UNIVERSITY OF MICHIGAN

OPEN ENROLLMENT

To make your benefit choices for 2023

Retired U-M Faculty & Staff | Surviving Spouses | Surviving Other Qualified Adults

OCTOBER 17-28
2022

open enrollment

FOR YOUR 2023 BENEFITS

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). Representatives are available to assist you with your benefits questions 8:00 a.m. – 5:00 p.m., Monday – Friday. Please have your UMID number available when you call.

Benefits Information on the Web

hr.umich.edu/benefits-wellness

711 for Telecommunications Relay Service

The Federal Communications Commission adopted use of the 711 dialing code for access to Telecommunications Relay Services (TRS). Dial 711 and ask the operator to connect you to the SSC Service Center at 734-615-2000 or toll free at 866-647-7657.

Limitations

The university in its sole discretion may modify, amend, or terminate the benefits provided in this book 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.

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your benefits choices

FOR 2023

Open Enrollment, October 17-28, 2022, is your opportunity to make changes to your University of Michigan benefits plans for 2023. This is an important decision, so please read this book carefully before you make your choices.

What's New

Health Plan Resources

Tools and resources are available to help you find the health plan that offers the most advantages to you and your family, and then to use it wisely.

Before choosing a plan, consider all the costs involved (including both premiums and out-of-pocket expenses like deductibles, coinsurance, and copays), the plan's service areas and access to your preferred doctors and hospitals. Think about the anticipated health need for you and your covered dependents as well as financial needs over the next year.

To access these resources, visit hr.umich.edu/health-plan-resources

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 or visit hr.umich.edu/mailorder.

Open Enrollment Deadlines

Open Enrollment is:
October 17-28, 2022

All elections must be submitted by:
October 28, 2022 at 5:00 p.m. (Eastern Time)

Changes are effective on:
January 1, 2023

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 the Employee Self Service tile.
3. Log in with your uniqname and UMICH password.
4. Click the Benefits tile.
5. Click the Dependent/Beneficiary Info tile.

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

Information Resources

There are many sources for more information about your benefits.

- **University Human Resources website.** Browse the website for information regarding Open Enrollment updates, detailed plan information and booklets, and for direct links to medical plan websites at: hr.umich.edu/benefits-wellness
- **Shared Services Center.** Call the SSC HR Customer Care Contact Center at: 734-615-2000 or 866-647-7657 (toll-free for off-campus long-distance calling within the United States) Monday through Friday from 8 a.m. to 5 p.m. to speak with a representative. Be sure to have your UMID number ready when you call.
- **eNewsletter.** To receive up-to-date benefits and employment information, subscribe to the University HR News. This twice-monthly email newsletter is available to anyone who is retired from or works at the university. 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.
- **Health Plans.** To get information about specific health plan providers and other details, you may contact the health plan companies directly using the information given in the Contact Information section on page 55.

Health Plan ID Cards

If you enroll in a different health plan, 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, 2023, call the health plan company to request a new card. Phone numbers are listed in the Contact Information section on page 55.

If your health plan changes for 2023, 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 55.

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.

University of Michigan Retirees Association

The University of Michigan Retirees Association (UMRA) helps retired U-M faculty and staff remain connected to the university and with one another. UMRA represents retiree interests and concerns on the Faculty Senate and U-M committees.

Monthly meetings are on the second Thursday of each month from September to May at Weber's Inn. Each meeting features a Learn and Grow presentation with information useful to retirees, followed by a second speaker who covers a wide range of topics of current interest. All meetings are live streamed and posted on our website for those who can't attend in person. UMRA also sponsors social activities, shared interest groups, local travel outings, an annual Health Day in April and volunteer opportunities. Annual dues are only $15.00.

You can find lots of information on our website at umra.hr.umich.edu. Please check it out. Join today! Questions? Send them to our email at umra@umich.edu and we will answer them quickly.

how to enroll in benefits

Look over the information in this book to decide which benefit plans are best for you. If you do not want to change your benefit elections, no action is required. Your current coverage will continue in 2023 as long as your premiums are paid.

How to Make Changes to Your Benefits for 2023

If you want to make changes to your benefits, you have two options. You can make your benefits choices online using self-service on the Wolverine Access website, or you can complete and return the benefits enrollment form included in the back of this book. You do not need to do both. If you submit a paper form and enroll online, your online enrollment will be used for your 2023 benefits.

Option 1: Enroll Online through Wolverine Access

If you choose to make your benefits choices electronically, you will use Wolverine Access. Supported browsers are Chrome, Edge, Firefox and Safari. If you need help logging in, call the Information and Technology Services (ITS) Service Center at 734-764-HELP (734-764-4357), Monday through Friday from 7 a.m. to 6 p.m. Eastern Time or email 4HELP@umich.edu. Please be sure to have your eight-digit UMID number available when you call.

To make your benefits choices:

1. Go to wolverineaccess.umich.edu
2. Click the **Employee Self Service** tile
3. Enter your Login ID (uniqname) and Password and click Log In
4. Click the **Open Enrollment** tile.
5. Follow the online instructions to view your benefits and rates and make your elections.
6. Click Store to hold your choices until you are ready to submit your elections. Your elections will not be complete until you click Submit to confirm your elections and then click Submit again to send your benefit choices for processing.
7. You may view or print a submitted Confirmation Statement summarizing your choices when you have successfully submitted your elections.
8. Click the **Exit** button to close the Open Enrollment window.

Your online elections must be submitted by 5 p.m. Eastern Time on Friday, October 28, 2022.

Option 2: Enroll Using a Paper Form

If you choose to use a paper form, complete the Open Enrollment Form for 2023 Benefits at the back of this book and return it by October 28, 2022. Please make sure you sign and date your form before returning it to SSC Benefits Transactions. There are several ways to return the form:

- **Fax your form to SSC Benefits Transactions at:** 734-763-0363. Check the transmission confirmation report to verify that all of your pages went through, and keep it with the form for your records.

—OR—

- **Mail your form to SSC Benefits Transactions.** Keep a copy for your records. You may use the postage-paid envelope included inside this book. If you send in your form without using the postage-paid envelope, mail to:

  SSC Benefits Transactions
  Wolverine Tower
  3003 South State Street
  Ann Arbor, MI 48109-1276

Return your form by fax or mail only. Wolverine Tower is closed during the COVID-19 pandemic, and no walk-in service is available.

In the event that your form is not received, the university will honor your elections if you have a copy of the form and can prove that it was sent by the October 28 deadline. A confirmation statement will be mailed to your home address the week of November 8. Carefully review your confirmation statement and verify that the benefits listed are the plans you selected.

how to pay

YOUR MONTHLY PREMIUMS

Retirees whose date of retirement was on or after January 1, 1987 will pay at least part of the premium cost for most health plan coverage. All retirees choosing Dental Plan Option 2 or Option 3 will pay at least a portion of their dental coverage premium and retirees enrolled in the Vision Plan and/or Legal Services Plan pay the full cost. There are two ways for you to pay your share of the premium: by electronic funds transfer or by personal check or money order.

Electronic Funds Transfer

Under the Electronic Funds Transfer (EFT) option, your monthly benefits premiums can be automatically deducted from your checking or savings account each month. The withdrawal will occur on the 20th of each month to pay for coverage for the following month. The withdrawal will be indicated on your bank statement and labeled as "UM Benefit Premium." There is no charge for this service; however, your financial institution may impose a fee if there are insufficient funds in your account when the withdrawal is made.

To initiate. To set up the Electronic Funds Transfer, complete the "Agreement for Preauthorized Benefit Premium Payments" form at the back of this booklet. Fill in the information requested on the form and, if the funds are to be taken from a checking account, attach a blank check with "void" written across it. Return the form with your Open Enrollment Form in the postage-paid envelope provided. If you are not making benefits changes, you may send the premium payment authorization form directly to the Payroll Office as instructed on the form. If you have already initiated an electronic fund transfer you do not need to resubmit the form.

Deadlines. The form must be received no later than the 1st day of the month for the withdrawal to take effect that same month (to pay for coverage for the following month). For example, the Payroll Office must receive the form no later than December 10 for the withdrawal on December 20 to pay for the January premium. You should mail your payment by check or money order by the 1st of the month if you will not be able to meet the 10th of the month deadline for EFT enrollment.

To cancel. If you wish to cancel the Electronic Funds Transfer service, or to change the account or financial institution from which the withdrawal is taken, you must complete another Agreement and return it to the Payroll Office by the 1st day of the month for the change to take effect in that calendar month.

Personal Check or Money Order

For your convenience and to better serve you, each month you will receive a billing statement if you have a co-premium to contribute and you do not arrange for Electronic Funds Transfer.

You must pay the premium by personal check or money order. Cash payments cannot be accepted.

The procedure is:

1. You will receive a billing statement and a remittance envelope in the mail at the end of the month to pay for the next month's coverage. For example, your January billing statement should arrive at the end of December.
2. The co-premium payment is due in the Payroll Office by the 1st of the month to pay for coverage for that month, and is accepted through the 30th of the month.
3. Make the check or money order payable to "University of Michigan."
4. Clip the coupon from the bottom of your billing statement and mail it with your check or money order in the envelope provided to:

   University of Michigan—Payroll
   Box 223081
   Pittsburgh, PA 15251-2081
5. If you do not receive your first 2022 billing statement by January 6, 2023, call the SSC Contact Center on the next business day at: 734-615-2000 or 866-647-7657 (toll-free for off-campus long-distance calling within the United States).

PLEASE NOTE: The University of Michigan will attempt to notify you when a premium payment is overdue.

If a payment is not received after multiple attempts to notify you, then the coverage will be canceled.

Naming a Designee for Premium Payment

Retirees can designate someone other than themselves to handle their premium payments and receive payment information. Other benefits correspondence, including Open Enrollment information, will continue to be sent to the retiree. A designee may be named on the Open Enrollment Form in the back of this booklet.

You may also submit in writing the designee's name, address, and phone number along with your name, UMID number, and a request to name them as a premium payment designee to:

SSC Benefits Transactions
Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1276
fax: 734-763-0363

medicare

About Medicare

Medicare is a federal health insurance program for people who are age 65 or older, or have been entitled to Social Security disability benefits for 24 months, or have end-stage renal disease (permanent kidney failure). Medicare is directed by the federal Centers for Medicare and Medicaid services. Local Social Security Administration offices take applications for Medicare and provide information about the program.

"Original" (fee-for-service) Medicare has two parts:

Part A, hospital insurance—Can help pay for inpatient hospital care, care in a skilled nursing facility, home health care, and hospice care.

Part B, medical insurance—Can help pay for medically necessary doctors' services, outpatient hospital services, home health services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

It is important to understand that Medicare does not cover everything, and it does not pay the total cost for most services or supplies that are covered. Medicare Parts A and B have separate deductibles that must be met before Medicare benefits are payable. Part B benefits are also subject to a 20% patient co-pay.

Medicare provider participation is voluntary. A participating provider is one who is enrolled in the Medicare program, and agrees to accept assignment on all Medicare claims. These doctors may bill you only for Medicare deductible and/or co-insurance amounts. Non-participating providers may bill for amounts in excess of Medicare's deductible, co-insurance amounts, and approved amounts.

Part D, prescription drug coverage—When you are eligible for Medicare Parts A and B, you are also eligible for Part D, prescription drug coverage. However, Part D was primarily designed for individuals who do not already have prescription drug coverage through an employer. The university recommends that you maintain your university medical/prescription drug plan whether or not you enroll in a non-university Part D plan, and that you do not enroll in a non-university Part D plan unless you qualify for federal low-income prescription drug assistance under a Part D plan. You can contact the Social Security Administration to find out if you qualify for federal low-income prescription drug assistance.

Medicare Advantage

The University of Michigan offers Medicare eligible retirees supplemental health plans which coordinate with traditional Medicare. Our plans work with Medicare to provide comparable coverage to our active employee plans.

You may have seen information about Medicare Advantage plans that are available in the individual health plan market. These plans are not currently offered as an option through your University of Michigan retiree benefits. If you are considering enrolling in a Medicare Advantage plan it is recommended that you compare the benefits and out of pocket costs with the University's Medicare plan to ensure they are equivalent.

How Medicare Affects Your U-M Medical Insurance

A health insurance plan provides "primary coverage" when it is responsible for paying health benefits before any other group health insurance is liable for payment. Medicare provides primary coverage to your U-M medical insurance plan. As soon as you or your covered dependent become eligible for Medicare for any reason, you or your covered dependent must enroll in Medicare Parts A and B. You must have Medicare in effect and be entitled to receive Medicare benefits when first eligible. If you or a dependent are eligible for Medicare coverage that is primary to U-M, but have failed to enroll when first eligible, your benefits would be drastically reduced because your U-M medical insurance will not make any payments that would be payable by Medicare if Medicare enrollment had occurred.

Re-Employment

If you return to active employment in a benefits-eligible position (are receiving salary and meet effort percentage requirements) with the University of Michigan, U-M will again provide primary coverage for you, your spouse, and other enrolled dependents during your period of active employment.

For More Information About Medicare:

Call Medicare at: 800-MEDICARE (800-633-4227; toll-free within the United States)

Access Medicare TTY/TDD for speech and hearing-impaired individuals by calling: 877-486-2048 (toll-free within the United States)

Visit the Medicare Website at: medicare.gov

Call the Social Security Administration at: 800-772-1213 (toll-free within the United States)

Access Social Security TTY/TDD for speech- and hearing-impaired individuals by calling: 800-325-0778 (toll-free within the United States)

Visit the Social Security Website at: ssa.gov

Understanding Your Health Plan Choices

The university offers retirees a choice of health plans. The plans differ in the benefit levels they provide, the doctors and hospitals you can use, and the cost to you. You may select your coverage from the following plan designs:

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

There are some important differences between the plans you should know before making your plan selection. Before choosing a plan, please refer to pages 10-11 for the Health Plan Profiles chart and pages 12-21 for the Health Plan Coverage Comparison Chart, which compare pertinent facts about each plan. Monthly premium cost charts for retirees are on pages 22-35. Make sure you refer to the correct chart based on your date of hire and retirement date.

Michigan Care

Michigan Care 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. Visit bcbsm.com to see if your preferred providers are included in the network.

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 Michigan Medicine providers.
- Agree to consult with your primary care physician (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 state of Michigan or within Fulton, Lucas, Williams or Woods counties in Ohio.

BCBSM Community 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, out-of-pocket network providers are reimbursed at 50% of BCBS allowed amount, the member is responsible for all charges beyond the allowed amount. Monthly premium for non-Medicare enrollees is higher than other plans offered.

Consider a PPO if you:

- Would like a plan that allows you to visit any in-network doctor or hospital without a referral.
- Would like coverage within the United States and globally through BCBS Global Care, bcbsglobalcare.com.
- 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.
- Understand that monthly premiums will be higher than premiums for other plans for new Medicare enrollees.
- Live or travel outside southeast Michigan.

Comprehensive Major Medical

The Comprehensive Major Medical plan, administered by Blue Cross Blue Shield of Michigan, offers comprehensive benefits with a wide selection of providers and lower monthly contributions, but requires more out of pocket expense at the time of care. Your total plan cost (monthly contribution and out-of-pocket costs) is dependent on how much care you require over the course of the year, and you are protected from unlimited expenses by an out of pocket maximum amount of $3,000 (individual) or $6,000 (family). 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 Blue Cross allowed amount, and nonparticipating providers may charge more than the allowed amount. You pay 100% of any charges in excess of the allowed amount.

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 the allowed amount for most eligible services, while you pay the remaining 20%. It is important to note that fees charged by non-participating providers, beyond the allowed amount, do not count toward your out-of-pocket maximums and annual deductibles.

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 and globally through BCBS Global Care, bcbsglobalcare.com.
- A plan with flexible provider choices, but don't mind paying an annual deductible and co-insurance for services.

Physician and Hospital Plan Participation

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

In the event your Primary Care Physician's (PCP's) affiliation with 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. Before enrolling in a new medical plan, check the provider directory to make sure it includes a doctor and hospital of your choice. You can find provider information on the plan's website, or call the plan's customer service number for provider information. You will not be able to change plans midyear 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 U-M health plan coverage. For more information, see the Prescription Drug Plan section on page 36.

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 or call the SSC Contact Center at: 734-615-2000 or 866-647-7657 (toll-free for off-campus long-distance calling within the United States). Please give the name or description of the material you want and your name, address, and daytime telephone number.
- To see additional information or a list of participating care providers, 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 54.

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. The opioid prescribing rate in Michigan exceeds the national average. In 2019, Michigan health care providers wrote 58 opioid prescriptions for every 100 persons, compared to the average US rate of 46.7 prescriptions for every 100 persons. (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 evidence-based community resources, research, and educational opportunities relating to the opioid epidemic. The network draws on nearly 100 U-M faculty whose research explores prevention, treatment, data and evaluation, recovery, and training. For more information about U-M's community resources and evidence-based solutions, visit opioids.umich.edu.

A Nonopioid Directive helps fight the opioid epidemic by allowing patients to notify their health care providers that they do not want opioids administered or prescribed. The Nonopioid Directive form can be downloaded at michigan.gov/opioids/find-helphere. Complete the form and **give it to your health care provider** as part of your medical record.

hr.umich.edu/health-plans

A health plan choice for 2023

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.

Because of the narrow provider network, access to the plan is 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 17-28, 2022. **Coverage will go into effect January 1, 2023.**

hr.umich.edu/michigan-care

2023 Health Plan Profiles

PLAN TYPE	MANAGED CARE PLANS		
	GradCare Only Available to U-M Graduate Students	**Michigan Care** Administered by Physicians Health Plan (PHP)	**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	bcbsm.com or call: 800-658-8878	michigancare.com or call: 833-484-8450	bcbsm.com 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	8,026	6,496	69,875
Number of PCPs	Network 1 1,821	689	Network 1 1,821
Number of Specialists	22,026	4,184	22,026
Number of Hospitals	43	9	43
Percentage of Board Certified PCPs	91%	90%	91%
Percentage of Board Certified Specialists	87%	85%	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: 888-288-1726	On the Web at: bcbsm.com or call: 888-288-1726
Traditional fee-for-service plan	PPO
7005187	7005187
More than 5 million	More than 5 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.

2023 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[4] **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			
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.
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 allowed amount 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 allowed amount 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 allowed amount 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
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	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply.
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% of BCBS's allowed amount. Visit co-pay may also apply.
Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply.
Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply.

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 allowed amount for a particular service for all plans.

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

2023 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; limited to 60 visits combined per condition per calendar year	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; limited to 60 visits combined per condition per calendar year
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% of BCBS's allowed amount. Visit co-pay may also apply.
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% of BCBS's allowed amount. Visit co-pay may also apply.
Partially covered	Covered	Covered at 50%[12]
Partially covered	Covered	Covered at 50%[12]
Covered[10]	Covered[10]	Not covered
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%[12]
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%[12]
Partially covered	Covered; a $30 co-pay may apply	Covered at 50%[12]

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 the plan for the preventive services separately from the office visit.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

2023 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.
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

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%[12] for acute conditions
Partially covered	Covered with a $25 co-pay	Covered at 50%[12]
Partially covered	Covered with a $25 co-pay	Covered at 50%[12]
Partially covered	Covered with a $25 co-pay	Covered at 50%[12]
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	Covered at 50%[12]
Partially covered	Covered with a $25 co-pay per visit	Covered at 50%[12]
Partially covered	Covered with a $25 co-pay per visit	Covered at 50%[12]

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.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

2023 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**
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%[12]
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.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

2023 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 with a $30 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
Private Duty Nursing	Not covered	Not covered	Not covered
Home Health Aides	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
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]	**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]**
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
Covered at 70%[12] when medically necessary and approved by the plan.	Covered at 70%[12] when medically necessary and approved by the plan.	Covered at 50%[12]
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%[12]
Partially covered; maximum of 38 visits per calendar year	Covered with a $25 co-pay; limited to 24 visits per year	Covered at 50%[12]; 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 allowed amount 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.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

2023 Monthly Costs for Health Plans

Chart A:

Use this chart if you retired before January 1, 1987.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 841	$ 666	$ 710	$ 724
2 People Regular				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 1,682	$ 1,332	$ 1,420	$ 1,448
2 People Regular + Child(ren)				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 2,321	$ 1,838	$ 1,960	$ 1,998
1 Person Regular + Child(ren)				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 1,480	$ 1,172	$ 1,250	$ 1,274
1 Person with Medicare				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 436	$ 436	$ 436	$ 436
2 People with Medicare				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 872	$ 872	$ 872	$ 872
3 or More People with Medicare				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 1,203	$ 1,203	$ 1,203	$ 1,203
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 1,277	$ 1,102	$ 1,146	$ 1,160
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 0**	**$ 0**	**$ 0**	**$ 0**
University Cost	$ 1,763	$ 1,521	$ 1,582	$ 1,601

Chart B:

Use this chart if you are retired and your date of service is on or after July 1, 1988, and you are under age 62.

Retirees with a service date on or after July 1, 1988 pay the full cost of benefits up to the first of the month following the month they turn age 62.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 841**	**$ 666**	**$ 710**	**$ 724**
University Cost	$ 0	$ 0	$ 0	$ 0
2 People Regular				
Your Cost	**$ 1,682**	**$ 1,332**	**$ 1,420**	**$ 1,448**
University Cost	$ 0	$ 0	$ 0	$ 0
2 People Regular + Child(ren)				
Your Cost	**$ 2,321**	**$ 1,838**	**$ 1,960**	**$ 1,998**
University Cost	$ 0	$ 0	$ 0	$ 0
1 Person Regular + Child(ren)				
Your Cost	**$ 1,480**	**$ 1,172**	**$ 1,250**	**$ 1,274**
University Cost	$ 0	$ 0	$ 0	$ 0
1 Person with Medicare				
Your Cost	**$ 436**	**$ 436**	**$ 436**	**$ 436**
University Cost	$ 0	$ 0	$ 0	$ 0
2 People with Medicare				
Your Cost	**$ 872**	**$ 872**	**$ 872**	**$ 872**
University Cost	$ 0	$ 0	$ 0	$ 0
3 or More People with Medicare				
Your Cost	**$ 1,203**	**$ 1,203**	**$ 1,203**	**$ 1,203**
University Cost	$ 0	$ 0	$ 0	$ 0
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 1,277**	**$ 1,102**	**$ 1,146**	**$ 1,160**
University Cost	$ 0	$ 0	$ 0	$ 0
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 1,763**	**$ 1,521**	**$ 1,582**	**$ 1,601**
University Cost	$ 0	$ 0	$ 0	$ 0

2023 Monthly Costs for Health Plans

Chart C:

Use this chart if you retired on or after January 1, 1987 and before January 1, 2000 and you either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 173**	**$ 0**	**$ 42**	**$ 56**
University Cost	$ 668	$ 666	$ 668	$ 668
2 People Regular				
Your Cost	**$ 540**	**$ 190**	**$ 278**	**$ 306**
University Cost	$ 1,142	$ 1,142	$ 1,142	$ 1,142
2 People Regular + Child(ren)				
Your Cost	**$ 770**	**$ 287**	**$ 409**	**$ 447**
University Cost	$ 1,551	$ 1,551	$ 1,551	$ 1,551
1 Person Regular + Child(ren)				
Your Cost	**$ 402**	**$ 94**	**$ 172**	**$ 196**
University Cost	$ 1,078	$ 1,078	$ 1,078	$ 1,078
1 Person with Medicare				
Your Cost	**$ 31**	**$ 31**	**$ 31**	**$ 31**
University Cost	$ 405	$ 405	$ 405	$ 405
2 People with Medicare				
Your Cost	**$ 162**	**$ 162**	**$ 162**	**$ 162**
University Cost	$ 710	$ 710	$ 710	$ 710
3 or More People with Medicare				
Your Cost	**$ 261**	**$ 261**	**$ 261**	**$ 261**
University Cost	$ 942	$ 942	$ 942	$ 942
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 351**	**$ 176**	**$ 220**	**$ 234**
University Cost	$ 926	$ 926	$ 926	$ 926
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 516**	**$ 274**	**$ 335**	**$ 354**
University Cost	$ 1,247	$ 1,247	$ 1,247	$ 1,247

Chart D:

Use this chart if you retired on or after January 1, 2000 and before January 1, 2013 and you either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 195**	**$ 20**	**$ 64**	**$ 78**
University Cost	$ 646	$ 646	$ 646	$ 646
2 People Regular				
Your Cost	**$ 533**	**$ 183**	**$ 271**	**$ 299**
University Cost	$ 1,149	$ 1,149	$ 1,149	$ 1,149
2 People Regular + Child(ren)				
Your Cost	**$ 790**	**$ 307**	**$ 429**	**$ 467**
University Cost	$ 1,531	$ 1,531	$ 1,531	$ 1,531
1 Person Regular + Child(ren)				
Your Cost	**$ 452**	**$ 144**	**$ 222**	**$ 246**
University Cost	$ 1,028	$ 1,028	$ 1,028	$ 1,028
1 Person with Medicare				
Your Cost	**$ 44**	**$ 44**	**$ 44**	**$ 44**
University Cost	$ 392	$ 392	$ 392	$ 392
2 People with Medicare				
Your Cost	**$ 175**	**$ 175**	**$ 175**	**$ 175**
University Cost	$ 697	$ 697	$ 697	$ 697
3 or More People with Medicare				
Your Cost	**$ 274**	**$ 274**	**$ 274**	**$ 274**
University Cost	$ 929	$ 929	$ 929	$ 929
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 354**	**$ 179**	**$ 223**	**$ 237**
University Cost	$ 923	$ 923	$ 923	$ 923
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 533**	**$ 291**	**$ 352**	**$ 371**
University Cost	$ 1,230	$ 1,230	$ 1,230	$ 1,230

2023 Monthly Costs for Health Plans

Chart E:

Use this chart if you retired on or after January 1, 2013 and before January 1, 2015, and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Care Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Care
1 Person Regular				
Your Cost	**$ 213**	**$ 38**	**$ 82**	**$ 96**
University Cost	$ 628	$ 628	$ 628	$ 628
2 People Regular				
Your Cost	**$ 587**	**$ 237**	**$ 325**	**$ 353**
University Cost	$ 1,095	$ 1,095	$ 1,095	$ 1,095
2 People Regular + Child(ren)				
Your Cost	**$ 871**	**$ 388**	**$ 510**	**$ 548**
University Cost	$ 1,450	$ 1,450	$ 1,450	$ 1,450
1 Person Regular + Child(ren)				
Your Cost	**$ 497**	**$ 189**	**$ 267**	**$ 291**
University Cost	$ 983	$ 983	$ 983	$ 983
1 Person with Medicare				
Your Cost	**$ 54**	**$ 54**	**$ 54**	**$ 54**
University Cost	$ 382	$ 382	$ 382	$ 382
2 People with Medicare				
Your Cost	**$ 207**	**$ 207**	**$ 207**	**$ 207**
University Cost	$ 665	$ 665	$ 665	$ 665
3 or More People with Medicare				
Your Cost	**$ 322**	**$ 322**	**$ 322**	**$ 322**
University Cost	$ 881	$ 881	$ 881	$ 881
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 397**	**$ 222**	**$ 266**	**$ 280**
University Cost	$ 880	$ 880	$ 880	$ 880
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 597**	**$ 355**	**$ 416**	**$ 435**
University Cost	$ 1,166	$ 1,166	$ 1,166	$ 1,166

Chart F:

Use this chart if you retired on or after January 1, 2015 and before January 1, 2017, and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type Premier	BCBSM Care Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Care
1 Person Regular				
Your Cost	**$ 231**	**$ 56**	**$ 100**	**$ 114**
University Cost	$ 610	$ 610	$ 610	$ 610
2 People Regular				
Your Cost	**$ 641**	**$ 291**	**$ 379**	**$ 407**
University Cost	$ 1,041	$ 1,041	$ 1,041	$ 1,041
2 People Regular + Child(ren)				
Your Cost	**$ 953**	**$ 470**	**$ 592**	**$ 630**
University Cost	$ 1,368	$ 1,368	$ 1,368	$ 1,368
1 Person Regular + Child(ren)				
Your Cost	**$ 542**	**$ 234**	**$ 312**	**$ 336**
University Cost	$ 938	$ 938	$ 938	$ 938
1 Person with Medicare				
Your Cost	**$ 65**	**$ 65**	**$ 65**	**$ 65**
University Cost	$ 371	$ 371	$ 371	$ 371
2 People with Medicare				
Your Cost	**$ 239**	**$ 239**	**$ 239**	**$ 239**
University Cost	$ 633	$ 633	$ 633	$ 633
3 or More People with Medicare				
Your Cost	**$ 372**	**$ 372**	**$ 372**	**$ 372**
University Cost	$ 831	$ 831	$ 831	$ 831
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 440**	**$ 265**	**$ 309**	**$ 323**
University Cost	$ 837	$ 837	$ 837	$ 837
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 663**	**$ 421**	**$ 482**	**$ 501**
University Cost	$ 1,100	$ 1,100	$ 1,100	$ 1,100

2023 Monthly Costs for Health Plans

Chart G:

Use this chart if you retired on or after January 1, 2017 and before January 1, 2019, and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 249**	**$ 74**	**$ 118**	**$ 132**
University Cost	$ 592	$ 592	$ 592	$ 592
2 People Regular				
Your Cost	**$ 695**	**$ 345**	**$ 433**	**$ 461**
University Cost	$ 987	$ 987	$ 987	$ 987
2 People Regular + Child(ren)				
Your Cost	**$ 1,034**	**$ 551**	**$ 673**	**$ 711**
University Cost	$ 1,287	$ 1,287	$ 1,287	$ 1,287
1 Person Regular + Child(ren)				
Your Cost	**$ 588**	**$ 280**	**$ 358**	**$ 382**
University Cost	$ 892	$ 892	$ 892	$ 892
1 Person with Medicare				
Your Cost	**$ 76**	**$ 76**	**$ 76**	**$ 76**
University Cost	$ 360	$ 360	$ 360	$ 360
2 People with Medicare				
Your Cost	**$ 272**	**$ 272**	**$ 272**	**$ 272**
University Cost	$ 600	$ 600	$ 600	$ 600
3 or More People with Medicare				
Your Cost	**$ 421**	**$ 421**	**$ 421**	**$ 421**
University Cost	$ 782	$ 782	$ 782	$ 782
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 483**	**$ 308**	**$ 352**	**$ 366**
University Cost	$ 794	$ 794	$ 794	$ 794
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 728**	**$ 486**	**$ 547**	**$ 566**
University Cost	$ 1,035	$ 1,035	$ 1,035	$ 1,035

Chart H:

Use this chart if you retired on or after January 1, 2019 and before January 1, 2021, and either:
(a) Were hired before July 1, 1988 and are any age, or
(b) Were hired on or after July 1, 1988 and are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 267**	**$ 92**	**$ 136**	**$ 150**
University Cost	$ 574	$ 574	$ 574	$ 574
2 People Regular				
Your Cost	**$ 749**	**$ 399**	**$ 487**	**$ 515**
University Cost	$ 933	$ 933	$ 933	$ 933
2 People Regular + Child(ren)				
Your Cost	**$ 1,115**	**$ 632**	**$ 754**	**$ 792**
University Cost	$ 1,206	$ 1,206	$ 1,206	$ 1,206
1 Person Regular + Child(ren)				
Your Cost	**$ 633**	**$ 325**	**$ 403**	**$ 427**
University Cost	$ 847	$ 847	$ 847	$ 847
1 Person with Medicare				
Your Cost	**$ 87**	**$ 87**	**$ 87**	**$ 87**
University Cost	$ 349	$ 349	$ 349	$ 349
2 People with Medicare				
Your Cost	**$ 305**	**$ 305**	**$ 305**	**$ 305**
University Cost	$ 567	$ 567	$ 567	$ 567
3 or More People with Medicare				
Your Cost	**$ 470**	**$ 470**	**$ 470**	**$ 470**
University Cost	$ 733	$ 733	$ 733	$ 733
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 527**	**$ 352**	**$ 396**	**$ 410**
University Cost	$ 750	$ 750	$ 750	$ 750
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 793**	**$ 551**	**$ 612**	**$ 631**
University Cost	$ 970	$ 970	$ 970	$ 970

2023 Monthly Costs for Health Plans

Chart I:

Use this chart if you are retired on or after January 1, 2021 with more than 10 years of service but less than 12 years of service and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 554**	**$ 379**	**$ 423**	**$ 437**
University Cost	$ 287	$ 287	$ 287	$ 287
2 People Regular				
Your Cost	**$ 1,215**	**$ 865**	**$ 953**	**$ 981**
University Cost	$ 467	$ 467	$ 467	$ 467
2 People Regular + Child(ren)				
Your Cost	**$ 1,718**	**$ 1,235**	**$ 1,357**	**$ 1,395**
University Cost	$ 603	$ 603	$ 603	$ 603
1 Person Regular + Child(ren)				
Your Cost	**$ 1,056**	**$ 748**	**$ 826**	**$ 850**
University Cost	$ 424	$ 424	$ 424	$ 424
1 Person with Medicare				
Your Cost	**$ 261**	**$ 261**	**$ 261**	**$ 261**
University Cost	$ 175	$ 175	$ 175	$ 175
2 People with Medicare				
Your Cost	**$ 588**	**$ 588**	**$ 588**	**$ 588**
University Cost	$ 284	$ 284	$ 284	$ 284
3 or More People with Medicare				
Your Cost	**$ 836**	**$ 836**	**$ 836**	**$ 836**
University Cost	$ 367	$ 367	$ 367	$ 367
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 902**	**$ 727**	**$ 771**	**$ 785**
University Cost	$ 375	$ 375	$ 375	$ 375
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 1,278**	**$ 1,036**	**$ 1,097**	**$ 1,116**
University Cost	$ 485	$ 485	$ 485	$ 485

Chart J:

Use this chart if you retired on or after January 1, 2021 with more than 12 years of service but less than 14 years of service and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 497**	**$ 322**	**$ 366**	**$ 380**
University Cost	$ 344	$ 344	$ 344	$ 344
2 People Regular				
Your Cost	**$ 1,122**	**$ 772**	**$ 860**	**$ 888**
University Cost	$ 560	$ 560	$ 560	$ 560
2 People Regular + Child(ren)				
Your Cost	**$ 1,597**	**$ 1,114**	**$ 1,236**	**$ 1,274**
University Cost	$ 724	$ 724	$ 724	$ 724
1 Person Regular + Child(ren)				
Your Cost	**$ 972**	**$ 664**	**$ 742**	**$ 766**
University Cost	$ 508	$ 508	$ 508	$ 508
1 Person with Medicare				
Your Cost	**$ 227**	**$ 227**	**$ 227**	**$ 227**
University Cost	$ 209	$ 209	$ 209	$ 209
2 People with Medicare				
Your Cost	**$ 532**	**$ 532**	**$ 532**	**$ 532**
University Cost	$ 340	$ 340	$ 340	$ 340
3 or More People with Medicare				
Your Cost	**$ 763**	**$ 763**	**$ 763**	**$ 763**
University Cost	$ 440	$ 440	$ 440	$ 440
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 827**	**$ 652**	**$ 696**	**$ 710**
University Cost	$ 450	$ 450	$ 450	$ 450
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 1,181**	**$ 939**	**$ 1,000**	**$ 1,019**
University Cost	$ 582	$ 582	$ 582	$ 582

2023 Monthly Costs for Health Plans

Chart K:

Use this chart if you retired on or after January 1, 2021 with more than 14 years of service but less than 16 years of service and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 439**	**$ 264**	**$ 308**	**$ 322**
University Cost	$ 402	$ 402	$ 402	$ 402
2 People Regular				
Your Cost	**$ 1,029**	**$ 679**	**$ 767**	**$ 795**
University Cost	$ 653	$ 653	$ 653	$ 653
2 People Regular + Child(ren)				
Your Cost	**$ 1,477**	**$ 994**	**$ 1,116**	**$ 1,154**
University Cost	$ 844	$ 844	$ 844	$ 844
1 Person Regular + Child(ren)				
Your Cost	**$ 887**	**$ 579**	**$ 657**	**$ 681**
University Cost	$ 593	$ 593	$ 593	$ 593
1 Person with Medicare				
Your Cost	**$ 192**	**$ 192**	**$ 192**	**$ 192**
University Cost	$ 244	$ 244	$ 244	$ 244
2 People with Medicare				
Your Cost	**$ 475**	**$ 475**	**$ 475**	**$ 475**
University Cost	$ 397	$ 397	$ 397	$ 397
3 or More People with Medicare				
Your Cost	**$ 690**	**$ 690**	**$ 690**	**$ 690**
University Cost	$ 513	$ 513	$ 513	$ 513
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 752**	**$ 577**	**$ 621**	**$ 635**
University Cost	$ 525	$ 525	$ 525	$ 525
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 1,084**	**$ 842**	**$ 903**	**$ 922**
University Cost	$ 679	$ 679	$ 679	$ 679

Chart L:

Use this chart if you retired on or after January 1, 2021 with more than 16 years of service but less than 18 years of service and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 382**	**$ 207**	**$ 251**	**$ 265**
University Cost	$ 459	$ 459	$ 459	$ 459
2 People Regular				
Your Cost	**$ 936**	**$ 586**	**$ 674**	**$ 702**
University Cost	$ 746	$ 746	$ 746	$ 746
2 People Regular + Child(ren)				
Your Cost	**$ 1,356**	**$ 873**	**$ 995**	**$ 1,033**
University Cost	$ 965	$ 965	$ 965	$ 965
1 Person Regular + Child(ren)				
Your Cost	**$ 802**	**$ 494**	**$ 572**	**$ 596**
University Cost	$ 678	$ 678	$ 678	$ 678
1 Person with Medicare				
Your Cost	**$ 157**	**$ 157**	**$ 157**	**$ 157**
University Cost	$ 279	$ 279	$ 279	$ 279
2 People with Medicare				
Your Cost	**$ 418**	**$ 418**	**$ 418**	**$ 418**
University Cost	$ 454	$ 454	$ 454	$ 454
3 or More People with Medicare				
Your Cost	**$ 617**	**$ 617**	**$ 617**	**$ 617**
University Cost	$ 586	$ 586	$ 586	$ 586
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 677**	**$ 502**	**$ 546**	**$ 560**
University Cost	$ 600	$ 600	$ 600	$ 600
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 987**	**$ 745**	**$ 806**	**$ 825**
University Cost	$ 776	$ 776	$ 776	$ 776

2023 Monthly Costs for Health Plans

Chart M:

Use this chart if you are retired on or after January 1, 2021 with more than 18 years of service but less than 20 years of service and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 324**	**$ 149**	**$ 193**	**$ 207**
University Cost	$ 517	$ 517	$ 517	$ 517
2 People Regular				
Your Cost	**$ 842**	**$ 492**	**$ 580**	**$ 608**
University Cost	$ 840	$ 840	$ 840	$ 840
2 People Regular + Child(ren)				
Your Cost	**$ 1,236**	**$ 753**	**$ 875**	**$ 913**
University Cost	$ 1,085	$ 1,085	$ 1,085	$ 1,085
1 Person Regular + Child(ren)				
Your Cost	**$ 718**	**$ 410**	**$ 488**	**$ 512**
University Cost	$ 762	$ 762	$ 762	$ 762
1 Person with Medicare				
Your Cost	**$ 122**	**$ 122**	**$ 122**	**$ 122**
University Cost	$ 314	$ 314	$ 314	$ 314
2 People with Medicare				
Your Cost	**$ 362**	**$ 362**	**$ 362**	**$ 362**
University Cost	$ 510	$ 510	$ 510	$ 510
3 or More People with Medicare				
Your Cost	**$ 543**	**$ 543**	**$ 543**	**$ 543**
University Cost	$ 660	$ 660	$ 660	$ 660
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 602**	**$ 427**	**$ 471**	**$ 485**
University Cost	$ 675	$ 675	$ 675	$ 675
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 890**	**$ 648**	**$ 709**	**$ 728**
University Cost	$ 873	$ 873	$ 873	$ 873

Chart N:

Use this chart if you retired on or after January 1, 2021 with 20 years of service or more and either:
(a) Your date of service is before July 1, 1988 and you are any age, or
(b) Your date of service is on or after July 1, 1988 and before January 1, 2013, and you are age 62 or older.

If your date of service is on or after July 1, 1988 and you are under age 62, refer to Chart B for your monthly health plan rates.

Chart Terms

"Regular" refers to retirees or their dependents who are not eligible for Medicare.
"Child(ren)" refers to retiree's covered dependent child or children under age 26, who are not eligible for Medicare.
"With Medicare" refers to retirees or their covered dependents (any age) who are eligible for Medicare.

Coverage Type	BCBSM Community Blue PPO	Comprehensive Major Medical	Michigan Care	U-M Premier Care
1 Person Regular				
Your Cost	**$ 267**	**$ 92**	**$ 136**	**$ 150**
University Cost	$ 574	$ 574	$ 574	$ 574
2 People Regular				
Your Cost	**$ 749**	**$ 399**	**$ 487**	**$ 515**
University Cost	$ 933	$ 933	$ 933	$ 933
2 People Regular + Child(ren)				
Your Cost	**$ 1,115**	**$ 632**	**$ 754**	**$ 792**
University Cost	$ 1,206	$ 1,206	$ 1,206	$ 1,206
1 Person Regular + Child(ren)				
Your Cost	**$ 633**	**$ 325**	**$ 403**	**$ 427**
University Cost	$ 847	$ 847	$ 847	$ 847
1 Person with Medicare				
Your Cost	**$ 87**	**$ 87**	**$ 87**	**$ 87**
University Cost	$ 349	$ 349	$ 349	$ 349
2 People with Medicare				
Your Cost	**$ 305**	**$ 305**	**$ 305**	**$ 305**
University Cost	$ 567	$ 567	$ 567	$ 567
3 or More People with Medicare				
Your Cost	**$ 470**	**$ 470**	**$ 470**	**$ 470**
University Cost	$ 733	$ 733	$ 733	$ 733
2 People (1 Regular and 1 with Medicare)				
Your Cost	**$ 527**	**$ 352**	**$ 396**	**$ 410**
University Cost	$ 750	$ 750	$ 750	$ 750
3 or More People (at least 1 Regular and 1 with Medicare)				
Your Cost	**$ 793**	**$ 551**	**$ 612**	**$ 631**
University Cost	$ 970	$ 970	$ 970	$ 970

prescription drug plan

MAGELLAN RX MANAGEMENT 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.

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 Birdi Rx as an alternative to retail pharmacies. Use of the mail-order service may result in savings to you and to the U-M Prescription Drug Plan. Birdi provides convenient, secure deliveries to your home. This is particularly convenient for participants who take certain medications on an ongoing basis.
- **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 54 for health plan contact information.

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 Michigan Medicine 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 page 37.

Brand-Name Drugs/Tier 2 and Tier 3—Brand-name drugs are patent-protected and product-trademarked. After the patent ends, a generic equivalent can be manufactured and made available as a lower-cost alternative. For each drug class (e.g., cardiovascular, depression), there may be several drugs produced by different manufacturers with different prices that are equivalent in therapeutic value.

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 opioid overdose reversal agent.

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.

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 84% of all prescriptions dispensed are at Tier 1 or Tier 2. Approximately 13% of all prescriptions filled under the U-M Prescription Drug Plan are dispensed with $0 co-pay. For co-pay amounts for preferred brand-name drugs, see the U-M Prescription Drug Plan Co-pays chart below.

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 below.

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 Birdi mail-order pharmacy.

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

This section is not intended to be a full description of the Prescription Drug Plan coverage. The complete plan description is available online 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.

2023 Prescription Drug Plan Co-pays

Drug Type	Retail Pharmacy Co-pay [1, 2, 3]			Mail Order Co-pay [1, 2, 3] Birdi Mail Order Pharmacy
	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 Pharmacy)
Generic Drugs/Tier 1	$10	$20	$30	$20
Preferred Brand-Name Drugs/Tier 2	$20	$40	$60	$40
Non-Preferred Brand-Name Drugs/Tier 3	$45	$90	$135	$90

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.

hr.umich.edu/prescription-drug-plan

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 41-42 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 at 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. See the rates on page 43.

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 41-42). 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 41-42). 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 41-42). 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, view a Delta Dental dentist directory by viewing Delta Dental's website at: deltadentalmi.com. You can call Delta Dental's Customer Service department toll-free, at: 800-524-0149.

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

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

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

ID Card

Delta Dental does not require ID cards. When visiting a Delta Dental dentist, simply provide your eight-digit UMID or your Social Security number. The dental office can use that information to verify your eligibility and benefits through Delta Dental's website or toll-free number. If you still would like an ID card, you can print a 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 balance 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 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 postoperative care.	0%	0%	0%	100%	60%	60%	100%	100%	100%
Minor Restorative Services—Used to repair teeth damaged by disease or injury (for example, fillings).	0%	0%	0%	100%	60%	60%	100%	100%	100%
Endodontics—Used to treat teeth with diseased or damaged nerves (for example, root canals).	0%	0%	0%	100%	60%	60%	100%	100%	100%

*Emergency Palliative, Periodontal Maintenance, Scaling & Root Planing, and Occlusal Guard benefits are exempt from the Class II and III calendar year deductible and $1,250 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.

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 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

Chart A:

Use this chart if you:

Retired before January 1, 1987, or
Have a service date before July 1, 1988 and are any age, or
Have a service date on or after July 1, 1988 and are age 62 and older

Your 2023 Monthly Dental Plan Rates

Dental Plan Option	Your 2023 Monthly Contribution	University 2023 Monthly Contribution
Option 1		
You Only	$ 0	$ 22.12
You + Child	$ 0	$ 44.24
You + Adult	$ 0	$ 44.24
You + Adult + Children	$ 0	$ 70.58
You + Children	$ 0	$ 70.58
Option 2		
You Only	$ 14.02	$ 22.12
You + Child	$ 28.04	$ 44.24
You + Adult	$ 28.04	$ 44.24
You + Adult + Children	$ 41.82	$ 70.58
You + Children	$ 41.82	$ 70.58
Option 3		
You Only	$ 20.62	$ 22.12
You + Child	$ 41.24	$ 44.24
You + Adult	$ 41.24	$ 44.24
You + Adult + Children	$ 62.36	$ 70.58
You + Children	$ 62.36	$ 70.58

Chart B:

Use this chart if you are retired and your service date is on or after July 1, 1988, and you are under age 62.

Your 2023 Monthly Dental Plan Rates

Dental Plan Option	Your 2023 Monthly Contribution	University 2023 Monthly Contribution
Option 1		
You Only	$ 22.12	$ 0
You + Child	$ 44.24	$ 0
You + Adult	$ 44.24	$ 0
You + Adult + Children	$ 70.58	$ 0
You + Children	$ 70.58	$ 0
Option 2		
You Only	$ 36.14	$ 0
You + Child	$ 72.28	$ 0
You + Adult	$ 72.28	$ 0
You + Adult + Children	$ 112.40	$ 0
You + Children	$ 112.40	$ 0
Option 3		
You Only	$ 42.74	$ 0
You + Child	$ 85.48	$ 0
You + Adult	$ 85.48	$ 0
You + Adult + Children	$ 132.94	$ 0
You + Children	$ 132.94	$ 0

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 from 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

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 elect to use in-network services to receive the highest benefit from this plan. 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 provider when you need vision care services. The provider's office will verify your eligibility for services, and no claim forms or ID cards are required. You will pay a 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 Davis Vision Plan brochure and at hr.umich.ed/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 providers' normal charge or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Call the participating provider for inquiries on the available discount. For more information, please visit 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 chart on page 18 and/or contact your health plan company directly to ask if your plan covers eye exams.

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.

Your 2023 Monthly Vision Plan Rates

	Your 2023 Monthly Contribution	University 2023 Monthly Contribution
You Only	$ 7.71	$ 0
You + Child	$ 12.04	$ 0
You + Adult	$ 12.04	$ 0
You + Adult + Child(ren)	$ 20.90	$ 0
You + Children	$ 20.90	$ 0

davisvision.com

legal services plan

METLIFE LEGAL PLAN 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 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 with 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.

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

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.

info.legalplans.com

MetLife Legal Services Plan

You can enroll in the legal plan during Open Enrollment. For additional information on the plan, call MetLife directly at 800-821-6400.

Legal Services Plan Book

View the Legal Services Plan book at: hr.umich.edu/legal-services-plan

Enrollment

Once enrolled, the plan requires you to remain enrolled for the entire calendar year for which you initially enrolled.

ID Card

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

Will Preparation

Simple will preparation services through MetLife Legal Plan attorneys are available to U-M retirees enrolled in the U-M Retiree Life Insurance Plan through MetLife.

Your 2023 Monthly Legal Plan Rates

	Your 2023 Monthly Contribution	University 2023 Monthly Contribution
You Only	$ 8.34	$ 0
You + Child	$ 13.34	$ 0
You + Adult	$ 13.34	$ 0
You + Adult + Child(ren)	$ 13.34	$ 0
You + Children	$ 13.34	$ 0

eligibility for coverage

Coverage for Your Dependents

Dependents who were covered by your benefits at the time you retired can continue to be covered, as long as they satisfy the university's eligibility requirements.

Dependent Mid-Year Loss of Eligibility

If your covered dependent loses eligibility under your U-M benefit plan coverage due to an event occurring midway through the year, you must act within 30 days of the event to remove your dependent from your coverage. It is especially important to delete any ineligible dependents within that time frame to avoid overpaying premiums that will not be refunded. When your family member loses eligibility, coverage will end on the last day of the month in which the family change occurs. Failure to notify SSC Benefits Transactions within 60 days of a dependents' loss of eligibility will result in forfeiture of that dependent's COBRA continuation rights.

You are responsible to remove dependents from your coverage when they become ineligible.

A few examples of events that would cause your covered dependent to lose eligibility include:

- You and your spouse divorce, or your other qualified adult becomes ineligible
- Expiration of court-appointed Letters of Guardianship for your dependent ward
- Your dependent spouse, child, or other qualified adult dies

Changes that Impact Your Medical Coverage

Your benefits elections for 2023 will remain in effect from January 1 through December 31 as long as you remain eligible and any premiums are paid. Once you have enrolled, you generally may not change your coverage mid-year, unless you experience a qualified change in status.

Moving Out of a Managed Care Health Plan Service Area

If you are covered by a managed care health plan and move outside the service area for more than 60 days, you must change your health plan by completing a Moving Out of a Managed Care Service Area form available at: hr.umich.edu

Complete and mail the form to the SSC Benefits Transactions as instructed on the form. You need to do this within 30 days after the date you move. Your new coverage will become effective the first of the month following the date your application is received, or the first of the month after the date of your move, whichever is later. Remember to update your address with the university.

Waiving Coverage

Retirees Who Have a Service Date on or After July 1, 1988 and Are Under Age 62

Individuals with a service date on or after July 1, 1988 who have to pay the full cost of benefits because they retire under age 62 may choose not to enroll in coverage. Such individuals who choose to waive coverage are eligible for re-enrollment in U-M medical and/or dental coverage at age 62 providing the retiree maintains continuous comparable medical and/or dental coverage through another source and requests re-enrollment by contacting the SSC Contact Center within 30 days of turning 62 years of age. Certification that comparable coverage has been maintained will be required. Effective the first of the month after reaching age 62, the university will provide its contribution toward the cost of benefits.

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

Maintaining Comparable Medical and Dental Coverage

Comparable medical coverage is health coverage that is at least as comprehensive as the university sponsored BCBSM CMM plan. The health plan must offer the same scope of benefits as CMM, but benefits do not have to be exactly the same. The plan must include basic coverage for:

- Primary and Preventive Care
- Mental Health Services
- Hospitalization
- Office Calls
- Surgical Services
- Prescription Drugs
- Emergency Care Services
- Diagnostic Test (x-ray and lab work)

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

Comparable dental coverage is coverage that is at least as good as the university-sponsored Dental Option 1 plan. Emergency dental treatment under a medical plan does not qualify. The plan must include basic coverage for routine exams and cleaning, x-rays and emergency palliative care.

Loss of Comparable Coverage

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

1. The retiree and/or dependents were enrolled under U-M medical and/or dental coverage at the time of retirement, or if not enrolled were eligible for enrollment but were covered under another group health and/or dental plan;
2. A completed and signed Request to Waive Retiree Coverage form is submitted to the SSC Benefits Transactions within 30 days of the date you request waiver of your retiree benefits;
3. Comparable coverage has been continuously maintained in another medical and/or dental plan; that is, there has been no lapse in coverage between the time university coverage was waived and later applied for; and,
4. Enrollment must be requested within 30 days after the other medical and/or dental coverage is involuntarily lost and satisfactory evidence is provided as requested by the Benefits Office that all requirements for re-enrollment have been satisfied.

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

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

1. You and/or your spouse or dependents were eligible for medical and dental insurance at the time of your retirement from the university;
2. Coverage has been continuously maintained in another group medical or dental plan; that is, there has been no lapse in coverage between the time you waived university coverage and later apply for coverage;
3. A completed and signed Request to Waive Retiree Coverage form is submitted to the SSC Benefits Transactions within 30 days of the date you request waiver of your retiree benefits; and,
4. You must request enrollment within 30 days after the other medical or dental coverage is involuntarily lost and provide satisfactory evidence as requested by the Benefits Office that all requirements for re-enrollment have been satisfied. Coverage will go into effect the day following the termination. Remember to update your address with the university.

Important Facts for All Retirees to Consider Before Waiving Coverage

- You will not be allowed to enroll in a U-M benefit plan due to another employer's decision to change insurance companies; increase deductibles or co-pays; or change, reduce or eliminate benefit provisions under their plan in any way.
- You will not be allowed to enroll in a U-M benefit plan due to another employer's decision to replace a traditional group health defined benefit plan (example: Blue Cross coverage) with a group health defined contribution plan (example: Health Reimbursement Arrangement or Retiree Reimbursement Arrangement).

When you waive your U-M medical coverage, your U-M prescription drug coverage will also be discontinued.

important federal notices

REGARDING YOUR HEALTH COVERAGE

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 Coverage 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. Please be aware the SBC does not reflect what your actual costs may be if you have other coverage that pays first, including Medicare. The "Patient Pays" amounts in the SBC claims examples do not reflect amounts Medicare or any other carrier may have already paid first as the primary plan and your true cost may be less than is exhibited in the examples.

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.

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 the SSC Benefits Transactions within 60 days of the loss of eligibility. The form is available at: hr.umich.edu or may be obtained by calling the SSC 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 time frame will result in forfeiture of your dependent's rights to COBRA continuation coverage.

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of- network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in- network costs for the same service and might not count toward your annual out-of-pocket limit.

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

You are protected from balance billing for:

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

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

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

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

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

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

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

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

HIPAA notice of privacy practices

FOR PERSONAL HEALTH INFORMATION OF GROUP HEALTH PLANS OF THE REGENTS OF THE UNIVERSITY OF MICHIGAN

The Benefits Office is required by the Health Insurance Portability and Accountability Act and related rules (HIPAA) to provide you this notice related to protections and privileges assured by this federal law. You are not required to take any action as a result of receiving this notice.

The Health Insurance Portability and Accountability Act and related rules (HIPAA) require group health plans to protect the privacy of health information. The Benefits Administration Office ("BAO") of the Regents of the University of Michigan ("University") administers several self-insured group health plans for employees and retirees on behalf of the University. For a complete list of the current administrators of our self-funded plans, visit hr.umich.edu/health-plans.

The Benefits Office sends the notice of privacy practices to all current enrollees for the listed self-insured plans.

Participants in insured group health plans sponsored by the University may also receive a notice of privacy practice from those plans. A complete listing of our current insured group health plans subject to this notification requirement is available at hr.umich.edu/health-plans. However, because all of the group health plans, whether self-funded or insured, are sponsored by the University, they are part of an organized health care arrangement. This means that all the University sponsored group health plans, whether insured or self-funded, may share your protected health information with each other as needed for the purposes of treatment, payment and health care operations as described below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This notice gives you information about the duties and practices to protect the privacy of your medical or health information for each group health plan for University employees and retirees administered and self-insured by the University ("Plan"). Each Plan is sponsored by the University ("Plan Sponsor"). Each Plan is required by law to maintain the privacy of protected health information ("PHI") and to provide enrollees with a notice of its legal duties and privacy practices with respect to protected health information including notification to you following a breach of your unsecured PHI. Each Plan provides health benefits to you as described in your plan documents and plan informational materials. Each Plan receives and maintains health information in providing these benefits to you. Each Plan hires business associates to help provide these benefits. These business associates also receive and maintain health information related to you in the course of assisting each Plan.

The effective date of this notice is April 14, 2003, revised on June 7, 2016. Each Plan is required to follow the terms of this notice until it is replaced. Each Plan reserves the right to change the terms of this notice at any time. If a Plan amends this notice, the Plan will send a new notice to all subscribers covered by the Plan. Each Plan reserves the right to make the new changes apply to all your health information maintained by the Plan before and after the effective date of the new notice.

When a Plan May Use or Disclose Your Medical or Health Information Without Your Consent or Authorization.

The following categories describe when a Plan may use or disclose your medical or health information without your consent or authorization. Each category includes general examples of the type of use or disclosure, but not every use or disclosure that falls within a category will be listed:

TREATMENT. For example, a Plan may disclose health information at your doctor's request to facilitate receipt of treatment.

PAYMENT. For example, a Plan may use or disclose your health information to determine eligibility or plan responsibility for benefits; confirm enrollment and coverage; facilitate payment for treatment and covered services received; coordinate benefits with other insurance carriers; and adjudicate benefit claims and appeals.

HEALTH CARE OPERATIONS. For example, a Plan may use or disclose your health information to conduct quality assessment and improvement activities; underwriting, premium rating, or other activities related to creating an insurance contract; data aggregation services; care coordination, case management, and customer service; auditing, legal, and medical reviews of the Plan; and to manage, plan, or develop a Plan's business. The Plans may share information with other units within the University that assist the Plan Sponsor with plan administration and operations. For example, the University of Michigan Health System Faculty Group Practice Quality Management Program (QMP) assists the Plans with quality improvement and quality assessment by reviewing prescribed drugs for quality control and safety concerns. When other University units such as the QMP perform services for the Plans, those units are educated in HIPAA privacy and security requirements, receive only the minimum necessary information to complete their tasks, and must protect your information to the same extent the Plans must protect it. Other examples include educational programs, resolution of internal grievances, business planning, development and management, general administrative activities, including data and information systems management, and sales or consolidations with other providers.

In addition, we may use or disclose your PHI to contact you to tell you about alternative treatments or health-related benefits and services that may be of interest to you.

HEALTH SERVICES. A Plan or its business associates may use your health information to contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

TO BUSINESS ASSOCIATES. A Plan may disclose your health information to business associates that assist the Plan in administrative, billing, claims, and other matters. Each business associate must agree in writing to ensure the continuing confidentiality and security of your health information. As explained above, certain units of the University may provide services to the Plans to act as "internal" business associates. When such services are being performed the University makes sure that those units performing services for the Plans are trained to limit the use of your health information only for permitted purposes and in ways that comply with HIPAA and other applicable privacy laws.

TO THE PLAN SPONSOR. The University as the Plan Sponsor may receive your PHI from all group health plans whether self-funded or insured (Group Health Plans) because the University as the Plan Sponsor has agreed to the following:

- We will use PHI as needed to carry out our responsibilities as the Plan Sponsor of the Group Health Plans, provided such uses and disclosures are consistent with the requirements of HIPAA.
- We will not use or further disclose any PHI except as permitted or required to carry out our responsibilities as Plan Sponsor.
- We will require any agents, including subcontractors who assist us in plan administration, and receive PHI, to agree to the same restrictions, conditions and protections that we follow with respect to such information. This includes any agent or subcontractor such as a third party administrator, pharmacy benefit administrator or consultant that receives PHI we may receive from Group Health Plans.
- We will not use or disclose PHI obtained as the Plan Sponsor, for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the University.
- We will report to the Group Health Plans any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which we become aware.
- We will make PHI available to you as a Group Health Plan member.
- We will make PHI available to the Group Health Plans for amendment and will incorporate any amendments as required.
- We will make the information available when required for an accounting of disclosures.
- We will make our internal practices, books and records relating to the use and disclosure of PHI received from the Group Health Plans available to the Secretary of Health and Human Services for purposes of assessing compliance by Group Health Plans with HIPAA.
- We will, if feasible, return or destroy all PHI received from the Group Health Plans that we maintain in any form, and we will not retain copies of such information when no longer needed for the purpose for which it was disclosed. If destruction or return is not feasible we will limit any further uses of the information to those purposes that make the return or destruction infeasible.
- We will use PHI to improve the health of the workforce and to promote wellness or other health improvement programs as part of health care operations. For example, we may use your PHI to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you better manage your illness is available to you as a health plan member.

While any employee of the University who has a need to access or use PHI as the University carries out its plan administration responsibilities may receive PHI, PHI will generally only be disclosed to employees in the University Benefits Office Administration and then only the minimum necessary amount will be disclosed. Any University employee accessing or using PHI may do so only in carrying out the plan administration functions that the University performs for the employee plans. This includes those University units and employees who perform services for the Group Health Plans as internal business associates.

If there is any non-compliance with the required commitments to the Group Health Plans, the issue of noncompliance will immediately be brought to the attention of the Benefits Office Administration Director and the University Privacy Director for immediate attention.

AS REQUIRED BY LAW. A Plan may use or disclose your personal health information for other important activities permitted or required by state or federal law, with or without your authorization. These include, for example:

- To the U.S. Department of Health and Human Services to audit Plan records.
- As authorized by state workers' compensation laws.
- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a governmental agency authorized to oversee the health care system or government programs.
- To public officials for lawful intelligence, counterintelligence, and other national security purposes.
- To public health authorities for public health purposes.

Each Plan May Also Use and Disclose Your Health Information as Follows:

- To a family member, friend or other person, to help with your health care or payment for health care, if you are in a situation such as a medical emergency and cannot give your agreement to a Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- To consider claims and appeals regarding coverage, exclusion, cost, and privacy issues.
- For research purposes: In certain circumstances, we may use PHI to conduct research. Where permitted under federal law, institutional policy and approved by an insitituional review board on privacy, PHI may be further used or disclosed. In addition, PHI may be used or disclosed for research as limited or de-identified data sets that do not include names, addresses or other direct identities.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.

Other Applicable Laws

The Plan's use and disclosure of your personal health information must comply with applicable Michigan law and other federal laws besides HIPAA. Michigan law and federal regulations place certain additional restrictions on the use and disclosure of personal health information for mental health, substance abuse, HIV/AIDs and certain genetic information. In some instances your specific authorization may be required. Under no circumstance will genetic testing information be used for underwriting purposes.

Uses and Disclosures with Your Permission

Each Plan will not use or disclose your health information for other purposes, unless you give a Plan your written authorization. If you give a Plan written authorization to use or disclose your health information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your health information a Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You may request in writing that a Plan do the following concerning your health information that the Plan maintains:

- You have the right to ask us in writing that we limit how we use and disclose your PHI for treatment, payment or health care operations. In addition, you may request PHI disclosure restrictions to family members, other relatives, or close friends involved in your care. We are not required to agree to your restriction request, but if we do agree, we will honor our agreement except in cases of an emergency. Any restriction we agree to does not apply to prevent uses or disclosures that we are legally required or allowed to make.
- Communicate with you in confidence about your health information by a different means or at a different location than a Plan currently does. Your request must specify the alternative means or location to communicate with you. A Plan does not have to agree to your request.
- See or receive copies of your health information. A Plan may charge a reasonable fee to cover expenses associated with your request. In limited cases, a Plan does not have to agree to your request.
- Amend your health information. In some cases, a Plan does not have to agree to your request.
- Receive a list of disclosures of your health information from a stated time period during the 6 prior years that the Plan made for certain purposes. This listing will not include disclosures made to you; for treatment, payment, or health care operation purposes; or other exceptions. In some cases, the Plan may charge a nominal, cost-based fee to carry out your request.
- Send you a paper copy of this notice. You may also download a copy of this notice at hr.umich.edu/hipaa.

To exercise any right described in this notice or for a detailed explanation of the fee structure for possible fees for receiving information, please contact the University of Michigan Benefits Office.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain in writing to the Plan or to the Secretary of the United States Department of Health and Human Services. You may file a written complaint with the Plan at the address listed below. We will not retaliate against you if you choose to file a complaint with the Plan or the Department of Health and Human Services.

Contact Information for Questions

If you have questions about this HIPAA Notice of Privacy Practices, you may contact the Benefits Office by:

- calling the SSC Contact Center, Monday through Friday, 8:00 a.m. to 5:00 p.m. at (734) 615-2000 or (866) 647-7657,
- emailing questions to the University of Michigan Benefits Office: benefits.office@umich.edu, or visiting hr.umich.edu/hipaa, or
- mailing questions to:

  Benefits Administration Office
  University of Michigan
  G405 Wolverine Tower
  3003 South State Street
  Ann Arbor, MI 48109-1278

contact information

Plan Providers	Phone	Web Address
Birdi Rx Mail Order Pharmacy	877-269-1160	umich.birdirx.com
Blue Cross Blue Shield of Michigan 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
Magellan Rx Customer Plan	888-272-1346	umich.magellnrx.com
Medicare	800-633-4227	medicare.gov
Medicare TTY/TDD	877-486-2048	medicare.gov
MetLife Legal Plan	800-821-6400	legalplans.com
Michigan Care	833-484-8450	michigancare.com
U-M Premier Care	800-658-8878	bcbsm.com
Michigan Medicine Specialty Pharmacy	855-276-3002	uofmhealth.org/conditions-treatments/specialty-pharmacy-services

Other Helpful Contacts	Phone	Web Address
SSC Contact Center	734-615-2000 866-647-7657	askhr.umich.edu
University Human Resources, U-M Flint	810-762-3150	umflint.edu/hr
Telecommunications Relay Service	711	
Social Security Administration TTY/TDD	800-772-1213 800-325-0778	ssa.gov

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.

OG

University of Michigan

Open Enrollment
Effective Date 1/1/23

Open Enrollment Form for 2023 Benefits

For Retirees, Surviving Spouses, or Surviving Other Qualified Adults

If you do not wish to make any changes to your benefits elections for 2023 you do not need to submit this form. Please print all information in **black ink**. Completed and signed forms must be received by SSC Benefits Transactions or postmarked by the U.S. Postal Service by **Friday, October 28, 2022.** These elections remain in effect through December 31, 2023 as long as you remain eligible.

1. Retiree, Surviving Spouse, or Surviving Other Qualified Adult Information

Name (Last, First, Middle Initial)		UMID (Social Security Number if unknown)		☐ Single ☐ Married ☐ Divorced ☐ Widowed
Street Address	City	State	Zip Code	
Daytime Telephone Number	Email Address	Date of Birth (MM/DD/YY)		

2. Benefit Plan Selections "Adult" refers to your spouse or other qualified adult.

A. Health Plan Enrollment in any U-M health plan includes automatic enrollment in the U-M Prescription Drug Plan.

☐ BCBSM Community Blue PPO ☐ Comprehensive Major Medical ☐ Michigan Care* ☐ U-M Premier Care* ☐ Waive coverage

☐ You only ☐ You + Adult ☐ You + Adult + Child(ren) ☐ You + Child ☐ You + Children

* Enrollment is limited to those who live in the service area. To verify your eligibility, visit hr.umich.edu/health-plans.

B. Dental Plan: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Waive Coverage

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ You + Child ☐ You + Children

C. Vision Plan ☐ Waive coverage

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ You + Child ☐ You + Children

D. Legal Plan ☐ Waive coverage

☐ You only ☐ You + Adult ☐ You + Adult +Child(ren) ☐ You + Child ☐ You + Children

3. Persons to Be Enrolled

List all eligible persons to be covered using the first line for yourself. You cannot add new dependents. Please complete all blanks for each person. Circle "Yes" to enroll in a benefit or "No" to not enroll.

Last Name	First Name	Social Security Number [1]	Relationship Code [2]	Gender M/F	Date of Birth MM/DD/YY	Medical	Dental	Vision	Legal
			SL			Yes No	Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No	Yes No

[1] The federal Mandatory Insurer Reporting Law requires group health plans to report to Medicare the social security numbers of adults covered under a group health plan. Under the Affordable Care Act, the university is also required to request the social security number of each person enrolled under a U-M health plan. If you do not provide your dependents' social security numbers at this time, you will receive requests from U-M to allow the university to comply with federal legislation.

[2] Relationship Codes: SL = Self; SP = Spouse; C = Child; OQA = Other Qualified Adult (OQA); CO = Child of OQA; SC = Stepchild; GC = Grandchild; R = Other Relative (niece or nephew); SB = Sibling Proof of eligibility may be required. See the University Human Resources website at hr.umich.edu/benefits-eligibility for details.

4. Medicare

Are you or any of the dependents listed above eligible for Medicare? If yes, provide the following information. Use an additional sheet if necessary.

Name	Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date	Part D (Rx) Effective Date

5. Designee (optional)

If someone other than you handles your financial matters, you can designate that person to receive your benefits premium billing statements and make your payments. You will continue to receive other benefits mailings.

Designee Name (Last, First)		**Relationship**	**Daytime Phone Number**
Street Address	**City**	**State**	**Zip**

6. Certification and Signature

Please read the back of this form before signing.

I have read the back of this form and agree to the terms and conditions listed there. The information I provided is correct and to the best of my knowledge.

Signature of Retiree, Surviving Spouse, or Surviving Other Qualified Adult

Date Signed

Open Enrollment Form for 2023 Benefits

For Retirees, Surviving Spouse, or Surviving Other Qualified Adult

By signing the front of this form, you agree to abide by the following:

Authorization
You authorize any doctor, hospital, or other provider who renders service to you or your eligible dependents to furnish to the plan you have selected on this application any information requested concerning medical information, claims, and their insurance payments.

Changing Options or Coverage
You understand that the only conditions under which you can change options are:

- during Open Enrollment; or
- if you are covered by a managed care medical plan and you move outside the plan's service area.

Who Cannot be Covered
You cannot cover under your University of Michigan benefits plans:

(1) Anyone not already enrolled on your benefits plans prior to your retirement;

(2) Anyone who works for the university and has his or her own coverage as an employee of the university;

(3) Any eligible dependents who are already covered by another employee of the university;

(4) Anyone who is not your legal spouse or eligible dependent;

(5) Yourself if you are covered by another University of Michigan employee or retiree in the same plan.

When you sign this form, you state that you understand and agree that claiming such coverage is misconduct, and you agree to reimburse the university for any additional costs incurred as a result of that misconduct.

Health Plan ID Cards
If you enroll in a new plan, ID cards will arrive within six weeks from the date your enrollment form is processed. If you don't receive your cards, contact the health plan company directly.

How to Return This Form
Mail your completed and signed form to SSC Benefits Transactions at the address below. Keep a copy for your records. Or fax your form to: 734-763-0363. Please keep a copy of the fax transmission report for your records. Verification of receipt of your fax will be available after 24 hours.

Return your form by fax or mail only. Wolverine Tower is closed during the COVID-19 pandemic and no walk-in service is available.

SEE PAGES 48–49
FOR IMPORTANT FACTS TO CONSIDER
BEFORE WAIVING COVERAGE

Limitations
The University of Michigan in its sole discretion may modify, amend, or terminate the benefits provided with respect to any individual receiving benefits, including active employees, retirees, and their dependents. Although the university has elected to provide these benefits this 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.

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?
If you have any questions, view the hr.umich.edu/benefits-wellness, or call the SSC Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m.

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-763-0363.
Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **U.S. Mail to:**

SSC Benefits Transactions
Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1276

Agreement For Preauthorized Benefit Premium Payments BP

Payroll Office - The University of Michigan

To have your benefit premiums automatically withdrawn from your checking or savings account, complete the following information. If withdrawals will be made from your checking account, please **ATTACH A BLANK, VOIDED CHECK/DRAFT** to this form and mail it to:

Payroll Office
Wolverine Tower—Low Rise G395
3003 South State Street
Ann Arbor, MI 48109-1279

You can also FAX the information to: (734) 647-3983. If you have any questions, please contact the Payroll Customer Service Area at: (734) 615-2000, option 2, prompt 1 or toll free at (866) 647-7657.

Please note that it will be necessary to verify your account information. Therefore, if you are submitting this form after the 10th of the month, you are responsible for the current and next month's premium as well as any previous balance. See Section IV (1) for withdrawal schedule.

Section I Personal Information

Retiree/Surviving Spouse _____
Last First Middle

University of Michigan ID# (UMID) _____ Daytime Phone ( ) _____

Section II

☐ New Authorization ☐ Change Financial Institution/Change Account ☐ Cancel

☐ I authorize The University of Michigan to take a deduction to bring my account current. For inquiries about your balance, please contact the SSC Benefits Transaction Team at (734) 615-2000, option 1, prompt 1 or toll free at (866) 647-7657.

Section III Account Data

Financial Institution Name _____

Account Number _____

Type of Account (Check one)
☐ Checking/Share Draft **YOU MUST ATTACH A BLANK, VOIDED CHECK/DRAFT**
OR
☐ Savings Routing # for Savings Account _____
(Obtain From Your Financial Institution)

ATTACH VOIDED CHECK HERE

Section IV

I authorize the withdrawal of my benefit premiums on a monthly basis from the account indicated in Section III. I further agree to the following conditions:

1. Any change to or cancellation of this agreement **must be received by the Payroll Office by the 10th of the month for it to take effect in that calendar month**.
2. The Payroll Office will withdraw the benefit premiums from the account indicated in Section III on the 20th of each month. If the 20th is not a banking business day, the withdrawal will be made on the banking business day that is immediately following the 20th of the month. **This withdrawal will pay the premium for the following month.**
3. This agreement is to remain in force until canceled by me via letter or a revised "Agreement For Preauthorized Benefit Premium Payments" form sent to the Payroll Office. I realize that I cannot cancel this agreement by contacting my financial institution. Upon cancellation of this agreement, I will begin to make benefit premium payments by check if I wish to continue benefit coverage.
4. I release the University and its employees from any liability to pay charges for insufficient fund transactions that result from my account balance being less than the benefit premium withdrawal. If I do not have sufficient funds in my account, I realize that my coverage will be canceled.

Signature _____ Date _____

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

SSC HR Customer Care Center

Representatives are available by phone, 8 a.m. – 5 p.m., Monday – Friday, at 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).

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