutics.com
Retirement Savings Plan		
Fidelity Investments	(800) 343-0860	nb.fidelity.com/public/nb/uofm/home
TIAA	(800) 842-2776	tiaa.org/public/tcm/umich
All Other Plans		
Davis Vision by MetLife	(833) 393-5433	metlife.com/insurance/vision-insurance
Delta Dental of Michigan	(800) 524-0149	deltadentalmi.com
HealthEquity Health Savings Account	(877) 284-9840	healthequity.com
Inspira Financial	(877) 343-1346	inspirafinancial.com
MetLife Legal Plan	(800) 821-6400	legalplans.com
Other Helpful Contacts		
Benefits Office, UM-Ann Arbor	(734) 615-2000 (866) 647-7657	hr.umich.edu
University Human Resources, UM-Flint	(810) 762-3150	umflint.edu/hr
University Human Resources, UM-Dearborn	(313) 593-5190	umdearborn.edu/human-resources
Shared Services Center - HR Customer Care	(734) 615-2000 (866) 647-7657	ssc.umich.edu
Telecommunications Relay Service	711	

Prepared by Benefits Office

University of Michigan Benefits Office
1000 Victors Way
Ann Arbor, MI 48108

Phone: (734) 615-2000 or (866) 647-7657
(toll-free for off-campus long-distance calling)

Fax: (734) 763-0363

SSC - HR Customer Care

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

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

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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.

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

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Your Benefits 2026

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