UNIVERSITY OF MICHIGAN

OPEN ENROLLMENT

To make your benefit choices for 2024

OCTOBER 16-27

2023

Benefits Information by Phone

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

Benefits Information on the Web

hr.umich.edu/benefits-wellness

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711 for Telecommunications Relay Service

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

Limitations

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

Campus Safety

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

Sign Up for U-M Emergency Alerts

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

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

open enrollment

FOR 2024 BENEFITS

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

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

The benefit plans you select during Open Enrollment will become effective on January 1, and will remain in effect for the entire 2024 calendar year, as long as premiums are paid and you remain eligible. Outside of the Open Enrollment period, changes to these plans are only allowed within 30 days of a qualified family status change, such as marriage, divorce, or the birth or adoption of a child. Only changes consistent with the status change are allowed.

Open Enrollment Deadlines

Open Enrollment is:
October 16-27, 2023

All elections must be submitted by:
October 27, 2023 at 5:00 p.m. (Eastern Time)

Changes take effect on:
January 1, 2024

Find benefits plan information at:

hr.umich.edu/benefits-wellness

Find plan rates and enroll online at:

wolverineaccess.umich.edu

Questions about Benefits?

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

what's new for 2024

What's New

New Consumer-Directed Health Plan

The university is offering a new, Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA). This plan may appeal to those who prefer paying higher out-of-pocket costs in exchange for lower monthly premiums. An HSA lets you put money away for future healthcare costs while saving on taxes. When you enroll in a CDHP, you're also enrolled automatically into an HSA.

View more detailed plan information on pg. 6.

New Medicare Advantage Plans

For Medicare eligible retirees and survivors, new, comprehensive Medicare Advantage Plans will replace Medicare supplemental plans January 1, 2024 and will match or provide more coverage than the supplemental plans. Services will be provided by Physicians Health Plan (PHP), Blue Care Network (BCN) and Blue Cross Blue Shield of Michigan (BCBSM).

For more information, visit hr.umich.edu/medicare-advantage.

Michigan Care Expansion

Jackson County and Stockbridge will now be included in the Michigan Care service area. The zip codes include 49237, 49241, 49246, 49259, 49269, 49272, 49277, 49283, 49284 and 49285.

View more plan information on pg. 7.

Prescription Drug Plan Tier 3 Copay Increase

The tier 3 copay in the Prescription Drug Plan will increase from $45 in 2023 to $75 in 2024. Tier 1 and Tier 2 copays will remain the same.

View more plan information on pg. 24.

Legal Plan Enhancements

A number of new legal services will be added to the U-M Legal Services Plan, administered by MetLife Legal Plans. These include:

- Personal Caregiving Services
- Felony Defense
- Misdemeanor Defense
- Expungement
- Probate Proceedings
- Insurance Claims
- Social Security Disability
- Habeas Corpus
- Reproductive Assistance

View more plan information on pg. 35.

Vision Plan Name Change

New name, same benefits. The Vision Plan will now be referred to as Davis Vision by MetLife. The change will not impact your scope of benefits, vision provider network or premiums.

View more plan information on pg. 33.

Dental Plan Enhancements

The dental plan, administered by Delta Dental of Michigan, in 2024 will be introducing a plan enhancement to lower out-of-pocket cost for porcelain (white) crowns and bridges on back teeth.

In addition, there are a number of enhanced dental benefits for members with an intellectual or developmental disability.

View more detailed plan information on pg. 27.

Health Care Flexible Spending Account

For 2024, you can contribute a minimum of $120 up to a maximum of $3,050 per calendar year to your Health Care FSA.

View more information on pg. 39.

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.

review your benefits options

AND ENROLL ONLINE

1. Carefully review the Health Plan Coverage Comparison Chart in this publication, the benefits plan information at hr.umich.edu/benefits-wellness and the plan rates on Wolverine Access.
2. Determine which plans and options most closely meet your needs and those of your dependents while minimizing your out-of-pocket costs.
3. Enroll in your 2024 benefits plan online using Wolverine Access. Supported browsers are Chrome, Edge, Firefox, and Safari. You will need a University of Michigan uniqname and UMICH password to log in. Faculty and staff members without a uniqname or password should contact their supervisor.

Open Enrollment begins on October 16. Make your elections online as many times as needed until 5:00 p.m. Eastern Time on October 27, 2023.

If you do not want to change your benefit elections, no action is required unless you want to enroll in a Flexible Spending Account (FSA). FSA enrollments do not carry over year-to-year and you must re-enroll to participate in 2024. See page 39.

FSA Enrollment

You may enroll in a Health Care or Dependent Care FSA through Self Service > Benefits during Open Enrollment, or by completing and submitting a paper enrollment form by November 29, 2023. The 2024 FSA enrollment form and plan information is available at hr.umich.edu/open-enrollment.

How to Enroll

October 16 – 27, 2023 (5:00 p.m. Eastern Time deadline)

Step 1: Go to Wolverine Access:
wolverineaccess.umich.edu
Click the **Employee Self Service** tile**,** or click the **Students** tile and **Student Business** tile if you are a student.
Log in with your uniqname and UMICH password.

Step 2: Click the **Open Enrollment** tile.

Step 3: Follow the online instructions to view your benefits and rates and make your elections.

Step 4: When you have successfully submitted your elections, you may view or print a Confirmation Statement summarizing your choices.

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.

paying for your benefits

Benefits Plan Rates

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

To view your 2024 benefits plan rates:

1. Go to wolverineaccess.umich.edu.
2. Click the Employee Self Service tile, or the Student Business tile if you are a student.
3. Enter your Login ID (your uniqname) and UMICH Password and click Log In.
4. Click the Benefits tile.
5. Click the Display Benefits Plan Rates tile. Your current rates will be displayed at the top of the page; scroll down to view your 2024 rates.

Frequency of Deductions

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

Bi-weekly

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

Monthly

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

Tax Information for Coverage of Other Qualified Adults

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

If you marry your OQA, you will need to complete and submit a Dependent Information Form within 30 days of your marriage to report your change in relationship. Call the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, Monday - Friday 8:00-5:00 EST or email sharedservices@umich.edu to obtain the Dependent Information Form. Because benefits provided to your legal spouse are not considered a taxable fringe benefit, you will no longer be subject to tax witholding for OQA coverage as of the date of your marriage.

health plans

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

Find more detailed information at hr.umich.edu/health-plans.

You may select your coverage from the following plan designs:

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

NEW Consumer-Directed Health Plan

The university is offering a new, Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA).

The CDHP covers the same medical services as other plans, including no out-of-pocket costs for preventive care and screenings.

Like the Comprehensive Major Medical plan, you pay co-insurance after the deductible is met and have access to a national network of PPO providers.

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

While the CDHP has the lowest monthly premium cost, you may incur higher out-of-pocket costs depending on the amount of care you need.

When paired with a Health Savings Account (HSA), the CDHP provides flexibility in how you spend and save for your health care. With an HSA, you can put away money for future healthcare costs while saving on taxes. When you enroll in the CDHP, you're also automatically enrolled into an HSA. Financial hardship created from the costs for the deductible and out-of pocket maximum is not a qualifying event to change plans.

Consider the Consumer-Directed Health Plan if you:

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

Eligibility Requirements

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

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

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

IMPORTANT: If you enroll in the CDHP and currently have a Health Care FSA, you must spend your remaining balance AND have all claims processed by Dec. 31, 2023. Your balance must be $0.00. Otherwise, you will not be eligible for HSA contributions until Apr. 1, 2024.

Not sure if the CDHP is right for you? Visit Benefits Mentor to help you decide: hr.umich.edu/benefits-mentor.

Michigan Care

Michigan Care provides enhanced coordination to improve service, quality and clinical outcomes for plan members. Members have access to Michigan Medicine health care providers as well as other high-quality network providers in southeast Michigan, including providers from Integrated Health Associates (IHA) and Huron Valley Physicians Associates (HVPA), facilities that are part of the St. Joseph Mercy system (St. Joseph in Ann Arbor, Chelsea, Livingston and Oakland, and St. Mary Mercy in Livonia), and University Health Service. Access to the plan is limited to faculty, staff and retirees who live in a specific geographic area of southeast Michigan. Check your eligibility at hr.umich.edu/michigan-care-eligibility.

Consider Michigan Care if you:

- Live in the plan's service area
- Understand that you need a referral from your Primary Care Physician (PCP) if you need to see a specialist
- Agree to consult with your PCP for all services
- Agree to choose a physician from a list of network providers, including Michigan Medicine providers
- Would like chiropractic coverage
- Would like a plan that offers cost savings of a managed care plan
- Would like a plan that lowers overall medical costs for non-Medicare members

The plan is administered by Physicians Health Plan based in Lansing, MI. Michigan Medicine has a majority ownership as part of an affiliation agreement with Sparrow Health System reached in 2023.

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 administered by Blue Care Network (BCN) and is only offered to the University of Michigan community. Members save money in Network 1, which includes Michigan Medicine providers along with several other provider groups. You can also visit other **Michigan** BCN providers in Network 2, with an annual deductible and referral from your Network 1 primary care physician.

Consider the U-M Premier Care Plan if you:

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

Important information for those living in or near Ohio: Please note that this plan is a Michigan-based health plan. All providers, facilities and services are rendered in Michigan. You may not be able to receive services in your home, or DME deliveries, if you live outside Michigan. **If you plan to use providers and hospitals outside of Michigan you must select one of the BCBSM health plans.**

BCBSM Community Blue PPO

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

Consider a PPO if you:

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

Comprehensive Major Medical

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

Consider the Comprehensive Major Medical Plan if you:

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

GradCare

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

Consider GradCare if you:

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

Health Plan ID Cards

If your health plan changes, your ID cards will be mailed to you directly from your health plan company, not from the Benefits Office. Members enrolled in a BCBSM plan will be issued new cards this year with an updated customer service number. If you have changed health plans and do not receive new cards by January 2024, call the health plan company to request a new card.

If your health plan changes, contact your health plan company to find out how to receive services in January if your new cards arrive after January 1.

Prescription Drug Plan ID Cards

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

Addressing the Opioid Epidemic

Opioid drugs can be highly addictive, and their use and abuse is a growing issue in the United States. In 2021, over 75% of overdose deaths involved an opioid. The opioid prescribing rate in Michigan is decreasing but continues to exceed the national average.

In 2020, Michigan health care providers wrote 54 opioid prescriptions for every 100 persons, compared to the average US rate of 43 prescriptions for every 100 persons. (From the 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-help. Complete the form and give it to your health care provider as part of your medical record.

hr.umich.edu/health-plans

2024 Health Plan Profiles

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
Service Area	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	Genessee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties
Residency Requirement	Participants must reside in the service area	Must reside in Michigan or within Fulton, Lucas, Williams or Woods counties in Ohio	Level 1 and continuance: U-M academic campus
PCP selection required	Yes	Yes	Yes
Flexible Savings Account compatibility	Health Care FSA Dependent Care FSA	Health Care FSA Dependent Care FSA	Health Care FSA Dependent Care FSA
Health Savings Account compatibility	Not compatible	Not compatible	Not compatible
Phone Number for Customer Service and Provider Directory	833-484-8450	800-658-8878	800-658-8878
Number of U-M Members	8,547	68,926	7,286
Number of PCPs	805	Network 1 3,100	Network 1 3,100
Number of Specialists	7,323	22,145	22,145
Number of Hospitals	10	41	41
Percentage of Board Certified PCPs	90%	92%	92%
Percentage of Board Certified Specialists	85%	86%	86%
Website	michigancare.com	bcbsm.com	bcbsm.com
Address	1400 E. Michigan Ave Lansing MI 48912	20500 Civic Center Dr. Southfield, MI 48076	20500 Civic Center Dr. Southfield, MI 48076
Group Number	L0002184	001243160001	001243160002

Preferred Provider Organization (PPO)	Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO	**Comprehensive Major Medical**	**BCBSM Consumer-Directed Health Plan**
Nationwide/Worldwide	Nationwide/Worldwide	Nationwide/Worldwide
Not applicable	Not applicable	Not applicable
No	No	No
Health Care FSA Dependent Care FSA	Health Care FSA Dependent Care FSA	**Limited Purpose FSA** Dependent Care FSA
Not compatible	Not compatible	Compatible
855-669-8040	855-669-8040	855-669-8040
27,628	7,190	New Plan for 2024
National network	National network	National network
National network	National network	National network
National network	National network	National network
National network	National network	National network
National network	National network	National network
bcbsm.com	bcbsm.com	bcbsm.com
600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226
7005187	7005187	7005187

2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
General Information			
Deductible	$0	$0 for Network 1	$0
Annual Out-of-pocket maximum	$3,000 individual $6,000 family[4]	$3,000 individual $6,000 family[4]	$3,000 individual $6,000 family[4]
Lifetime Maximum Benefit	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).
Important Information About the Terms Used in This Chart	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[2,5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[1]
Preauthorization Required	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.
Preventive Services			
Routine Physical Exams	Covered[10]	Covered[10]	Covered[10]
Routine Pediatric Exams	Covered[10]	Covered[10]	Covered[10]
Routine Immunizations	Covered[10]	Covered[10]	Covered[10]
Pap Smears — Lab and Pathology	Covered[10]	Covered[10]	Covered[10]
Routine Mammograms	Covered[10]	Covered[10]	Covered[10]
PSA (Prostate) Test	Covered[10]	Covered[10]	Covered[10]

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

Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO		Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
In-Network	Out-of-Network		
$0		$500 individual $1,000 family	$1,600 individual $3,200 family[3]
$3,000 individual $6,000 family (in-network)[4]	$5,000 individual $10,000 family (out-of-network)[4]	$3,000 individual $6,000 family[4]	$5,500 individual $9,450 family (in-network)[3,4] $11,000 individual $18,900 family (out-ofnetwork)[3,4]
$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined)		$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).
"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]		"Partially covered" means you pay a $500/$1,000 deductible, then 20% coinsurance up to the annual out-of-pocket maximums, and costs that exceed the BCBSM allowed amount or balance billing when nonparticipating providers are used. Coinsurance means the percentage amount of the provider's charge you pay for a covered service.	"Partially covered" means you pay a $1,600/$3,200[3] deductible then 10% coinsurance up to the annual out-of-pocket maximums, and costs that exceed the BCBSM allowed amount or balance billing when nonparticipating providers are used. Coinsurance means the percentage amount of the provider's charge you pay for a covered service.
Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.		Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.
Covered[10]	Not covered	Covered[10]	Covered[10]
Covered[10]	Not covered	Covered[10]	Covered[10]
Covered[10]	Not covered	Covered[10]	Covered[10]
Covered[10]	Not covered	Covered[10]	Covered[10]
Covered[10]	Not covered	Covered[10]	Covered[10]
Covered[10]	Not covered	Covered[10]	Covered[10]

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.

3. Deductible and out-of-pocket is medical and pharmacy combined.
4. The out-of-pocket maximum does not include non-covered charges, and costs that exceed the plan's allowed amount for a particular service for all plans.
5. Co-pays may differ for bargained-for groups.
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.

2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
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[6]	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year[6]	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year[6]
Hospital Services — Inpatient			
Hospital Admissions	Covered	Covered	Covered
Days of Care	Unlimited days	Unlimited days	Unlimited days
Room Type	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary
Hospital Physician Service	Covered	Covered	Covered
Consultation Between Physicians	Covered	Covered	Covered
Surgery	Covered	Covered	Covered
Therapeutic Radiology	Covered	Covered	Covered
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered
Allergy Testing	Covered; a $30 co-pay may apply	Covered with a $30 co-pay	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	Covered, a $30 co-pay may apply	$30 office visit co-pay may apply	$30 office visit co-pay may apply

2. Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.
6. Physical, occupational, and speech therapies are covered for acute conditions and may be subject to plan prior authorization. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.
12. Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO		Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
In-Network	Out-of-Network		
Covered with a $25 co-pay for visits with PCPs and $30 for visits with specialists	Covered at 50%[12] of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay; limited to 60 visits per year combined (facility and professional services combined)[6]	Covered at 50%[12] of BCBS's allowed amount.; limited to 60 visits per year combined (facility and professional services combined)[6]	20% coinsurance after deductible, unlimited treatment[6]	10% coinsurance after deductible; limited to 60 visits per year combined (facility & professional services combined)[6]
Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Unlimited days		Unlimited days	Unlimited days
Semi-private room; private room if medically necessary		Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary
Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50%[12] of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible

2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
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			
Inpatient Days of Care	Covered	Covered for acute conditions	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 Use Care			
Inpatient Days of Care	Covered	Covered	Covered
Outpatient Individual Therapy	Covered with a $25 copay	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit
Group Therapy	Covered with a $25 copay	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit

2. Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.
12. Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO		Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
In-Network	Out-of-Network		
Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.		20% coinsurance after deductible for accidental or acute medical emergency.	10% coinsurance after deductible for accidental or acute medical emergency.
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.		20% coinsurance after deductible for accidental or acute medical emergency.	10% coinsurance after deductible for accidental or acute medical emergency.
Covered for emergency transportation when medically necessary		20% coinsurance after deductibled. For transfer to or from hospital; includes ground and air when medically necessary.	10% coinsurance after deductible. For transfer to or from hospital; includes ground and air when medically necessary.
Covered for acute conditions	Covered at 50%[12] for acute conditions	20% coinsurance after deductible for acute conditions	10% coinsurance after deductible for acute conditions
Covered with a $25 co-pay	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay per visit	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay per visit	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible

2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
Maternity Care			
Parental Care, Delivery, Postnatal Care	Covered	Covered	Covered
Skilled Nursing Facility			
(Non-Custodial Care)	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	Covered up to 45 days per calendar year if preauthorized by BCN
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 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	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

2. Coverage described applies to the U-M Premier Care Provider Network. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 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.

Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO		Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
In-Network	Out-of-Network		
Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered up to 120 days per calendar year		20% coinsurance after deductible. Up to 120 days per calendar year	10% coinsurance after deductible. Up to 120 days per calendar year
Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months
Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months
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	20% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	10% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]
Covered; one exam per year. Dilation not covered	Covered up to $40; one exam per year. Dilation not covered	20% coinsurance after deductible; one exam per year. Dilation not covered	10% coinsurance after deductible; one exam per year. Dilation not covered
Not Covered		Not covered	Not covered

2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans		
Plan Name	**Michigan Care**	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups
Nursing Care			
Visiting Nurse Home Care	Covered	Covered	Covered with a $30 co-pay when medically necessary and approved by the plan.
Private Duty Nursing	Not covered	Not covered	Not covered
Home Health Aides	Covered	Covered	Covered
Other Services			
Hospice Care	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	Covered when authorized by BCN
Durable Medical Equipment, Prosthetic Appliance	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	Covered when authorized by BCN
Voluntary Sterilization	Covered	Covered	Covered
Chiropractic Spinal Manipulation	Covered with a $25 copay; limited to 24 visits per year for spinal manipulation	Not covered	Not covered
Gender Affirming Procedures	Covered. Subject to medical criteria	Covered. Subject to medical criteria	
Infertility Treatment	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details

2. Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.
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.
12. Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement..

Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
BCBSM Community Blue PPO		Comprehensive Major Medical	BCBSM Consumer-Directed Health Plan
In-Network	Out-of-Network		
Covered	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
30% coinsurance[12]	50% coinsurance[12]	30% coinsurance[12]	30% coinsurance[12]
Covered	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
Covered; contact BCBSM for specific coverage levels before these services are provided	Not covered	Contact BCBSM for specific coverage levels before these services are provided	10% coinsurance after deductible
Covered when medically necessary	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Covered with a $25 co-pay limited to 24 visits per year	Covered at 50%[12] limited to 24 visits per year	20% coinsurance after deductible, limited to 38 visits per calendar year	10% coinsurance after deductible, limited to 24 visits per year
Covered. Subject to medical criteria	50% coinsurance	20% coinsurance after deductible. Subject to medical criteria	10% coinsurance after deductible. Subject to medical criteri
In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details		In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of $20,000 across all UM health plans. Contact plan for details

prescription drug plan

MAGELLAN RX ADMINISTERS THIS PLAN

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

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

Eligibility and Enrollment

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

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 as an alternative to retail pharmacies. Use of the mail-order service results in savings to you and to the U-M Prescription Drug Plan. Birdi provides convenient, secure deliveries to your home. This is particularly convenient for participants who take certain medications on an ongoing basis. Participants save a third of their out-of-pocket co-pay for a 90-day supply of medication through mail order. Visit hr.umich.edu/mailorder to learn more.
- Diabetic insulin, needles, and syringes are available to all participants in the University of Michigan Prescription Drug Plan. Select insulin products (see the formulary at hr.umich.edu/formulary), needles, and syringes are covered at $0 co-pay for all members.
- Coverage of diabetic supplies (injection devices, alcohol swabs, testing strips, lancets, and blood glucose testing monitors) is determined by your health plan.

hr.umich.edu/prescription-drug-plan

Terms You Need to Know

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

Generic Drugs/Tier 1—The Generic Drug co-pay level offers the opportunity to take advantage of generic drug savings. Generics cost significantly less on average than their counterpart brand-name drugs. Generic drugs are approved by the United States Food and Drug Administration (FDA), contain the same active ingredients as their brand-name equivalents, and must meet the same safety, production, and performance standards. Therefore, generic drugs often offer an effective and safe alternative to help reduce prescription drug costs for both you and the University of Michigan. Approximately 90% of all prescriptions under the U-M Prescription Drug Plan are dispensed as generic drugs. For co-pay amounts for generic drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

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

Generics are always preferred and are your lowest cost option. Preferred brand-name drugs are selected on the basis of therapeutic effectiveness, safety, and cost relative to other brand-name drugs used to treat the same conditions. Physicians are encouraged, but not required, to prescribe preferred drugs when appropriate for the patient's condition. Approximately 84% of all prescriptions dispensed are at Tier 1 or Tier 2. Approximately 13% of all prescriptions under the U-M Prescription Drug Plan are dispensed with a $0 co-pay. For co-pay amounts for preferred brand-name drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

Non-Preferred Drugs (Brand-Name)/Tier 3—Drugs on the third co-pay tier are FDA-approved drugs that a committee of university physicians and pharmacists have not designated as "preferred" and are subject to a higher co-pay and may have a product selection penalty. These products often are in drug classes that include several similar alternative brand-name or generic options. Brand-name products with generic equivalents will automatically be placed in Tier 3. Approximately 3% of all medications are dispensed as non-preferred drugs. For co-pay amounts for non-preferred brand-name drugs, see the U-M Prescription Drug Plan Co-pays chart on the next page.

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

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

hr.umich.edu/prescription-drug-plan

This section is not intended to be a full description of the Prescription Drug Plan coverage. The complete plan description is contained at hr.umich.edu/prescription-drug-plan. Every effort has been made to ensure the accuracy of this information. If statements in this section differ from the website, then the terms and conditions of the website prevail. All benefits are subject to change.

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

2024 U-M Prescription Drug Plan Co-pays

Group	Drug Type	Retail Pharmacy Co-pay [1, 2, 3, 4]			Mail Order Co-pay [1, 2, 3, 4] 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)
Active Employees [4] (see below for variance by collective bargaining agreement)	Generic Drugs/Tier 1 Brand Name/Tier 2 Non-Preferred Brand Name Drugs/Tier 3	$10 $20 $75	$20 $40 $150	$30 $60 $225	$20 $40 $150
MNA Active and LTD members (per contract)	Generic Drugs/Tier 1 Brand Name/Tier 2 Non-Preferred Brand Name Drugs/Tier 3	$7 $15 $30	$14 $30 $60	$21 $45 $90	$14 $30 $60

1 If the retail price of a covered medication is less than the tier co-pay, you pay only the cost of the medication. If the cost of the covered medication is more than the co-pay, you pay only the co-pay. The member always pays the full cost for prescriptions that are not covered by the plan.

2 Catastrophic coverage for prescription drugs goes into effect after the out-of-pocket maximum of $2,500 per individual coverage or $5,000 per family per year is met. Catastrophic coverage applies only to covered prescription drugs and does not include product selection penalties or health plan expenses such as physician office visits.

3 Member cost may be higher than the co-pay if a brand-name drug is selected when a generic equivalent is available.

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

Opioid Drugs

Opioid drugs can be highly addictive, and their use and abuse is a growing issue in the United States. If the opioid epidemic affects you or someone you know, the U-M Prescription Drug Plan covers Narcan Nasal Spray and other forms of naloxone, a life-saving opioid overdose reversal agent.

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

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

dental plan

DELTA DENTAL OF MICHIGAN ADMINISTERS THIS PLAN

Dental Plan Enhancements for 2024

The dental plan, administered by Delta Dental of Michigan, in 2024 will be introducing a plan enhancement to lower out-of-pocket cost for porcelain (white) crowns and bridges on back teeth.

In addition, there are a number of enhanced dental benefits for members with an intellectual or developmental disability:

- Additional visits to the dentist's office and/or consultations that can be helpful prior to the first treatment to help patients learn what to expect and what is needed for a successful dental appointment.
- Up to four total dental cleanings in a benefit year.
- The use of silver diamine fluoride that can be applied to cavities for patients who can't tolerate the use of dental instruments.
- Treatment delivery modifications necessary for dental staff to provide oral health care for patients with sensory sensitivities, behavioral challenges, severe anxiety or other barriers to treatment.

As defined by the American Academy of Pediatric Dentistry, special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma or environmental cause, and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

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

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

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

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

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

What Are the Advantages of Choosing a Delta Dental PPO 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. PPO dentists will also fill out and file your claim forms.

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

Delta Dental will pay the Premier dentist directly for covered services based on their submitted fee or the local Delta Dental maximum approved fee, whichever is less. If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference. As with PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services. 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. However, you could save more of your out-of-pocket expenses if you go to a dentist that participates with Delta Dental. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges.

How Can I Find a Participating Dentist?

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

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

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

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

Rates

Find your 2024 monthly dental plan rates on Wolverine Access at: wolverineaccess.umich.edu.

ID Card

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

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

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

Preauthorization

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

Where Can I Find Additional Information Regarding the Dental Plan?

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

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

Delta Dental Consumer Toolkit toolkitsonline.com

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

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

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

To start using this helpful instrument, log on to:

toolkitsonline.com and click on the "Consumer Toolkit" button. First-time users will need to register. You may use your eight-digit UMID number 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

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

What Dental Services are Covered

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

Filing Claims

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

deltadentalmi.com

vision plan

METLIFE ADMINISTERS THIS PLAN

New Name, Same Benefits

The Vision Plan is now referred to as Davis Vision by MetLife. The change does not impact your scope of benefits, vision provider network or premiums.

How the Vision Plan Works

MetLife 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 by MetLife provider directory.

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

1. Go to metlife.com/mybenefits
2. Select "Find a Vision Provider"
3. Choose "Davis Vision by MetLife"
   Complete the information requested, then select the "Search Now" button

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

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

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

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

Cost of Enhancements

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

Laser Vision Correction Services

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

Buy a Voucher Program

You can purchase additional pairs of eyeglasses or contact lenses directly from Davis Vision by MetLife. Call 833-393-5433 to speak to a representative. For voucher services and costs, please visit hr.umich.edu/vision-plan.

Eye Exams

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

Rates

Find your 2024 monthly vision plan rates on Wolverine Access at: wolverineaccess.umich.edu

ID Card

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

Warranty

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

Summary of Benefits

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

Questions?

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

metlife.com/insurance/vision-insurance

legal services plan

METLIFE ADMINISTERS THIS PLAN

Low-Cost Help With Legal Matters

For the cost of your monthly premium, you can receive professional legal assistance with matters such as 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 and fraud protection services are through MetLife + Aura Identity & Fraud Protection and provides assistance for emerging identity threats including phishing scams, mobile device attacks, cyberbulling, lost and destroyed documents, and many more identity theft issues. This service also includes an identity theft defense that provides attorney consultations, services, and representation in defense of identity theft.

Identity Management Services

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

Identity Theft Defense

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

Identity & Fraud Protection Services

Provide access to Identity Restoration Services along with proactively preventing fraud before it happens by protecting identity, assets, privacy, finances, connecting devices using a virtual private network along with antivirus protection, and many more included secured tools.

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 Legal at (800) 821-6400.

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. You can also call MetLife directly at 800-821-6400.

info.legalplans.com

New Legal Services for 2024

Personal Caregiving Services

Personalized solutions are available to solve employees' most urgent caregiving challenges. Our comprehensive approach addresses physical and mental health, family dynamics, financial challenges, clinical and home care needs, and offers guidance around difficult decision-making all of which helps deliver a unique, personalized experience and better outcomes for families.

Reproductive Assistance

This service covers the Participating Employee and/or spouse for the first twenty hours of legal services and court work related to reproductive assistance matters. Reproductive assistance matters may include, but shall not be limited to, as permitted by law, surrogacy, egg donation, sperm donation, gamete donation, embryo donation and embryo adoption. This service includes reviewing and preparing any necessary agreements or documents, the preparation and filing of any pleadings or other documentation to obtain any necessary orders or decrees, and representation at any hearing or other proceeding related to the matter as may be required by law. The service does not include representation of any party other than the participating employee and/or spouse/OQA, even if the participating employee and/or spouse/OQA may be required to pay that party's legal fees or expenses. It is the participating employee and/or spouse/OQA's responsibility to pay fees beyond the first twenty hours.

Felony Defense

This service covers representation for Participants in defense of any criminal felony charge. Representation includes court hearings, negotiation with the prosecutor and trial. This service does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.

Misdemeanors Defense

This service covers representation for Participants in defense of any criminal felony charge. Representation includes court hearings, negotiation with the prosecutor and trial. This service does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.

Expungement

Where permitted by law, this service covers the filing of a petition and appearance at any necessary hearing to expunge convictions from a Participant's criminal record.

Probate Proceedings

This service provides representation for the Plan Member or spouse when the Plan Member or spouse is probating an estate and has been appointed executor or administrator. The service includes all of the court proceedings to transfer probate assets from the decedent to the heirs; the correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and any tax filings. This service does not include prosecuting or defending any litigation including a will contest.

Insurance Claims

This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Plan Member's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

Social Security Disability

This service covers representation for a Plan Member or spouse through the administrative process including preparing initial forms, requests for reconsideration, hearing requests, attendance at hearings and review of decision order.

Habeas Corpus

This service covers the Participant for the preparation of all paperwork needed, and attendance at the hearing to pursue a habeas corpus proceeding to obtain the release of a Participant who is being unlawfully imprisoned.

MetLife Legal Services Plan

800-821-6400

Legal Services Plan Book

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

After-Tax

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

ID Card

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

Will Preparation

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

flexible spending accounts

CLAIMS PROCESSED BY PAYFLEX

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

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

There are three types of FSAs:

1. Health Care FSA - covers eligible health care expenses for you and your eligible dependents. If you are enrolled in the U-M Consumer-Directed Health Plan (CDHP), you are NOT eligible for this option.
2. Limited Purpose FSA - covers eligible dental, orthodontic, and vision expenses. Available only to employees enrolled in the Consumer-Directed Health Plan (CDHP).
3. Dependent Care FSA - covers eligible dependent daycare or elder care expenses so you can work or attend school full time.

Health Care FSA

For 2024 you can contribute a minimum of $120, and up to a maximum of $3,050 per calendar year to your Health Care FSA.

Many common health care expenses are eligible for reimbursement from your Health Care FSA, including medical and dental co-pays, deductibles, prescription co-pays, vision care, and LASIK surgery. Generally, any health care expenses you can deduct on your federal income tax return are eligible for reimbursement from your Health Care FSA. There are some exceptions. For example, a Health Care FSA may not reimburse participants for insurance premiums paid for individual or employer-sponsored coverage.

Health Care FSA: Eligible Expenses

Eligible expenses include, but are not limited to:

- Necessary medical, dental, and vision plan expenses not reimbursed by any benefits plan. This includes co-pays, deductibles, co-insurance, amounts above prevailing fee limits, and amounts exceeding plan dollar maximums.
- Hearing care.
- Services and equipment for the disabled.
- Prescription drug co-pays.
- Over-the-counter medications.

Due to IRS regulations, you cannot use the PayFlex Card to buy over-the-counter (OTC) medications. You may, however, obtain reimbursement from your Health Care FSA for OTC medications by submitting a prescription from your doctor and a receipt.

For a list of covered FSA expenses, visit the PayFlex website, payflex.com, and review the Flexible Spending Account Eligible Expense Guide.

Limited Purpose FSA

For 2024 you can contribute a minimum of $120, and up to a maximum of $3,050 per calendar year.

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

For a list of covered FSA expenses, visit the PayFlex website, payflex.com, and review the Flexible Spending Account Eligible Expense Guide.

Important Information About Enrollment:

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

How the Accounts Work

FSAs are simple. Here's how they work:

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

Claims Processing

An external vendor, PayFlex Systems, Inc., will process claims for reimbursement from your 2024 FSA account. PayFlex is a national provider of healthcare and benefits management services.

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

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

  PayFlex Systems USA, Inc.
  P.O. Box 8396
  Omaha, NE 68108-0396
- Or fax to PayFlex toll-free at (855) 703-5305.
- Submit claims online: Login at payflex.com, enter your claim information and fax or upload your receipts to (866) 932-2567.
- File Claims using the PayFlex Mobile app available from the App Store or Google Play.

See the 2024 Flexible Spending Account book for additional claim filing information: hr.umich.edu/fsa-forms-and-documents.

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

Dependent Care FSA

You can contribute a minimum of $120, and up to $5,000 each year to your Dependent Care FSA. Highly compensated faculty and staff (family gross earnings in 2023 of $150,000 or more) can contribute $3,600 per year.

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

Dependent Care FSA: Eligible Expenses

Eligible expenses include, but are not limited to:

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

For a list of covered Dependent Care FSA expenses, visit the PayFlex website at: payflex.com and review the Flexible Spending Account Eligible Expense Guide. Contact PayFlex at (877) 343-1346 if you have questions about whether a particular expense is eligible.

hr.umich.edu/flexible-spending-accounts

Things to Consider

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

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

- **IMPORTANT: If you enroll in the CDHP and currently have a Health Care FSA, you must spend your remaining balance AND have all claims processed by Dec. 31, 2023. Your balance must be $0.00. Otherwise, you will not be eligible for HSA contributions until Apr. 1, 2024.**
- You must enroll each year if you wish to participate. Internal Revenue Service regulations do not allow FSA enrollments to carry over from year to year.
- Your 2024 contributions for a Health Care or Dependent Care FSA must be used for eligible expenses you incur between January 1, 2024 and March 15, 2025.
- You incur an expense on the date the service is provided—not when you are billed or when you pay for it.
- By law, any unclaimed money remaining in your 2024 account(s) on June 1, 2025 is forfeited and will not be returned to you. This is known as the "use it or lose it" rule. Planning carefully with the PayFlex FSA Calculator at payflex.com and filing your claims promptly will help ensure that you can maximize the benefits of your account.
- You can enroll in either a Health Care FSA or Limited Purpose FSA, depending on what U-M Health Plan you have selected.
- The Health Care, Limited Purpose, and Dependent Care FSAs are separate accounts. Money cannot be transferred between the accounts, and health care, vision, and dental services cannot be reimbursed from a Dependent Care FSA or vice versa.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.
- With the Health Care and Limited Purpose FSAs, you have access to the total amount you elected for the plan year as soon as eligible expenses are incurred.
- For a Dependent Care FSA, you can be reimbursed only up to the amount available in your account. Claims for expenses exceeding that amount will be reimbursed as additional funds accumulate in your account. The university reports deduction amounts to PayFlex on the first of every month for deductions taken in the preceding month.
- The contribution amount you elect during Open Enrollment is in effect until the end of the plan year. You may change your contribution amount during the plan year only if you experience a qualified family status change.

Plan Booklet

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

Annual Enrollment Required to Participate

FSA participation does not carry forward from one year to the next due to IRS regulations. If you have a 2023 FSA and you wish to participate in 2024, you must re-enroll and designate the amount of money to be withheld.

Services Deadline

For a 2024 Health Care or Dependent Care FSA, you can incur expenses until March 15, 2025.

Claims Deadline

To receive reimbursement for 2024 expenses, you must submit your claims to PayFlex by May 31, 2025. 2024 money left in your account on or after June 1, 2025 will be forfeited. In accordance with Internal Revenue Code, the university uses forfeited funds to pay administration costs of the FSA program.

Questions?

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

Tax Savings

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

resources and reminders

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

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

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

Keep Your Beneficiary Up to Date

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

Update Your Address

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

1. Go to wolverineaccess.umich.edu
2. Select the 'Employee Self-Service' tile
3. Click 'Campus Personal Information'
4. Click 'Addresses'
5. Click 'Current Local'
6. Review 'Current Local' address and edit if needed

Information

- Benefits information: **hr.umich.edu/benefits-wellness**
- Call the SSC Contact Center: 5-2000 from the U-M Ann Arbor campus, 734-615-2000 local, or 866-647-7657 toll free. Have your UMID number ready when you call.
- Sign up for *UHR News*, a timely email newsletter for current benefits and helpful employment information. To subscribe, visit myumi.ch/uhr-news-sign-up.

important federal notices

REGARDING YOUR HEALTH COVERAGE

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

Women's Health and Cancer Rights

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

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

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

Newborns' and Mothers' Health Protection Act

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

Summary of Benefits and Coverage (SBC) and Uniform Glossary

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

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

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

Health Care Reform

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

Continuation of Benefits (COBRA)

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

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

Special Enrollment Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

HIPAA Privacy and Security

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

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

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

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 innetwork 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.

contact information

Plan Providers	Phone	Web Address
Birdi Rx Mail Order Pharmacy	877-269-1160	umich.birdirx.com
Blue Cross Blue Shield Community Blue PPO	855-669-8040	bcbsm.com
Blue Cross Blue Shield of Michigan Consumer Directed Health Plan	855-669-8040	bcbsm.com
Comprehensive Major Medical (provided by BCBS)	855-669-8040	bcbsm.com
Davis Vision by MetLife	833-393-5433	metlife.com/insurance/vision-insurance
Delta Dental Plan Information	800-524-0149	deltadentalmi.com
GradCare	800-658-8878	bcbsm.com
HealthEquity Health Saivngs Account	877-284-9840	healthequity.com
Magellan Rx Customer Support	888-272-1346	umich.magellanrx.com
MetLife Legal Plan	800-821-6400	legalplans.com
Michigan Care	833-484-8450	michigancare.com
PayFlex	877-343-1346	payflex.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
Benefits Office, U-M Ann Arbor	734-615-2000 866-647-7657	hr.umich.edu
University Human Resources, U-M Flint	810-762-3150	umflint.edu/hr
SSC Contact Center	734-615-2000 866-647-7657	ssc.umich.edu
Telecommunications Relay Service	711	

A Final Word

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

Prepared by
Benefits Office

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

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

Fax 734-763-0363

Web hr.umich.edu/benefits-wellness

SSC Contact Center

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

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

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HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

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