UNIVERSITY OF MICHIGAN

OPEN ENROLLMENT

To make your benefit choices for 2021

OCTOBER 19-30

2020

Benefits Information by Phone

Call the SSC HR Customer Care Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calling within the United States). If you are on the U-M Ann Arbor campus, call 5-2000. Representatives are available to assist you with your benefits questions 8:00 a.m. – 5:00 p.m., Monday – Friday. Have your UMID number available when you call.

Benefits Information on the Web

hr.umich.edu/benefits-wellness

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711 for Telecommunications Relay Service

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

Limitations

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

Campus Safety

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

Sign Up for U-M Emergency Alerts

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

- Register now at: wolverineaccess.umich.edu. Select the Faculty & Staff tab, select Employee Self-Service, log in, and then select Campus Personal Information.
- For more information, go to: dpss.umich.edu/content/emergency-preparedness/emergency-alerts/

open enrollment

FOR YOUR 2021 BENEFITS

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

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

The benefit plans you select during Open Enrollment will become effective on January 1, and will remain in effect for the entire 2021 calendar year, as long as premiums are paid and you remain eligible. Outside of the Open Enrollment period, changes to these plans are only allowed within 30 days of a qualified family status change, such as marriage, divorce, or the birth or adoption of a child. Only changes consistent with the status change are allowed.

Open Enrollment Deadlines

Open Enrollment is:
October 19-30, 2020

All elections must be submitted by:
October 30, 2020 at 5:00 p.m. (Eastern Time)

Changes take effect on:
January 1, 2021

Find benefits plan information at:

hr.umich.edu/benefits-wellness

Find plan rates and enroll online at:

wolverineaccess.umich.edu

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Questions about Benefits?

Call the HR Customer Care Center at (734) 615-2000, Monday – Friday, 8:00 a.m. – 5:00 p.m.

what's new for 2021

Here are the benefits changes that will go into effect on January 1, 2021:

- The Health Care Flexible Spending Account annual contribution limit will increase to $2,750.

- **New Health Plan Option: Michigan Care**

Eligible faculty, staff and retirees have an additional health plan choice for 2021. The university is adding Michigan Care to the available options, a new managed care plan similar to U-M Premier Care.

The new plan offers:

- Access to Michigan Medicine health care providers as well as other high-quality network providers in southeast Michigan.
- A narrower network than U-M Premier Care with a lower monthly premium for non-Medicare members.
- Chiropractic and expanded telehealth coverage.

Check Your Eligibility

Because of the narrower provider network, access to the plan will be limited to faculty, staff and retirees who live in a specific geographic area within southeast Michigan. Visit hr.umich.edu/michigan-care-eligibility to check your eligibility to enroll in the plan.

For more information on Michigan Care, see page 6.

The university continues to provide BCBSM Community Blue PPO, Comprehensive Major Medical and U-M Premier Care as health plan choices for faculty, staff and retirees. GradCare is exclusively available for benefits-eligible graduate students. For complete U-M health plan details, visit hr.umich.edu/health-plans.

Verify Your Covered Dependents' Information

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

1. Go to Wolverine Access: wolverineaccess.umich.edu.
2. Click **Employee Self-Service** on the Faculty & Staff tab.
3. Log in with your uniqname and UMICH password.
4. Click **Benefits**.
5. Under Benefits Summary Self Service, click **Dependent/Beneficiary Info**.

Check that names are spelled correctly and birth dates and social security numbers are correct. If the information is correct, no further action is required.

If the information is incorrect, complete the Dependent Information Form available at hr.umich.edu/update-dependent-information, and submit it to SSC Benefits Transactions as indicated on the form. Please note that submitting this form only corrects the information currently on record with the university and does not change benefits enrollment.

review your benefits options

AND ENROLL ONLINE

1. **Carefully review** the Health Plan Coverage Comparison Chart in this publication, the benefits plan information at hr.umich.edu/benefits-wellness and the plan rates on Wolverine Access.
2. **Determine** which plans and options most closely meet your needs and those of your dependents while minimizing your out-of-pocket costs.
3. **Enroll** in your 2021 benefits plan online using Self Service > Benefits on Wolverine Access. Supported browsers are Chrome, Edge, Internet Explorer, Firefox, and Safari. You will need a University of Michigan uniqname and UMICH password to log in. Faculty and staff members without a uniqname or password should contact their supervisor.

Open Enrollment begins on October 19. Make your elections online as many times as needed until 5:00 p.m. Eastern Time on October 30, 2020.

If you do not want to change your benefit elections, no action is required unless you want to enroll in a Flexible Spending Account (FSA). FSA enrollments do not carry over year-to-year and you must re-enroll to participate in 2021.

FSA Enrollment

You may enroll in a Health Care or Dependent Care FSA through Self Service > Benefits during Open Enrollment, or by completing and submitting a paper 2021 FSA enrollment form by November 30, 2020. The 2021 FSA enrollment form and plan information is available at hr.umich.edu/open-enrollment.

How to Enroll

October 19 – 30, 2020 (5:00 p.m. Eastern Time deadline)

Step 1: Go to Wolverine Access:

wolverineaccess.umich.edu

Select the **Faculty & Staff** tab and then select **Employee Self-Service,** or select the **Students** tab and **Student Business** if you are a student.

Log in with your uniqname and UMICH password.

Step 2: Click the **Benefits** Tile.

Step 3: The **Benefits Enrollment** window will open.

Step 4: Follow the online instructions to view your benefits and rates and make your elections for 2021.

Time-Saving Reminder

The University of Michigan's mail order prescription drug program offers convenience with free delivery of 90-day supplies of eligible prescriptions right to your door. If you or someone in your family is currently taking one or more maintenance medications, consider signing up for mail order delivery. Call 877-269-1160, visit hr.umich.edu/mailorder, or download the free NoviXus Pharmacy app from the App store or Google Play.

paying for your benefits

Benefits Plan Rates

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

To view your 2021 benefits plan rates:

1. Select **Wolverine Access** under "quick links" on the U-M gateway, or go to: wolverineaccess.umich.edu
2. Select the **Faculty & Staff** tab, or select the **Students** tab if you are a student
3. Select **Employee Self-Service**, or select **Student Business** if you are a student
4. Enter your Login ID (your uniqname) and UMICH Password and click **Log In**
5. Click the **Benefits** tile
6. Under Benefits Summary Self Service, select **Display Benefits Plan Rates.** Your current rates will be displayed at the top of the page; scroll down to view your 2021 rates.

Frequency of Deductions

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

Bi-weekly

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

Monthly

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

Tax Information for Coverage of Other Qualified Adults

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

If you marry your OQA, you will need to complete and submit a Dependent Information Form within 30 days of your marriage to report your change in relationship. Call the SSC Contact Center at 5-2000 from the Ann Arbor campus, (734) 615-2000 locally, or (866) 647-7657 toll free, Monday through Friday from 8 a.m. to 5 p.m. to obtain the Dependent Information Form. Because benefits provided to your legal spouse are not considered a taxable fringe benefit, you will no longer be subject to tax witholding for OQA coverage as of the date of your marriage.

The university offers a number of health plan options. These options differ in the benefit levels they provide, the doctors and hospitals you can use, and the cost to you. See pages 10-11 for the Health Plan Profiles chart and pages 12-21 for the Health Plan Coverage Comparison Chart, which compares pertinent facts about each plan. View your 2021 monthly health plan rates on Wolverine Access.

Understanding Your Health Plan Choices

You may select your coverage from the following plan designs:

- Michigan Care, if eligible
- U-M Premier Care
- Blue Cross/Blue Shield Community Blue PPO
- Comprehensive Major Medical

In addition, the university's GradCare program is a health plan offered exclusively to eligible graduate students.

There are some important differences between the plans, and you should know and understand these differences before making your plan selection. The differences and what you should consider when selecting a health plan are outlined below. Before choosing a plan, please refer to the Health Plan Coverage Comparison Chart on pages 12-21.

Michigan Care

Michigan Care is a new health plan offered to eligible faculty, staff, and retirees. The plan offers a narrower network than U-M Premier Care and a lower monthly premium for non-Medicare members. It includes:

- Chiropractic coverage
- Expanded telehealth coverage through Amwell Online Care Group.
- Access to Michigan Medicine health care providers as well as other high-quality network providers in southeast Michigan

Because of the narrow provider network, access to the plan is limited to faculty, staff and retirees who live in a specific geographic area within southeast Michigan. Visit hr.umich.edu/Michigan-Care-eligibility to find out if you are eligible for the plan.

Michigan Care is a managed care plan. Members must live in the plan's service area and choose a Primary Care Physician (PCP) from the Michigan Care provider network. In order to visit a specialist, you will need a referral from your PCP. See michigancare.com to see if your preferred providers are included in the network. Services received outside of the network are not covered except in the event of emergency. Plan documents will provide details.

The plan is administered by Physicians Health Plan based in Lansing, MI. Michigan Medicine purchased a minority stake in PHP as part of an affiliation agreement with Sparrow Health System in 2019. Michigan Medicine leaders are engaged in and committed to the development and success of the plan. This engagement includes an emphasis on enhanced coordination between Michigan Medicine and the Michigan Care plan administrator (PHP) to improve service, quality and clinical outcomes for plan members.

Telehealth Coverage through Amwell Online Care Group
Michigan Care members will have on-demand video access to Amwell physicians and scheduled access to the Amwell behavioral health network, with the same copays as Michigan Care in-network coverage and no extra fees.

The US based, board certified and credentialed Amwell Online Care Group physicians can address urgent health concerns 24/7/365. In addition, the Amwell Online Care Group licensed and credentialed behavioral health providers (psychiatrists, psychologists and therapists) provide scheduled behavioral health services like medication evaluation and management, counseling and assessment, and therapy services. The availability of Amwell Online Care Group providers extends the Michigan Care network using telehealth for urgent health issues and behavioral health needs. You may also continue to use telehealth services with your current Michigan Medicine and other network providers based on availability.

Consider the Michigan Care plan if you:

- Would like a health plan that lowers overall medical costs for non-Medicare members.
- Would like a plan that offers cost savings of a managed care plan.
- Agree to choose a physician from a list of network providers, including Michigan Medicine providers.
- Would like chiropractic coverage.
- Would like increased telehealth coverage through Amwell Online Care Group.
- Agree to consult with your PCP for all services.
- Understand that you need a referral from your PCP if you need to see a specialist.
- Understand that you must live in the plan's service area to be eligible for coverage under the plan.

Michigan Care and U-M Premier Care Out-of-Area Dependent Coverage
Michigan Care and U-M Premier Care provide coverage for members' dependents who reside outside the network service area and who qualify under existing eligibility guidelines. Pre-certification is required for certain services. The member must register with Michigan Care or U-M Premier Care to obtain approval for out-of-area dependent coverage.

U-M Premier Care

U-M Premier Care is a Blue Care Network (BCN) health plan offered only to the University of Michigan community. The greatest savings are achieved using the U-M Premier Care Provider Network 1. Members must select a Primary Care Physician (PCP) from U-M Premier Care's Provider Network 1. See hr.umich.edu/health-plans for a provider directory.

Members have access to more limited coverage if they choose to use providers associated with Provider Network 2 (other Michigan BCN providers not included in Network 1). Coverage with these Network 2 providers is subject to an annual deductible of $2,000 per individual and $4,000 per family. A referral from a Network 1 PCP is required for coverage through a Network 2 provider.

Consider the U-M Premier Care plan if you:

- Would like a health plan that lowers your overall medical costs.
- Would like a plan that offers the cost savings of an HMO when using U-M Premier Care Provider Network 1, and the option of using other state-wide providers after paying an annual deductible.
- Agree to choose a physician from a list of approved physicians that includes University of Michigan providers.
- Agree to consult with your primary care physician (PCP) for all services.
- Understand that to receive coverage for emergency services you must follow plan requirements.
- Understand that you need a referral from your PCP if you need to see a specialist.
- Understand that you must live in the state of Michigan.

BCBSM Community Blue PPO

PPOs offer limited out-of-pocket costs and access to healthcare providers throughout the U.S. Plan members can refer themselves to doctors of their choice, including specialists, inside and outside the network. However, higher out-of-pocket costs are incurred for using out-of-network providers.

Consider a PPO if you:

- Would like a health plan that allows you to visit any doctor or hospital without a referral.
- Would like the affordability of a fixed co-pay when receiving services through a national network of providers.
- 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 covered with BCBSM Community Blue PPO.
- Live or travel outside southeast Michigan.

Enhancement to Medical Coverage for Services Received Outside the U.S.
Blue Cross Blue Shield Community Blue PPO 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 Blue Cross Blue Shield Community Blue PPO is the only plan offering this enhanced level of coverage. To obtain in-network benefits while out of the U.S., check for participating providers at: bcbsm.com/find-a-doctor.

Comprehensive Major Medical

The Comprehensive Major Medical plan, administered by Blue Cross Blue Shield of Michigan, offers the most limited benefits and has the highest out-of-pocket cost of all of the university medical plans. You are free to use the provider of your choice, but your out-of-pocket costs are lower if you use a participating Blue Cross Blue Shield of Michigan provider. Benefits are limited to a Blue Cross fee schedule, and nonparticipating providers may charge more than the fee schedule allows. You pay 100% of any charges in excess of the fee schedule.

No matter which provider you use, you must meet your deductible of $500 per individual or $1,000 per family before benefits are paid. Once you satisfy your deductible, the plan will pay 80% of most eligible services, while you pay the remaining 20%.

Consider the Comprehensive Major Medical Plan if you are looking for:

- A plan that provides comprehensive coverage at a lower monthly rate, but requires more out-of-pocket costs at the time of service.
- A plan that includes all contracted providers with Blue Cross Blue Shield of Michigan (BCBSM) and access to non-contracted providers with additional out-of-pocket costs.
- Coverage within the United States.
- A plan with flexible provider choices, but don't mind paying an annual deductible and co-insurance for services.

GradCare

GradCare is a health plan exclusively for Graduate Student Instructors, Graduate Student Staff Assistants, and Graduate Student Research Assistants.

Consider GradCare if:

- You want a plan with low out-of-pocket costs.
- You want to use U-M Premier Care Network 1 physicians.
- You understand that when you are in the GradCare service area you must use your network Primary Care Physician 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.

Physician and Hospital PPO, Michigan Care, and U-M Premier Care Plan Participation

BC/BS Community Blue PPO, Michigan Care and U-M Premier Care plan participating physicians and participating hospitals are always subject to change. Contract renewal dates between health plans and their doctors and hospitals vary, and renewal is at the option of either party.

In the event your Primary Care Physician's (PCP's) affiliation with the Michigan Care or U-M Premier Care plan ends midway through the calendar year, you will need to select another PCP within your plan's service area. The PPO plan does not require you to designate a PCP; however, you will always receive a greater benefit, and less out-of-pocket costs, if your care is received in-network. Before enrolling in a new health plan, check the provider directory to make sure it includes a doctor and hospital of your choice. You can find provider information on the plan's website, or call the health plan's customer service number for provider information. You will **not** be able to change plans mid-year due to a physician's or hospital's disaffiliation with your health plan.

Prescription Drug Coverage

Prescription drugs are covered through Magellan Rx Management for everyone enrolled in a U-M health plan. For more information, see the Prescription Drug Plan section on page 22.

For More Detailed Information

Other booklets, plan documents, certificates, contracts, and riders provide more detailed information.

- To see more details about a plan, visit hr.umich.edu/health-plans
- To see additional information or a list of participating care providers, you may contact the health plan company directly using the contact information on the Health Plan Profiles Chart on pages 10-11 or the Contact Information on page 42.

Health Plan ID Cards

If your health plan changes, your ID cards will be mailed to you directly from your health plan company, not from the Benefits Office. You will not receive new ID cards if you do not change plans. If you have changed health plans and do not receive new cards by January 6, 2021, call the health plan company to request a new card. Phone numbers are listed in the Contact Information section on page 42.

If your health plan changes for 2021, contact your health plan company to find out how to receive services in January if your new cards arrive after January 1. See Contact Information on page 42.

Prescription Drug Plan ID Cards

Prescription drug ID cards from Magellan Rx are the same across all health plans. If you need additional cards for dependents, or a replacement for a lost card, please call the SSC HR Customer Care Center.

Addressing the Opioid Epidemic
Opioid drugs can be highly addictive, and their use and abuse is a growing issue in the United States. On average, 130 Americans die every day from an opioid overdose. Michigan is among the states with more opioid prescriptions than residents. In 2016, Michigan health care providers wrote 11 million prescriptions for opioid drugs, more than the estimated population of 9.9 million. (From the federal Centers for Disease Control website.)

The University of Michigan is addressing the opioid epidemic across multiple fields, from psychiatry, pharmacy, and public policy to basic science and law.

The Michigan Opioid Prescribing Engagement Network (Michigan OPEN) takes a preventive approach to the opioid epidemic in the state of Michigan by tailoring postoperative and acute care opioid prescribing. For information, visit michigan-open.org.

MHealthy has compiled university and community resources to help faculty and staff learn more about opioids. For information on how to talk with your doctor or dentist, alternatives to manage your pain, and where to get support if you or someone you know needs help, visit mhealthy.umich.edu/opioids.

Opioid Solutions serves as a central hub for U-M research, educational activities, and community outreach related to opioids. The network draws on nearly 100 U-M faculty whose research explores opioid misuse and overdose. For more information about opioid research, pain management, or treatment for addiction, visit opioids.umich.edu.

hr.umich.edu/health-plans

Introducing a new health plan choice for 2021!

MICHIGAN CARE

A PHP Health Plan

Available to eligible employees and retirees.

Similar to U-M Premier care, Michigan Care is a managed care plan with a narrower provider network and a lower monthly cost for non-Medicare members. See page 6 to learn more.

Because of the narrow provider network, access to the plan will be limited to those who live in a specific geographic area within Southeast Michigan. Visit the University Human Resources website to:

- See if your zip code is in the coverage area
- Check the provider directory for your preferred doctor or hospital
- Watch a video with plan highlights
- Review your monthly rates

If you are eligible you may select Michigan Care during Open Enrollment, October 19-30, 2020. Coverage will go into effect January 1, 2021.

hr.umich.edu/michigan-care

2021 HEALTH PLAN PROFILES

PLAN TYPE	MANAGED CARE PLANS		
	GradCare Only Available to U-M Graduate	**Michigan Care** Administered by Physicians Health	**U-M Premier Care**
Address	20500 Civic Center Dr. Southfield, MI 48076	1400 E. Michigan Ave Lansing MI 48912	20500 Civic Center Dr. Southfield, MI 48076
Questions?	800-658-8878	833-484-8450	800-658-8878
Directory or Contact Information	On the Web at: hr.umich.edu or call: 800-658-8878	michigancare.com	On the Web at: hr.umich.edu or call: 800-658-8878
Type of Plan	Plan for U-M graduate students only	Managed Care Plan	Managed Care Plan
Group Number	001243160002	L0002184	001243160001
Number of Members	7,609	TBD	78,624
Number of PCPs	Network 1 1,823	530	Network 1 1,823
Number of Specialists	21,553	3,688	21,553
Number of Hospitals	43	9	43
Percentage of Board Certified PCPs	91%	92%	91%
Percentage of Board Certified Specialists	87%	86%	87%
Policy for Selecting and Changing PCPs or Physicians	GradCare Level 1, contact BCN Customer Service or visit bcbsm.com	Contact PHP Customer service or visit michigancare.com	Contact BCN Customer Service or visit bcbsm.com
Three Reasons You Should Choose this Plan (Provided by the Plan)	1. Excellent medical care for graduate students at a fair and reasonable price. 2. Worldwide access to care. 3. Access to outstanding provider network, great customer service, money saving programs, and award winning health management programs.	1. Access to well known, highly respected provider network that includes Michigan Medicine, University Health Services and Trinity Health. 2. Robust benefits including chiropractic services and expanded telehealth services. 3. Lower monthly contributions and uncompromised quality and service.	1. Dedicated customer service line. 2. Worldwide access to care. 3. Access to outstanding provider network, great customer service, money saving programs, and award winning health management programs.

TRADITIONAL PLAN Comprehensive Major Medical	PPO Blue Cross Blue Shield of Michigan Community Blue PPO
600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226
877-790-2583	877-790-2583
On the Web at: bcbsm.com or call: 877-790-2583	On the Web at: bcbsm.com or call: 877-790-2583
Traditional fee-for-service plan	PPO
7005187	7005187
More than 5 million	More than 4 million
National network. Contact plan for provider information.	National network. Contact plan for provider information.
National network. Contact plan for provider information.	National network. Contact plan for provider information.
National network. Contact plan for provider information.	National network. Contact plan for provider information.
National network. Contact plan for provider information.	National network. Contact plan for provider information.
National network. Contact plan for provider information.	National network. Contact plan for provider information.
Not applicable	Not applicable
1. Blue ID card access to all hospitals and doctors nationwide. 2. Valuable online resources, including health management programs and member discounts. 3.Worldwide access to care.	1. Blue ID card access to all hospitals and doctors nationwide. 2. Valuable online resources, including health management programs and member discounts. 3. Worldwide access to care.

2021 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS		
Plan Name	**GradCare** Only Available to U-M Graduate Students	**Michigan Care[1]**	**U-M Premier Care[1,3]** **Provider Network 1**
General Information			
Service Area	Only available to GSIs, GSSAs, GSRAs, medical students, and sponsored graduate student groups at the University of Michigan	Most of Washtenaw and Livingston counties, and portions of Jackson, Lenawee, Monroe, Oakland and Wayne counties	Genessee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties
Residency Requirement	Level 1 and continuance: U-M academic campus	Participants must reside in the service area	Participants must reside in the service area
Important Information About the Terms Used in This Chart	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.[2]	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.[5]
Maximum Annual Out-of-Pocket Amount	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family).[4]	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family).[4]	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family) for Network 1 and 2 providers combined.[4]
Lifetime Maximum Benefit	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.
Phone Number for Customer Service and Provider Directory	800-658-8878	833-484-8450	800-658-8878
Web Site	bcbsm.com	michigancare.com	bcbsm.com
Hospital Services—Inpatient			
Hospital Admissions	Covered	Covered	Covered
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
Consultation Between Physicians	Covered	Covered	Covered
Surgery	Covered	Covered	Covered

TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Comprehensive Major Medical[1]	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
Nationwide/Worldwide	Nationwide/Worldwide	Not applicable
Not applicable	Not applicable	Not applicable
"Partially covered" means you pay a $500/$1,000 deductible, 20% co-insurance up to the annual out-of-pocket maximums, and costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-insurance means the percentage amount of the provider's charge you pay for a covered service.	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. You pay costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-pay means the set dollar amount you pay for a covered service.[5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. You pay costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-pay means the set dollar amount you pay for a covered service.[5]
Including the annual deductible, the maximum out-of-pocket amount is $3,000 per individual and $6,000 per family. [4]	Annual out-of-pocket maximumis $3,000 (individual) and $6,000 (family).[4]	Out-of-pocket maximum is $5,000 per individual, $10,000 per family. [4]
$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). $30,000 lifetime maximum benefit across all plans for selected gender affirming services.
877-790-BLUE	877-790-BLUE	877-790-BLUE
bcbsm.com	bcbsm.com	bcbsm.com
Partially covered	Covered	Covered at 50%
Unlimited days	Unlimited days	Unlimited days
Semi-private room; private room not covered	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary
Partially covered	Covered	Covered at 50%
Partially covered	Covered	Covered at 50%
Partially covered	Covered	Covered at 50%

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 contracts, certificates, or riders, 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.

1 These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

2 Coverage described applies to GradCare Level 1. For details on out-of-network services, call BCN.

3 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.

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

5 Co-pays may differ for bargained-for groups.

2021 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS		
Plan Name	**GradCare** Only Available to U-M Graduate Students	**Michigan Care[1]**	**U-M Premier Care[1,3]** **Provider Network 1**
Preventive Services			
Routine Physical Exams	Covered[10]	Covered[10]	Covered[10]
Routine Pediatric Exams	Covered[10]	Covered[10]	Covered[10]
Pap Smears — Lab and Pathology	Covered[10]	Covered[10]	Covered[10]
Routine Mammograms	Covered	Covered[10]	Covered
PSA (Prostate) Test	Covered[10]	Covered[10]	Covered[10]
Outpatient Services			
Office Visits	Covered with a $25 co-pay for visits with PCPs and $30 for visits with specialists	Covered with a $25 co-pay for visits with PCPs and $30 for visits with specialists	Covered with a $25 co-pay for visits with PCPs and $30 for visits with specialists
Outpatient Physical, Occupational and Speech Therapy	Covered with a $25 co-pay per visit; major diagnoses limited to 60 visits per calendar year; minor diagnoses limited to 15 visits per calendar year. Major and minor diagnoses are determined by the plan.[6]	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year	Covered with a $25 co-pay per visit; major diagnoses limited to 60 visits per calendar year; minor diagnoses limited to 15 visits per calendar year. Major and minor diagnoses are determined by the plan.[6]
Therapeutic Radiology	Covered	Covered	Covered
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered
Routine Immunizations	Covered[10]	Covered[10]	Covered[10]
Allergy Testing	Covered with a $30 co-pay	Covered; a $30 co-pay may apply	Covered with a $30 co-pay
Allergy Injections	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply
Other Injections	$30 office visit co-pay may apply	Covered, a $30 co-pay may apply	$30 office visit co-pay may apply

TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Comprehensive Major Medical[1]	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
Covered[10]	Covered[10]	Not covered
Covered[10]	Covered[10]	Not covered
Covered[10]	Covered[10]	Not covered
Covered	Covered	Not covered
Covered[10]	Covered[10]	Not covered
Partially covered	Covered with a $25 co-pay for visits with PCPs and $30 for visits with specialists	Covered at 50%
Partially covered for unlimited treatments[6]	Covered with a $25 co-pay (co-pay applies to professional billed services only); limited to 60 visits per year (facility & professional services combined)[6]	Covered at 50%; limited to 60 visits per year (facility and professional services combined)[6]
Partially covered	Covered	Covered at 50%
Partially covered	Covered	Covered at 50%
Partially covered	Covered	Covered at 50%
Covered[10]	Covered[10]	Not covered
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] 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.

[6] Physical, occupational, and speech therapies are covered for acute conditions and subject to prior plan authorization. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.

[10] 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 you for the preventive services separately for the office visit.

2021 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS		
Plan Name	**GradCare** Only Available to U-M Graduate Students	**Michigan Care[1]**	**U-M Premier Care[1,3]** **Provider Network 1**
Emergency Care			
In Area	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.
Out of Area	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary
Mental Health Care			
Preauthorization Required	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.
Inpatient Days of Care	Covered for acute conditions	Covered	Covered for acute conditions
Outpatient Individual Psychiatric Care	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay
Group Therapy	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay
Psychological Testing	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay
Substance Abuse Care			
Preauthorization Required	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.

TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Comprehensive Major Medical[1]	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
Partially covered	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.
Partially covered	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.
Partially covered for transfer to or from hospital; includes ground and air when medically necessary.	Covered for emergency transportation when medically necessary	Covered for emergency transportation when medically necessary
Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	No
Partially covered	Covered for acute conditions	Covered at 50% for acute conditions
Partially covered	Covered with a $25 co-pay	Covered at 50%
Partially covered	Covered with a $25 co-pay	Covered at 50%
Partially covered	Covered with a $25 co-pay	Covered at 50%
Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	No

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] 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.

2021 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS		
Plan Name	**GradCare** Only Available to U-M Graduate Students	**Michigan Care[1]**	**U-M Premier Care[1,3]** **Provider Network 1**
Substance Abuse Care (continued)			
Inpatient Days of Care	Covered	Covered	Covered
Outpatient Individual Therapy	Covered with a $25 co-pay per visit	Covered with a $25 copay	Covered with a $25 co-pay per visit
Group Therapy	Covered with a $25 co-pay per visit	Covered with a $25 copay	Covered with a $25 co-pay per visit
Maternity Care			
Parental Care, Delivery, Postnatal Care	Covered	Covered	Covered
Skilled Nursing Facility			
(Non-Custodial Care)	Covered up to 45 days per calendar year if preauthorized by BCN	Covered up to 120 days per calendar year when arranged and authorized by Physicians Health Plan	Covered up to 120 days per calendar year when arranged and authorized by BCN
Hearing Care			
Examinations	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months
Tests	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months
Hearing Aids	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]
Vision Care			
Eye Examinations	Covered at plan vision providers – one exam per year; at non-plan providers, covered up to $40. Dilation not covered.	Covered at plan providers – one exam per year; at non-plan providers, covered up to $40. Dilation not covered.	Covered at plan vision providers – one exam per year; at non-plan providers, covered up to $40. Dilation not covered.
Eyeglasses	Not covered	Not covered	Not covered

TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Comprehensive Major Medical[1]	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
Partially covered	Covered	Covered at 50%
Partially covered	Covered with a $25 co-pay per visit	Covered at 50%
Partially covered	Covered with a $25 co-pay per visit	Covered at 50%
Partially covered	Covered	Covered at 50%
Partially covered up to 120 days per calendar year	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year
Partially covered; once every 36 months	Covered; once every 36 months	Not covered
Partially covered; once every 36 months	Covered; once every 36 months	Not covered
Partially covered; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Not covered
Covered; one exam per year. Dilation not covered.	Covered; one exam per year. Dilation not covered.	Covered up to $40; one exam per year. Dilation not covered.
Not covered	Not covered	Not covered

1 These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

3 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.

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

9 Includes ordering and fitting of hearing aids.

2021 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS		
Plan Name	**GradCare** Only Available to U-M Graduate Students	**Michigan Care[1]**	**U-M Premier Care[1, 3] Provider Network 1**
Nursing Care			
Preauthorization Required	These services must be medically necessary and recommended by your Primary Care Physician or approved by your plan.	These services must be medically necessary and recommended by your Primary Care Physician or approved by the plan.	These services must be medically necessary and recommended by your Primary Care Physician or approved by your plan.
Visiting Nurse Home Care	Covered when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.
Private Duty Nursing	Not covered	Not covered	Not covered
Home Health Aides	Covered with a $20 co-pay when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.
Other Services			
Hospice Care	Covered when authorized by BCN	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN
Durable Medical Equipment, Prosthetic Appliance	Covered when authorized by BCN	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN
Voluntary Sterilization	Covered	Covered	Covered
Chiropractic Spinal Manipulation	Not covered	Covered with a $25 copay; limited to 24 visits per year for spinal manipulation	Not covered
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. 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. 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. Contact plan for details.

TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Comprehensive Major Medical[1, 4, 11]	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1, 4, 11]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1, 4]**
These services must be medically necessary and recommended by the plan physician. Coverage for home health aide services must be provided by a BCBSM-approved agency. Contact BCBSM for specific coverage requirements before these services are provided.	These services must be medically necessary and recommended by the plan physician. Coverage for home health aide services must be provided by a BCBSM approved agency. Contact BCBSM for specific coverage requirements before these services are provided.	Not applicable
Partially covered under a BCBSM-approved Home Care Program; no visit limits	Covered	Not covered
Partially covered with a 50% co-insurance for authorized services	Covered at 50%[11]	Covered at 50%
Partially covered under an approved Home Care Program	Covered	Not covered
Contact BCBSM for specific coverage levels before these services are provided.	Covered; contact BCBSM for specific coverage levels before these services are provided.	Not covered
Partially covered	Covered when medically necessary	Not covered
Covered	Covered	Covered at 50%
Partially covered; maximum of 38 visits per calendar year	Covered with a $25 co-pay; limited to 24 visits per year	Covered at 50%; limited to 24 visits per year
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. 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. 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. Contact plan for details.

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] 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.

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

[11] Any expense paid at 50% does not apply to the out-of-pocket maximum for the CMM plan. Private duty nursing expenses do not apply to the out-of-pocket maximum under the BCBSM Community Blue PPO plan.

prescription drug plan

MAGELLAN RX ADMINISTERS THIS PLAN

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

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

Eligibility and Enrollment

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

NoviXus Pharmacy App

Download the free NoviXus Pharmacy app from the App Store or Google Play. You can use it to:

- Register for mail order
- Submit refill orders and more
- Check your order status

Plan Features

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

- **Access to local and national chain pharmacies.** Up to 90-day supplies are available for many medications. Participants can fill prescriptions for one- to 34-day supplies for one co-pay, 35- to 60-day supplies for two co-pays, or 61- to 90-day supplies for three co-pays.

- **Mail-order pharmacy** is provided by NoviXus Pharmacy Services as an alternative to retail pharmacies. Use of the mail-order service results in savings to you and to the U-M Prescription Drug Plan. NoviXus provides convenient, secure deliveries to your home. This is particularly convenient for participants who take certain medications on an ongoing basis. Participants save a third of their out-of-pocket co-pay for a 90-day supply of medication through mail order. Visit hr.umich.edu/mailorder to learn more.

- **Diabetic insulin, needles, and syringes** are available to all participants in the University of Michigan Prescription Drug Plan. Select insulin products (see the formulary at hr.umich.edu/formulary), needles, and syringes are covered at $0 co-pay for all members.

- **Coverage of diabetic supplies** (injection devices, alcohol swabs, testing strips, lancets, and blood glucose testing monitors) is determined by your health plan. See page 42 for health plan contact information.

hr.umich.edu/prescription-drug-plan

Terms You Need to Know

Formulary—A formulary is a list of available prescription drugs offered by the plan to serve the pharmaceutical needs of patients requiring self-administered drug therapy on an outpatient basis. In addition, there may be drugs covered but not listed on the formulary. Inclusions (or exclusions) of drugs on the formulary 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. The U-M formulary can be found at: hr.umich.edu/formulary.

Generic Drugs/Tier 1—The Generic Drug co-pay 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 United States Food and Drug Administration (FDA), contain the same active ingredients as their brand-name equivalents, and must meet the same safety, production, and performance standards. Therefore, generic drugs often offer an effective and safe alternative to help reduce prescription drug costs for both you and the University of Michigan. Approximately 89% of all prescriptions under the U-M Prescription Drug Plan are dispensed as generic drugs. For co-pay amounts for generic drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

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 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. Approximately 86% of all prescriptions dispensed are at Tier 1 or Tier 2. Approximately 11% of all prescriptions under the U-M Prescription Drug Plan are dispensed with a $0 co-pay. For co-pay amounts for preferred brand-name drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

Non-Preferred Drugs (Brand-Name)/Tier 3—Drugs on the third co-pay tier are FDA-approved drugs that a committee of university physicians and pharmacists have not designated as "preferred" and are subject to a higher co-pay 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. Approximately 3% of all medications are dispensed as non-preferred drugs. For co-pay amounts for non-preferred brand-name drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

Select medications for participants as defined by the Affordable Care Act with a prescription from your doctor are covered at zero ($0) co-pay when you use your Magellan Rx prescription drug ID card at a network retail pharmacy or the NoviXus mail-service pharmacy.

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

hr.umich.edu/prescription-drug-plan

This section is not intended to be a full description of the Prescription Drug Plan coverage. The complete plan description is contained at hr.umich.edu/prescription-drug-plan. 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.

Note: Mail order offers the best value for 90-day supplies of maintenance medications. You save a third of your out-of-pocket cost over retail with the added convenience of home delivery. For more information, visit hr.umich.edu/mailorder.

2021 U-M Prescription Drug Plan Co-pays

Group	Drug Type	Retail Pharmacy Co-pay [1, 2, 3, 4]			Mail Order Co-pay [1, 2, 3, 4] NoviXus Pharmacy Services
		1- to 34-day supply	35- to 60-day supply	61- to 90-day supply	Up to 90-day supply (Compare to 61- to 90-day supply at retail)
Active Employees [4] (see below for variance by collective bargaining agreement)	Generic Drugs/Tier 1 Brand Name/Tier 2 Non-Preferred Brand Name Drugs/Tier 3	$10 $20 $45	$20 $40 $90	$30 $60 $135	$20 $40 $90
MNA Active and LTD members (per contract)	Generic Drugs/Tier 1 Brand Name/Tier 2 Non-Preferred Brand Name Drugs/Tier 3	$7 $15 $30	$14 $30 $60	$21 $45 $90	$14 $30 $60

1 If the retail price of a covered medication is less than the tier co-pay, you pay only the cost of the medication. If the cost of the covered medication is more than the co-pay, you pay only the co-pay. 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 co-pay if a brand-name drug is selected when a generic equivalent is available.

4 Co-pays for union members may differ based on their collective bargaining agreement.

Opioid Drugs

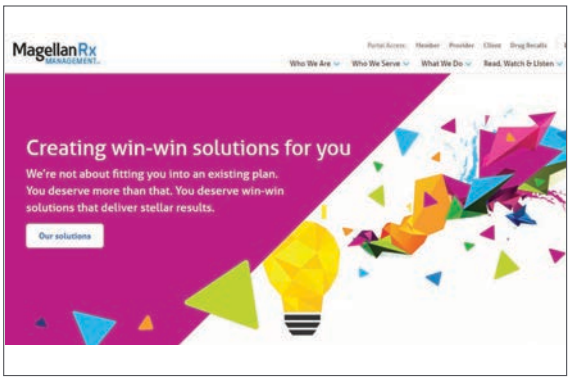
Opioid drugs can be highly addictive, and their use and abuse is a growing issue in the United States. If the opioid epidemic affects you or someone you know, the U-M prescription drug plan covers Narcan Nasal Spray and other forms of naloxone, a life-saving antidote to overdoses of opioids.

To improve member safety, the university has directed Magellan Rx to run a quarterly opioid review program to flag instances of potential opioid abuse since early 2016. The program alerts health care providers whose patients have claims for a high level of opioids for more than 90 days in the last six months.

For information to help you understand opioid pain medications and learn how to talk to your doctor or dentist about pain control, visit mhealthy.umich.edu/opioids.

Access your prescription history, price a drug, and more!

At Magellan Rx Management, we are on a quest to provide a connected healthcare experience that truly leads humanity to healthy, vibrant lives. We are committed to delivering quality service and personalized care. Our secure member portal provides support to help you stay on track.



STEP ONE

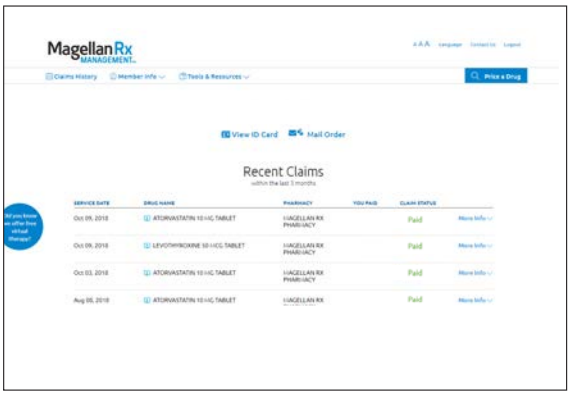
Visit www.umich.magellanrx.com and select Portal Access: Member.

STEP TWO

Login. If it's your first time on the site, you will need to complete the one-time registration process.

To register, fill out the registration form. Click on confirmation link sent to the email you registered with within 24 hours (if you don't click on the link within 24 hours you will need to re-register).

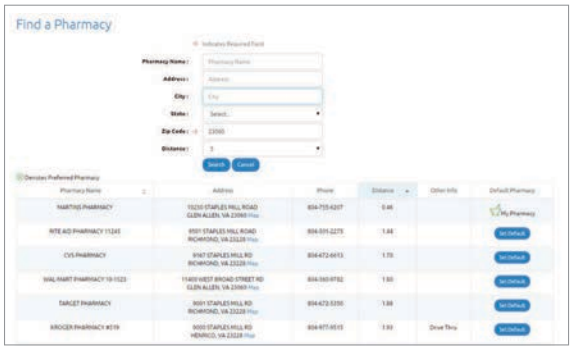
The link will take you to the member login page and will complete your registration.



STEP THREE

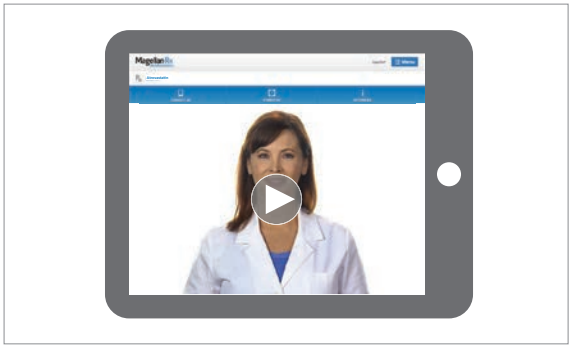
Get to know your dashboard. It's easy to view recent claims, access on-demand medication videos, and more!

ADDITIONAL RESOURCES:



Smart Pharmacy Locator

- Locate pharmacies in your area
- Set default pharmacy



Medication Videos

In an effort to empower our members with rich, relevant content for more informed healthcare decision-making, we offer more than 500 medication videos through our member portal. These videos provide:

- Traditional and specialty medication details
- Disease education
- Side effect awareness

Price a Drug

- Auto-complete feature assists in searching for a drug
- Ability to select from previously filled drug and see dosage and strength options based on the drug selected
- Comparative drug pricing for up to 5 retail pharmacies
- Drug pricing messages in clear, understandable language

Login today at umich.magellanrx.com.

If you have any questions about your prescription benefits, please call us at 1.888.272.1346.

MagellanRx MANAGEMENT℠

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.

As our workplace evolves, our commitment to supporting your health and well-being goals remains the same. We are here to help you:

- Improve your mood
- Solve ergonomic issues
- Drink less alcohol
- Be tobacco-free
- Eat smarter
- Be active
- And much more!

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

M HEALTHY

mhealthy.umich.edu

dental plan

DELTA DENTAL OF MICHIGAN ADMINISTERS THIS PLAN

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 under Delta Dental PPO (Point-of-Service). Delta Dental PPO (Point-of-Service) is Delta Dental's national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists–the Delta Dental PPO network and the Delta Dental Premier network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.

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 on pages 28-29 for information on benefit levels and covered services. For full details on coverage and limitations of the plan, see the Delta Dental certificate of coverage that is available for download from hr.umich.edu/dental-plan.

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

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 (PPO) Dentist?

Delta Dental will pay the PPO dentist directly for covered services based on his or her submitted fee or the amount in the local Delta Dental's PPO dentist schedule, whichever is less. If the PPO dentist schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a PPO dentist for covered services (see the coverage comparison chart on pages 28-29). PPO dentists will also fill out and file your claim forms.

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

Delta Dental will pay the Premier dentist directly for covered services based on his or her submitted fee or the local Delta Dental maximum approved fee, whichever is less. If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference. As with PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services (see the coverage comparison chart on pages 28-29). And, like PPO dentists, Premier dentists will fill out and file your claim forms for you.

What if I Go to a Nonparticipating Dentist?

If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier, you will still be covered (see the coverage comparison chart on pages 28-29). However, you could save more of your out-of-pocket expenses if you go to a dentist that participates with Delta Dental. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges.

How Can I Find a Participating Dentist?

To find the names of participating dentists near you, log on to the Delta Dental dentist directory via their website at: deltadentalmi.com. You can also call Delta Dental's Customer Service department toll free, at: 800-524-0149.

DASI (Delta's Automated Service Inquiry) system is available 24 hours a day, seven days a week, and can provide you with a list of participating dentists. You can also speak to a Customer Service representative at any time during normal business hours (Monday through Friday from 8:30 a.m. to 8 p.m. Eastern Time).

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

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

Rates

Find your 2021 monthly dental plan rates on Wolverine Access at: wolverineaccess.umich.edu.

ID Card

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

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

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

Preauthorization

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

Where Can I Find Additional Information Regarding the Dental Plan?

Several resources are available to find out what your dental plan covers:

- Refer to the Dental Plan booklet that is available for viewing and downloading at: hr.umich.edu/dental-plan
- Call Delta Dental's Customer Service department at: 800-524-0149.
- Register and log onto Delta Dental's Consumer Toolkit. See below for instructions on how to access and use the Toolkit.

Delta Dental Consumer Toolkit
toolkitsonline.com

Stay current on your dental benefits with Delta Dental's easy-to-use Consumer Toolkit. This secure on-line tool is designed to give you 24/7 access to important information regarding your dental benefits, including:

- Eligibility information for yourself and covered dependents;
- Current benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, and levels of coverage for specific dental services);
- Specific claims information including what has been approved and when it was paid.

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

To start using this helpful instrument, log on to: toolkitsonline.com and click on the "Consumer Toolkit" button. First-time users will need to register. You may use your eight-digit UMID number followed by a zero for your member ID, or you may use your Social Security number. Either number will be accepted.

The privacy of your benefits information is assured. Delta Dental employs state-of-the-art, ultra-secure computer technology to protect your personal information.

Summary of Dental Plan Benefits

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 bicuspids 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 post-operative 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 $1,250 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.

Continued on next 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 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	• 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.	• $1,250 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 $1,250 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.

hr.umich.edu/dental-plan

Dental Care Outside the United States

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

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

How to Find a Dentist

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

What Dental Services are Covered

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

Filing Claims

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

deltadentalmi.com

DELTA DENTAL®

Your Delta Dental benefits, at your fingertips!

The ***new*** Delta Dental Mobile App helps you get the most out of your dental benefits anytime, anywhere. Use the dentist search or toothbrush timer without logging in, or enter your username and password* to securely access your personal benefit information.

» Dentist Search

Find a dentist in your plan/network, narrow the list with criteria like 'language spoken' and 'specialty', and even find a dentist nearby using your current location. After you pick a dentist you can save the contact information and get directions.

» Mobile ID Card

No more paper! Provide your dentist with the information he or she needs by accessing your ID card right on your phone.

» View Coverage & Review Claims

See your plan type, benefit levels, deductibles, maximums, and more. Check the status of recent dental claims for you and your dependents. To keep this information secure, you'll have to log in each time. No personal information is ever stored in the app.

» Toothbrush Timer

Make sure you brush for the recommended two minutes with this handy timer that can use a song from your phone or a pre-loaded tune to keep you going.

The Delta Dental Mobile App is available for Apple iOS or Android users. Visit the App Store (*Apple*) or Google Play (*Android*) and search for 'Delta Dental.' Or, scan this QR code to download the app.^

* *To register, go to www.DeltaDental.com and sign up for an account that will also work in the mobile app.*

^ *To scan the code, you must have a QR code reader on your smartphone.*

vision plan

DAVIS VISION ADMINISTERS THIS PLAN

How the Vision Plan Works

Davis Vision, a national administrator of routine vision care programs, provides benefits under the Vision Plan. You can receive benefits in-network or out-of-network. You should plan to use in-network services to receive the highest benefit. In-network means you use a provider who is in the Davis Vision provider directory. To find an in-network provider, call: 800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

To access plan information exclusively for U-M participants and to find a Davis Vision provider in your area:

1. Go to the Davis Vision website at: davisvision.com/Members
2. Select "Open Enrollment," and then enter 2032 in the Client Code field.

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.

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

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

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

Cost of Enhancements

If your prescription requires additional enhancement, a co-pay will be added; however, the costs are generally at wholesale prices when ordered through a Davis Vision provider. The co-pays are listed in the Vision Care Plan Benefit Description available at: hr.umich.edu/vision-plan.

Laser Vision Correction Services

Davis Vision 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 charge or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Call the participating provider for inquiries on the available discount. For more information, please visit www.davisvision.com or call 1-800-999-5431.

Buy a Voucher Program

You can purchase additional pairs of eyeglasses or contact lenses directly from Davis Vision. Call Davis Vision at 1-800-999-5431 to speak to a representative. For voucher services and costs, please visit hr.umich.edu/vision-plan.

Eye Exams
Your health plan may cover your eye exam. Review the Vision Care section of the Health Plan Coverage Comparison Chart on pages 18–19 and/or contact your health plan office directly to ask if your plan covers eye exams.

Rates
Find your 2021 monthly vision plan rates on Wolverine Access at: wolverineaccess.umich.edu

ID Card
No ID Card is issued or needed for the Vision Plan. Davis Vision will automatically send you a welcome kit and plan brochure when you enroll.

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

Summary of Benefits
The Vision Care Plan Benefit Description from Davis Vision is available at: hr.umich.edu/vision-plan.

Questions?
If you have questions about the Vision Plan, or need a provider directory, call Davis Vision at: 800-999-5431.

davisvision.com

legal services plan

METLIFE ADMINISTERS THIS PLAN

Low-Cost Help With a Variety of Legal Matters

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

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

MetLife Legal Plans identity protection services provides assistance for emerging identity threats including phishing scams, mobile device attacks, company data breaches, medical identity theft, lost and destroyed documents, and many more identity theft issues. This service also includes an identity monitoring and protection service to provide you with credit score monitoring at one bureau and alerts based on your social security number.

Identity Management Services
This service provides plan members access to LifeStages Identity Management Services. Services include proactive services when you believe your personal data has been compromised and resolution services to assist you in recovering from account takeover or identity theft. It offers unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring.

Credit Monitoring
This service provides credit monitoring for you only with a single credit bureau and includes alerts based on your social security number. A credit report monitors your credit activity including new lines of credit.

info.legalplans.com

Non-Credit Monitoring
Bank Accounts: The service monitors internet surveillance of your personal information that could be associated with financial accounts. Daily monitoring and alerts based on your bank account, routing, and credit card numbers and expiration date are included.

Medical/Insurance Records: Monitoring of medical records and insurance claims based on your policy number, insurance card, and medical identification numbers.

One of the most valuable features of the Legal Services Plan is that it covers telephone advice and office consultations. So, 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

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

If you need representation on a matter not covered by the plan, your MetLife Legal Plan attorney will give you a written fee agreement in advance. That means you will know from the start what those services will cost you. To obtain a fee schedule, call Hyatt.

If you need legal assistance with a family will and estate planning or services where both you and your spouse or other qualified adult are required to sign legal documents (such as in real estate matters), you must enroll at the level of You + Adult or You + Adult + Children in order for these services to be fully paid by the plan.

For information, visit **info.legalplans.com**. Under "Not a Member?" enter the U-M access code:
Member only: 2100010
Member and family: 2120010

Click "Learn About Your Legal Plan" for informatiton on the U-M plan.

Rates

Find your 2021 monthly Legal Services Plan rates on Wolverine Access.

MetLife Legal Services Plan

800-821-6400

Legal Services Plan Book

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

After-Tax

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

ID Card

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

Will Preparation

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

PAYFLEX®

Flexible Spending Account (FSA)

The simple way to save for out-of-pocket expenses

What's an FSA?

It's an account that you contribute money into from your paycheck, before taxes are taken out. You'll save money when you use it to pay for health and dependent care expenses.

Health Care FSA

Contribute up to your plan's limit in pretax dollars from your paycheck. Your full contribution is available to use at the start of the plan year to pay for eligible health care expenses, such as:

- copays, coinsurance and deductibles
- dental and vision expenses
- prescription medicine and over-the-counter items

Dependent Care FSA

You can contribute up to the IRS limit of $5,000.* Funds are for your dependent(s) age 12 or younger or a spouse or dependent incapable of self-care. This FSA pays for eligible child and adult care expenses, such as day care, preschool and nursery school, in-home aid, and more.

Pay yourself back

Pay for eligible expenses with cash, a check or your personal credit card. Then withdraw funds from your FSA to pay yourself back and have your payment deposited.

Pay your provider

You may pay your provider directly from your account.

Pay with your PayFlex Card®

When you use it, your expense is automatically paid from your account.

Pay with your phone

By using your digital wallet, you can save your PayFlex Card® on your phone and use Samsung Pay or Apple Pay® at checkout where digital payments are accepted.

UNIVERSITY OF MICHIGAN

Keep it simple with the PayFlex Mobile® app

- Manage your account and view alerts.
- Snap a photo of your receipts to submit claims.
- Use our barcode scanner to verify eligible items in-store.

Note: Standard text messaging rates and other rates from your wireless carrier may apply when using the PayFlex Mobile app.

*IRS limits can change year to year, and some employers may set a lower limit. Please check your plan details for how much you can contribute.

Handy FSA reminders and tips

- Save all of your itemized statements and detailed receipts.
- View the IRS contribution limits and a list of common eligible expense items on PayFlex.com.
- You can change your contribution if you have a change in status,* such as your marital or employment status, your number of tax dependents, etc.
- FSAs have a use-it-or-lose-it rule, which means if you don't use your funds by the end of the plan year, you'll lose them. After your plan year ends, you have a certain time period during which you need to submit your claims. Check your plan details to understand these dates.
- Your plan has a grace period,** which means you'll have an extra two and a half months after your plan year to spend your funds. Check your plan details to learn more.
- For Dependent Care FSAs, you must be working or looking for work to use your dependent care funds. If you're married, your spouse must either be working, looking for work or a full-time student.

Want to learn more?

Just visit payflex.com

Call us at 1-877-343-1346 (TTY: 711)

We're here to help Monday–Friday 7a.m.–7p.m.CT, and Saturday 9a.m.–2p.m.CT

*You must apply for a change in your election through your employer. See your employer's Summary Plan Description for specific details about your plan.

** If your plan allows you to carry over unused Health Care FSA funds, the grace period doesn't apply.

This material is for informational purposes only and is not an offer of coverage. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. It does not contain legal or tax advice. You should contact your legal counsel if you have any questions or if you need additional information. In case of a conflict between your plan documents and the information in this material, the plan documents will govern. Eligible expenses may vary from employer to employer.

Please refer to your employer's Summary Plan Description ("SPD") for more information about your covered benefits. Information is believed to be accurate as of the production date; however, it is subject to change. PayFlex cannot and shall not provide any payment or service in violation of any United States (U.S.) economic or trade sanctions. For more information about PayFlex, go to **payflex.com.**

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flexible spending accounts

CLAIMS PROCESSED BY PAYFLEX

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

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

There are two types of FSAs. You may participate in either or both:

1. **Health Care FSA**—covers eligible health care expenses for you and your eligible dependents.
2. **Dependent Care FSA**—covers eligible dependent daycare or elder care expenses so you can work or attend school full-time.

How the Accounts Work

FSAs are simple. Here's how they work:

- You decide whether to participate in one or both accounts.
- You decide how much you want to deposit during the calendar year.
- The university's claims processor, PayFlex, 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 and/or dependent care expenses. The calculator is available at: hr.umich.edu/flexible-spending-accounts
- The money you allocate to one or both accounts 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.
- When you have an eligible Health Care FSA expense, such as prescription drug co-pay, save the itemized receipt. You may pay the expense at the pharmacy with your PayFlex Card or you may submit a claim form and the receipt to PayFlex for reimbursement.
- For dependent care claims, save the itemized receipts from your daycare provider and submit a claim form with your receipts to PayFlex. The PayFlex Card is not available for daycare expenses.

Claims Processing

An external vendor, PayFlex Systems, Inc., will process claims for reimbursement from your 2021 Dependent Care and Health Care FSAs. PayFlex is a national provider of health care and benefits management services.

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

The PayFlex Card can only be used at merchants and service providers that have merchant category codes related to health care, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers. **When using the card it is important to retain your receipts. They will be requested by PayFlex to substantiate a claim.**

- Mail your claims directly to PayFlex. The mailing address is:

  PayFlex Systems USA, Inc.
  P.O. Box 8396
  Omaha, NE 68103-8396
- Or fax to the PayFlex toll-free fax number at: 402-231-4310.
- Submit claims online: Login at: payflex.com, enter your claim information and fax or upload your receipts to: 866-932-2567.
- File Claims using the PayFlex Mobile app available from the App Store or Google Play.

See the 2021 Flexible Spending Account book for additional claim filing information.

- For helpful FSA information, visit the PayFlex website at: payflex.com
- Claim forms are available at: payflex.com.
- PayFlex pays claims on a daily basis.
- Check your account balance and view transactions and claim histories at: payflex.com.
- PayFlex can directly deposit your reimbursements to your bank account.
- Click on: payflex.com for the FSA tutorial, savings calculator, expense planning worksheets, lists of eligible expense items, frequently asked questions, forms and publications, and IRS forms and publications.

Health Care FSA

For 2021 you can contribute a minimum of $120 up to a maximum of $2,750 per calendar year to your Health Care FSA.

Many common health care expenses are eligible for reimbursement from your Health Care FSA, including medical and dental co-pays, deductibles, prescription co-pays, vision care, and LASIK surgery. Generally, any health care expenses you can deduct on your federal income tax return are eligible for reimbursement from your Health Care FSA. There are some exceptions. For example, a Health Care FSA may not reimburse participants for insurance premiums paid for individual or employer-sponsored coverage. For a list of covered Health Care FSA expenses, visit the PayFlex website, payflex.com, and review the Flexible Spending Account Eligible Expense Guide.

Health Care FSA: Eligible Expenses

Eligible expenses include, but are not limited to:

- Any necessary medical, dental, and vision plan expenses not reimbursed by any benefits plan. This includes co-pays, deductibles, co-insurance, amounts above prevailing fee limits, and amounts exceeding plan dollar maximums.
- Hearing care.
- Prescription co-pays.
- Certain over-the-counter medications to treat illness; this-requires a prescription for OTC drugs and medicines in order to be eligible for reimbursement from an FSA. Health Care debit cards cannot be used to purchase OTC drugs and medicines, even with a prescription.
- Services and equipment for the disabled.

Dependent Care FSA

You can contribute a minimum of $120 up to $5,000 each year to your Dependent Care FSA. Highly compensated faculty and staff (family gross earnings in 2020 of $130,000 or more) can contribute $3,600 per year.

You can use the Dependent Care FSA only if you are paying for dependent care so you can work. In addition, if you are married, your spouse must either work, attend school full-time for at least five months each year, or be disabled to be eligible. Eligible dependent care expenses include qualified daycare centers for children or qualified adults as well as care inside or outside your home. See the 2021 Flexible Spending Account book for additional information on eligible dependents.

Dependent Care FSA: Eligible Expenses

Eligible expenses include, but are not limited to:

- Care for dependents age 12 or younger, 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 PayFlex website at: payflex.com and review the Flexible Spending Account Eligible Expense Guide. Contact PayFlex at: 877-343-1346 if you have questions about whether a particular expense is eligible.

hr.umich.edu/flexible-spending-accounts

Things to Consider for Health Care and Dependent Care FSAs

There are some IRS rules you should be aware of before you decide to participate in an FSA.

- **You must enroll each year if you wish to participate.** Internal Revenue Service regulations do not allow FSA enrollments to carry over from year to year.
- Your 2021 contributions for a Health Care or Dependent Care FSA must be used for eligible expenses you incur between January 1, 2021 and March 15, 2022.
- 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 2021 account(s) on June 1, 2022 is forfeited and will not be returned to you. This is known as the "use it or lose it" rule. Planning carefully with the PayFlex FSA Calculator, which is available at: www.payflex.com and filing your claims promptly will help ensure that you can maximize the benefits of your account.
- The Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account must be maintained as two separate accounts. Money cannot be transferred between the accounts, and health care 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.
- With the Health Care Flexible Spending Account, you have access to the total amount you elected for the plan year as soon as eligible expenses are incurred.
- For a Dependent Care Flexible Spending Account, you can only be reimbursed 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 PayFlex on the first of every month for deductions taken in 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), you will want to review the FSA plan book carefully before you enroll. View the book and plan information at: hr.umich.edu/flexible-spending-accounts

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 2020 FSA and you wish to participate in 2021, you must re-enroll and designate the amount of money to be withheld.

Services Deadline

For a 2021 Health Care or Dependent Care FSA, you can incur expenses until March 15, 2022.

Claims Deadline

To receive reimbursement for 2021 expenses, you must submit your claims to PayFlex by May 31, 2022. 2021 money left in your account on or after June 1, 2022 will be forfeited. In accordance with Internal Revenue Code, the university uses forfeited funds to pay administration costs of the FSA program.

Questions?

For more information, call PayFlex at: 877-343-1346, or visit payflex.com

Tax Savings

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

changes

YOU CAN MAKE AT ANY TIME

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

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

See hr.umich.edu/benefits-wellness for plan details and information on eligibility and enrollment.

Keep Your Beneficiary Up to Date

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

Update Your Address

if you move, be sure to update your home address with the university through Wolverine Access.

You Can Help Control Costs...

Be a Wise Healthcare Consumer.

Think of your healthcare investment just as you would any other important expense. Use the information provided in this booklet and on hr.umich.edu to make an informed decision.

Use In-Network Doctors and Pharmacies.

You'll pay less out of pocket and there's no need to fill out forms.

Ask for Generic Drugs.

Generic drugs have the same active ingredients as brand-name medications and they save you money.

Keep Yourself and Your Family Healthy.

Visit mhealthy.umich.edu for information on programs and resources to support your health and well-being.

information resources

- Benefits information: **hr.umich.edu/benefits-wellness**
- Call the SSC Contact Center: 5-2000 from the U-M Ann Arbor campus, 734-615-2000 local, or 866-647-7657 toll free. Have your UMID number ready when you call.
- Sign up for *UHR News*, a twice-monthly email newsletter for current benefits and employment information. To subscribe, send an email message to: university-hr-news-request@umich.edu. Type "subscribe" in the subject line of the message for automatic subscription.

Enroll in a Flexible Spending Account and Save!

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to pay for certain out-of-pocket health care and dependent care expenses.

A Health Care FSA helps you save on health-related expenses for you or your dependents:

- Will have LASIK or other refractive surgery in 2021
- Wear glasses or contact lenses
- Purchase prescription medications
- Receive orthodontic treatment, such as braces
- Buy certain over-the-counter medications (with a doctor's prescription)

A Dependent Care FSA allows you to set aside pre-tax dollars to pay for eligible dependent daycare or elder care expenses incurred so you can work or attend school full-time.

Already enrolled? Remember that you must re-enroll every year to participate. You can enroll online during Open Enrollment, or submit a paper 2021 FSA enrollment form by November 30.

For more information on Flexible Spending Accounts, visit: **hr.umich.edu/flexible-spending-accounts**

important federal notices

REGARDING YOUR HEALTH COVERAGE

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

Women's Health and Cancer Rights

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

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

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

Newborns' and Mothers' Health Protection Act

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

Summary of Benefits and Coverage (SBC) and Uniform Glossary

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

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

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

Health Care Reform

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

Continuation of Benefits (COBRA)

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

If you need to remove ineligible dependents from your benefits, do not remove them when you make your Open Enrollment elections. If you do, continuation of benefits under the federal COBRA law will not be available to them. Your dependent children who become ineligible due to age limits will be automatically dropped from your group health coverage and will be sent information on coverage under COBRA provisions at that time. If dependents become ineligible for reasons other than age ineligibility, you must complete and return a Notice of Qualifying Event form to SSC Benefits Transactions within 60 days of the loss of eligibility. The form is available at hr.umich.edu or may be obtained by calling the SSC Contact Center at: 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calling within the United States). Failure to submit the notification during the 60-day timeframe will result in forfeiture of your dependent's rights to COBRA continuation coverage.

Special Enrollment Rights

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

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

- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for health coverage outside the annual Open Enrollment period, provided you previously declined enrollment due to coverage elsewhere and you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

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

2. You or your dependent(s) enrolls in Medicaid or the state CHIP. You may cancel coverage in U-M's group health plan within sixty (60) days of your or your dependent's coverage effective date.

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

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

If you have any questions regarding your eligibility for U-M benefits, call the SSC Contact Center Monday - Friday, 8 a.m. – 5 p.m. at 5-2000 from the Ann Arbor campus, 734-615-2000 locally, or toll free at 866-647-7657.

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

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage.
(For a list of participating states as of January 31, 2017, visit dol.gov/ebsa/chipmodelnotice.doc) If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, or you may contact 1-877-KIDS NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

HIPAA Privacy and Security

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

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

Read the information carefully and contact the SSC Contact Center, Monday through Friday, 8:00 a.m. to 5:00 p.m. at (734) 615-2000 or (866) 647-7657 if you have any questions or would like to request a copy.

contact information

Plan Providers	Phone	Web Address
Blue Cross Blue Shield Community Blue PPO	877-790-2583	bcbsm.com
Comprehensive Major Medical (provided by BCBS)	877-790-2583	bcbsm.com
Davis Vision	800-999-5431	davisvision.com
Delta Dental Plan Information	800-524-0149	deltadentalmi.com
GradCare	800-658-8878	mibcn.com
Magellan Rx Customer Support	888-272-1346	umich.magellanrx.com
MetLife Legal Plan	800-821-6400	legalplans.com
Michigan Care	833-484-8450	michigancare.com
NoviXus Pharmacy Services	877-269-1160	umich.novixus.com
PayFlex	877-343-1346	www.payflex.com
U-M Premier Care	800-658-8878	bcbsm.com specialty_pharmacy
University of Michigan Specialty Pharmacy	855-276-3002	pharm.med.umich.edu/

Other Helpful Contacts	Phone	Web Address
Benefits Office, U-M Ann Arbor	734-615-2000 866-647-7657	hr.umich.edu
University Human Resources, U-M Flint	810-762-3150	umflint.edu/hr
SSC Contact Center	734-615-2000 866-647-7657	ssc.umich.edu
Telecommunications Relay Service	711	

A Final Word

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

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

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

SSC Contact Center

Representatives are available by phone,
8 a.m. – 5 p.m., Monday – Friday, 734-615-2000 locally,
5-2000 from the U-M Ann Arbor campus, or 866-647-7657 (toll free for off-campus long-distance calling).

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

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

Brian Vasher
Interim Senior Director for Benefits

HUMAN RESOURCES
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