



YOUR BENEFITS 2024

Benefits Information by Phone

The Shared Services Center (SSC) Contact Center can answer many of your benefits questions.

Call the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Benefits Information on the Web

For benefits plan information, visit hr.umich.edu/benefits-wellness

Telecommunications Relay Service

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

Subscribe to UHR News

Sign up for UHR News, a timely email newsletter for current benefits and helpful employment information. To subscribe, visit myumi.ch/uhr-news-sign-up.

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

Limitations

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

Campus Safety

The **University of Michigan Annual Security Report and Annual Fire Safety Report** is available from the Department of Public Safety and Security website at dpss.umich.edu/content/crime-safety-data/annual-security-fire-safety-report/, as well as several administrative offices and main libraries, including the Office of Student Life and the Admissions office in the Student Activities Building.

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

The publication also includes three-year statistics of reported crime, including bias-motivated crimes, on the Ann Arbor campus, adjoining properties and remote locations under University control in compliance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act. Additional safety and security information, including crime alerts and daily crime and fire incident logs, can be viewed on this site. If you have any questions or would like to request a copy of the report, please call DPSS at 734-763-8391.

Sign up for U-M Emergency Alerts

Be informed when there is an emergency on campus. Sign up for U-M Emergency Alerts. If there is a major emergency, you will receive a text through the U-M Emergency Alert system. Go to Wolverine Access, enter "Emergency Alerts" in the Search box, and then click the **Set Up Emergency Alerts** tile. Register now at: wolverineaccess.umich.edu. For more information go to: dpss.umich.edu/content/emergency-preparedness/emergency-alerts/

The university also encourages you to enter your Emergency Contact information under Campus Personal Information. This information will be used solely for the purpose of notifying the emergency contact(s), beginning with the primary contact you name, of medical emergencies, missing person(s), or other emergency situations.

Contents

1. General Information	3
Paying for your Benefits.....	4
Your Responsibilities.....	5
Eligibility	8
Eligibility Charts.....	9-15
Enrollment	17
How to Enroll	18
Confirmation Statement	19
2. Benefit Plans	20
Retirement Savings Plans Overview	21
Retirement Savings Plans.....	22
Basic Retirement Savings Plan	22
Save More with the 403(b) SRA and 457(b)	24
Roth 403(b) SRA & Roth 457(b)	24
How to Enroll as a New Hire	26
Investment Company Profiles	28
Health Plan Coverage	30
Understanding Your Health Plan Choices	30
Coordination of Benefits with Michigan No-fault Auto Insurance	33
Health Plan Profiles	36-37
Health Plan Coverage Comparison Chart	38-46
Prescription Drug Plan	48
Expanded Long-Term Disability	51
Basic Long-Term Disability	54
Flexible Spending Accounts	56
Health Care FSA	57
Dependent Care FSA	57
Business Travel Accident Insurance & Travel Assistance	61
Group Term Life Insurance	62
University Life Insurance Plan	62
Optional Life Insurance Plan	62
Dependent Plan	65
Dental Plan	66
Vision Plan	72
Legal Services Plan	75
3. Graduate Student Benefits	76
4. Changes to Your Benefits	77
Qualified Family Status Change	77
Leaves of Absence	78
When You Leave the University	79
Your Benefits When Your Employment Ends	79
Your Benefits When You Retire	81
5. Important Federal Notices	86
6. Workplace Resources	88
7. Contact Information	92

1. General Information

Welcome to *Your Benefits 2024*, a comprehensive resource containing information about the benefits packages offered by the University of Michigan. These benefits packages are some of the most competitive available. Your University of Michigan benefits package is an important part of your total compensation package at the university, adding value and giving you peace of mind.

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

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

Paying for Your Benefits contains information about frequency of deductions.

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

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

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

Benefits Are Subject to Change

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

The university reserves the right to change, amend, or terminate the plans at any time. This benefits overview is not intended to give rise to any right to employment, continued employment, or any benefit with or from the University of Michigan. To view official plan documents, go to: hr.umich.edu/benefits-wellness

For benefits information, see:

hr.umich.edu/benefits-wellness

To enroll in benefits, go to:

wolverineaccess.umich.edu

Paying for Your Benefits

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

Cost of Your Benefit Plans

Each benefit plan has its own rate structure. The cost of each benefit for which you are eligible is included on Self Service> Benefits when you enroll online.

Frequency of Deductions

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. Rates shown in this book are monthly deductions.

Monthly

If you are paid monthly, payroll deductions will be taken in one equal installment from each monthly paycheck. The rates shown in this book are for monthly deductions.

Payroll Deductions for Faculty and Staff

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

- Health Plan
- Dental Plan
- Vision Plan
- Flexible Spending Account
- Basic Retirement Savings Plan
- Pre-tax 403(b) SRA and 457(b)

The plans with after-tax deductions are:

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

Questions about your benefits?

Call the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Your Responsibilities

Review Benefit Information and Enroll Within Your Deadline

It is important that you review benefit plan information, make your benefits selections, and enroll within 30 days or as specified by your collective bargaining agreement. Enrollment is online for most benefits. Paper forms are used to enroll in Flexible Spending Accounts.

Check Your Confirmation Statement

After making an online election, you can view or print your submitted confirmation statement immediately after your elections are submitted. Final and Submitted Confirmation Statements are available in Wolverine Access. Select the **Benefits Self-Service** tile then click the **Benefits Statement** tile.

Update Your Address

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

Go to wolverineaccess.umich.edu. Click **Employee Self Service > Campus Personal Information > Addresses**. Edit your "Current Local" address.

Update Your Beneficiary Designations

It is important to name your beneficiaries and update your beneficiary designations as needed when your circumstances change. You may change your beneficiary designations at any time.

It is important to note that there are four separate companies that require you to name your beneficiary to receive funds in the event of your death. You must complete a separate beneficiary designation for each plan in which you are enrolled.

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

HealthEquity: healthequity.com

TIAA: tiaa.org/beneficiaries

Fidelity Investments: netbenefits.com/uofm

MetLife: metlife.com/mybenefits

Emergency Contact Information

The university also encourages you to enter your emergency contact information. Log into [Wolverine Access](#) and enter Emergency Contacts in the search bar. Click **Set Up Emergency Alerts & Contacts**. Once a year you will receive a prompt from Wolverine Access to review your addresses, emergency contacts, and U-M Emergency Alert notification preferences.

Check Your Deductions

Verify your benefit deductions on your pay stub to be sure they match the coverage you requested. You can view your pay stub online through Wolverine Access. Enter "Payroll and Compensation" in the Search box, and then click the **View Paycheck** tile. If you find an error in your deductions, [call the SSC Contact Center](#) immediately.

Know Your Rights and Responsibilities Under Federal Law

The Benefits Office is required to provide you with important information and notices about federal laws and acts that affect your coverage. These notices can be found on page 86. While these notices do not cover all the details of these laws, they do give you and your family information about your rights and protections under these laws. You are encouraged to carefully review these notices.

Make Dependent Coverage Changes Promptly

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

It is especially important to delete any ineligible dependents within the 30-day period to avoid overpaying premiums, because the university will not refund payment for coverage of ineligible dependents. In addition, failure to notify the SSC Contact Center or complete and return a COBRA Notice of Qualifying Event form within 60 days of your dependent's loss of eligibility will result in forfeiture of COBRA continuation rights. See page 86 for more information.

Change forms can be downloaded from the Human Resources website: hr.umich.edu/benefits-wellness.

Questions should be directed to the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Watch for Communications from U-M

Watch for emails and mailings from the Benefits Office and the University of Michigan. Dated and time-sensitive materials may require your prompt attention. Please note that emails go to "@umich.edu" addresses only. If you have an email address with a prefix (such as "@med.umich.edu"), edit your personal profile in MCommunity to set up forwarding to @umich.edu. Go to mcommunity.umich.edu. If you need help, contact the Information and Technology Services help desk. Visit its.umich.edu/help or call 734-764-4357 (dial 4-HELP from the Ann Arbor campus).

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

Protect Your Personal Information and the University

Be on the lookout for spam, phishing, and other malicious email. Criminals can use them to gain access to your personal and financial information, as well as sensitive university information and access. To learn about how to recognize and avoid phishing emails and protect the university and your personal information, visit safecomputing.umich.edu.



Your Way to Well-Being

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

MHEALTHY

YOUR WAY TO WELL-BEING

Well-being is a life-long journey.

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

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

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



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

M
HEALTHY

mhealthy.umich.edu



Eligibility

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

New Hire/Newly Eligible

If you are a new hire or newly eligible for benefits, your specific benefits options will be shown when you log on to Self Service > Benefits on wolverineaccess.umich.edu. The eligibility charts also show the benefits for which you are eligible and the eligible dependents you can cover on your benefits.

If You Return to U-M

Continuous Appointments

If you are re-appointed to your same position at the university with no break in service, it is considered a continuous appointment and your benefits enrollments will simply continue. This primarily affects supplemental faculty and graduate student career/job families who are appointed on an academic term basis. In these positions, benefits are only active for the duration of the term.

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

To confirm your re-appointment and your benefits enrollments, including retirement savings plans, [call the SSC Contact Center](#) at the beginning of the new term.

Break in Service/Rehire

If you are rehired into the university after a break in service, you must re-enroll in benefits. A break in service is defined as a period when you did not work for the university. For example, if you are a lecturer who teaches the fall term, does not teach the winter term and returns the following fall term, you must re-enroll in benefits when you are rehired. Enrollment information will be sent to you after your personnel record is created.

You will also need to re-enroll in the Basic Retirement Savings Plan, 403(b) Supplemental Retirement Account (SRA), and/or 457(b).

Research Fellows

There are specific guidelines in the university's Standard Practice Guide (SPG) regarding the benefits that must be provided for Research Fellows (see SPG 203.02 and 203.03). For example, the university requires that Research Fellows be required to enroll themselves and their dependents, if any, in a university group health plan at the same costs charged to university departments and university staff. This requirement can be waived only if the Research Fellow provides proof of comparable coverage elsewhere.

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

Eligibility for University of Michigan Benefits by Career/Group

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

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

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

³ For more information on MHealthy Rewards program, please visit: mhealthy.umich.edu/rewards

⁴ For more information on MHealthy wellness programs, please visit: mhealthy.umich.edu

⁵ You could become eligible to continue medical benefits at a different monthly cost if you move to a temporary position, reduce your effort below 50% or return after a break in service of less than 26 weeks. For more information, please visit: hr.umich.edu/esr-for-employees.

Eligibility for University of Michigan Benefits by Career/Group

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

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

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

³ For more information on MHealthy Rewards program, please visit: mhealthy.umich.edu/rewards

⁴ For more information on MHealthy wellness programs, please visit: mhealthy.umich.edu

⁵ You could become eligible to continue medical benefits at a different monthly cost if you move to a temporary position, reduce your effort below 50% or return after a break in service of less than 26 weeks. For more information, please visit: hr.umich.edu/esr-for-employees.

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Spouse A person who:</p> <ul style="list-style-type: none"> • Is legally married to you, and • Is not already covered through the university as an employee.¹ <p>OR</p> <p>Other Qualified Adult (OQA) See page 16 for imputed tax information regarding OQAs and instructions in the event you and your OQA marry.</p>	<p>AFSCME COAM Faculty and Staff GSI GSRA GSSA HOA POAM IUOE LEO LEO-GLAM MNA Research Fellows Supplemental Trades UPAMM</p>	<ul style="list-style-type: none"> • Health Plan³ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance if employee is enrolled in the University Life plan • Legal Services Plan • MHealthy Tobacco Independence Program³ (if enrolled in a U-M health plan) • MHealthy Rewards program⁴ (if enrolled in a U-M health plan) 	<ul style="list-style-type: none"> • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan² • MHealthy Tobacco Independence Program³ (if enrolled in a U-M health plan) • MHealthy Rewards program⁴ (if enrolled in a U-M health plan) 	<ul style="list-style-type: none"> • Vision Plan • Long-Term Disability • University Life, Optional Life, and Dependent Life Insurance • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan³ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
	<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan² (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program

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

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

³ For more information on the MHealthy Tobacco Independence Program (MTIP), please call: 734-998-2193 or visit: mhealthy.umich.edu/mtip

⁴ For more information on the MHealthy Rewards program, please visit: mhealthy.umich.edu/rewards

Eligibility for University of Michigan Benefits for Dependents

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

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

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

Eligibility for University of Michigan Benefits for Dependents

Dependents	Group	Eligible	Not Eligible
<p>Never Married Principally Supported Children, to Age 19¹</p> <p>Children through the end of the year in which they reach age 19 who:</p> <ul style="list-style-type: none"> • Are not your own children by birth or marriage; • Are related to you by blood or marriage; • Live with you on a permanent basis; • Are not eligible for coverage through the university as an employee; • Are not already covered through the university as a dependent on another university employee's coverage; • Will be claimed as a dependent on your income tax return for the current year; • Have been principally supported by you for at least six consecutive months before you apply for coverage. <p>Coverage will go into effect the first day of the month following 90 days after the application is received.</p>	<p>AFSCME COAM Faculty and Staff GSI GSRA GSSA HOA POAM IUOE LEO LEO-GLAM MNA Research Fellows Supplemental Trades UPAMM</p>	<ul style="list-style-type: none"> • Health Plan¹ • Dental Plan (Option 1, 2, or 3) • Vision Plan • Dependent Life Insurance (eligible from 15 days to age 26)² if employee is enrolled in the University Life plan • Legal Services Plan 	<ul style="list-style-type: none"> • Long-Term Disability • Group Term Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • MHealthy Rewards program
	<p>Professional Specialists</p>	<ul style="list-style-type: none"> • Health Plan¹ 	<ul style="list-style-type: none"> • Vision Plan • University Life, Optional Life, and Dependent Life Insurance • Long-Term Disability • Legal Services Plan • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Dental Plan (Option 1, 2, or 3) • Business Travel Accident Insurance • MHealthy Rewards program
	<p>Benefit-Eligible Fellowship Holders</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program
	<p>Medical School Students</p>	<ul style="list-style-type: none"> • Health Plan¹ (GradCare only) • Dental Plan (Option 1, 2, and 3) • Legal Services Plan • Vision Plan 	<ul style="list-style-type: none"> • University Life, Optional Life, and Dependent Life Insurance • Flexible Spending Accounts • Retirement Plans — Basic, 403(b) SRA and 457(b) • Business Travel Accident Insurance • Long-Term Disability • MHealthy Rewards program

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

² Your eligible children meeting the listed requirements may continue eligibility through the end of the year in which the child reaches age 19.

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

Eligibility for University of Michigan Benefits for Dependents

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

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

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

“Other Qualified Adult” Eligibility Criteria

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

- The employee is eligible for U-M benefits;
- The Other Qualified Adult, at the time of proposed enrollment, shares a primary residence with the employee and has done so for the previous 6 continuous months, other than as an employee or tenant.
- You have 30 days from the date six months of shared residency have been established to add your OQA to your benefits coverage. If you do not enroll your OQA within the 30-day deadline, you must wait until the next Open Enrollment period to make changes to your benefits enrollments.

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

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

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

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

Tax Information for Coverage of Other Qualified Adults

You will 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 health, dental, and vision coverage for other qualified adults and their children who do not satisfy the definition of a dependent under the Internal Revenue Code. As a result of this law, U-M must add to your compensation reported to the Internal Revenue Service any amount representing the fair market value of providing the coverage in enrolled health, dental, and/or vision plans your other qualified adult less your after-tax contribution. This is referred to as “imputed income.” You will pay tax on this imputed income. This amount is also subject to applicable income taxes as well as FICA/FUTA.

For additional information on imputed income, please refer to Taxation of OQA Coverage at: hr.umich.edu/eligibility-other-qualified-adult

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, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Because benefits provided to your legal spouse are not considered a taxable fringe benefit, you will no longer be subject to tax withholding for OQA coverage as of the date of your marriage.

Enrollment

When to Enroll

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

- as a newly hired/rehired or newly eligible faculty or staff member,
- after experiencing a qualifying job status change,
- after experiencing a qualifying family status change, and
- during Open Enrollment, usually in October with benefits effective January 1.

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

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

If you do not enroll in the life insurance or Expanded LTD plans when you are first eligible, you will be required to complete appropriate health statements and prove insurability before you can enroll. Enrollment information for each of the benefits plans is included in this book and at: hr.umich.edu/benefits-wellness

Effective Date of Benefits Elections

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

- Health, Prescription Drug, Dental, Vision, and Legal plans
- Life Insurance (if a health statement is required, coverage will not begin until the date the health statement is approved by MetLife; this may take 4-6 weeks)
- Long-Term Disability

If you do not enroll within the deadline, you will not have health plan coverage. AFSCME, IUOE, POAM, UPAMM, GEO, GSRAs, benefits-eligible fellowship and medical school students, House Officers and MNA members who do not enroll will be enrolled by default into single-person health plan coverage. Research Fellows' default coverage will be determined by university policy. See the University Standard Practice Guide for more information: spg.umich.edu

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

If you enroll in the Consumer-Directed Health Plan, you are eligible to enroll in the Health Savings Account (HSA). With an HSA, you can put away money for future healthcare costs while saving on taxes. Additional information on the HSA is available at: hr.umich.edu/cdhp

You are automatically covered for Travel Accident Insurance and Secure Travel Plan beginning on your first day of service with the university.

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

Job or Family Status Change

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

If you have a qualified family status change, you must act **within 30 days** of the qualifying event for the change to be accepted by the university. Otherwise you will have to wait for the next Open Enrollment period to make the change to your benefits. See page 77.

Questions about mid-year changes affecting your University of Michigan benefits should be directed to the SSC Contact Center. Change forms are available at: hr.umich.edu/benefits-wellness

During Open Enrollment

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

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

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

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

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

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

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

How to Enroll

Use Benefits Self-Service on Wolverine Access

Enroll online using Self Service > Benefits, which is available through Wolverine Access at:

wolverineaccess.umich.edu

Supported browsers are Chrome, Firefox, Edge and Safari.

Your Uniqname and UMICH Password

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

Accessing Benefits Self-Service

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

Follow these instructions to enroll in benefits:

1. Log on to Wolverine Access. Wolverine Access is the online gateway to administrative systems at the University of Michigan. Go to: wolverineaccess.umich.edu. Enter '**Benefits**' in the search bar then select **Benefits Self-Service**.
2. Complete [DUO two-factor authentication](#) to continue the log in process.
3. Click the **UM New Benefits Eligibility** tile
4. Follow the prompts to make your elections.

If you are unable to enroll online, Call the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Enrollment Forms

Separate forms are required to enroll in the Health Care or Dependent Care Flexible Spending Account. Enrollment forms are available for download at:

hr.umich.edu/fsa-forms-and-documents

Confirmation Statement

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

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

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

hr.umich.edu/benefits-wellness

To enroll in benefits, go to Wolverine Access:

wolverineaccess.umich.edu

Questions about Your Benefits or Benefits Enrollment

If you have questions or need assistance completing your benefits enrollment, call the Shared Services Center - HR Customer Care at 734-615-2000 locally, or toll free at 866-647-7657, or email sharedservices@umich.edu, if you have any questions or need additional assistance. Shared Services Center - HR Customer Care is open Monday - Friday 8:00-5:00 EST.

Protect Your Personal Information

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

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

To learn more about Duo two-factor authentication, visit U-M Safe Computing on the U-M ITS website.

safecomputing.umich.edu/two-factor-authentication

2. Benefit Plans

This section provides information on benefit plans offered by the university to eligible faculty, staff and graduate students. The plans and options available to you and your dependents depend upon your career/job family, your appointment duration and percentage effort (regular hours worked per week), and your funding type. See the Eligibility Charts on pages 9-15.

Retirement Savings Plans

The Basic Retirement Savings Plan is a tax-deferred 403(b) and 401(a) plan with a two-for-one matching contribution. You may enroll at any time and all contributions are immediately vested. Individuals newly hired or newly eligible to participate in the plan must complete a waiting period of twelve consecutive months of eligible service in order to become eligible to receive the university contribution. In addition to Basic Retirement Savings Plan, you may also contribute to the 403(b) Supplemental Retirement Account (SRA) and 457(b) Deferred Compensation Plan. See page 21.

Health Plan Coverage

A number of health plan coverage options are available. Choose the plan that covers you and your dependents' health needs in ways that are most advantageous to you. See page 30.

Prescription Drug Plan

If you are enrolled in a university health plan, you are automatically enrolled in the U-M Prescription Drug Plan. See page 48.

Expanded Long-Term Disability

This plan pays up to 65% of your covered pre-disability base salary in the event you should become totally disabled. The plan also pays the cost to continue most of the benefits you have at the time of disability. (House Officers and AFSCME members have separate plans.) See page 51.

Basic Long-Term Disability

This plan is available to AFSCME members only. It pays up to \$1,200 per month. The plan also pays the cost to continue most of the benefits you have at the time of disability. See page 54.

Flexible Spending Accounts

Enrolling in either or both the Health Care or Dependent Care Flexible Spending Account allows you to pay certain health care, dental, childcare, and elder care bills with tax-free money. See page 56.

Travel Accident Insurance and Secure Travel Plan

While traveling on business for the university, all active faculty or staff members are covered by travel accident insurance and the Secure Travel Plan, the entire cost of which is paid by the university. See page 61.

Group Term Life Insurance

The university offers three group term life insurance plans to eligible faculty and staff.

University Plan—\$30,000 of coverage for you paid for by the university;

Optional Plan—your choice of coverage of \$5,000, \$50,000, or one to eight times your annual salary, paid for by you;

Dependent Plan—coverage for your spouse or other qualified adult or your dependent children, paid for by you.

See page 62 for more information.

Dental Plan

The Dental Plan offers three coverage choices with differing features: Option 1, Option 2, and Option 3. If you are eligible, you may select the option most suited to your needs. See page 66.

Vision Plan

Each enrolled person may receive an eye exam, lenses, and frames once each calendar year. See page 72.

Legal Services Plan

For a low monthly fee, you can obtain help on a personal legal matter from an attorney in private practice in your area who participates with MetLife Legal Services. Your plan attorney will maintain strict confidentiality. See page 75.

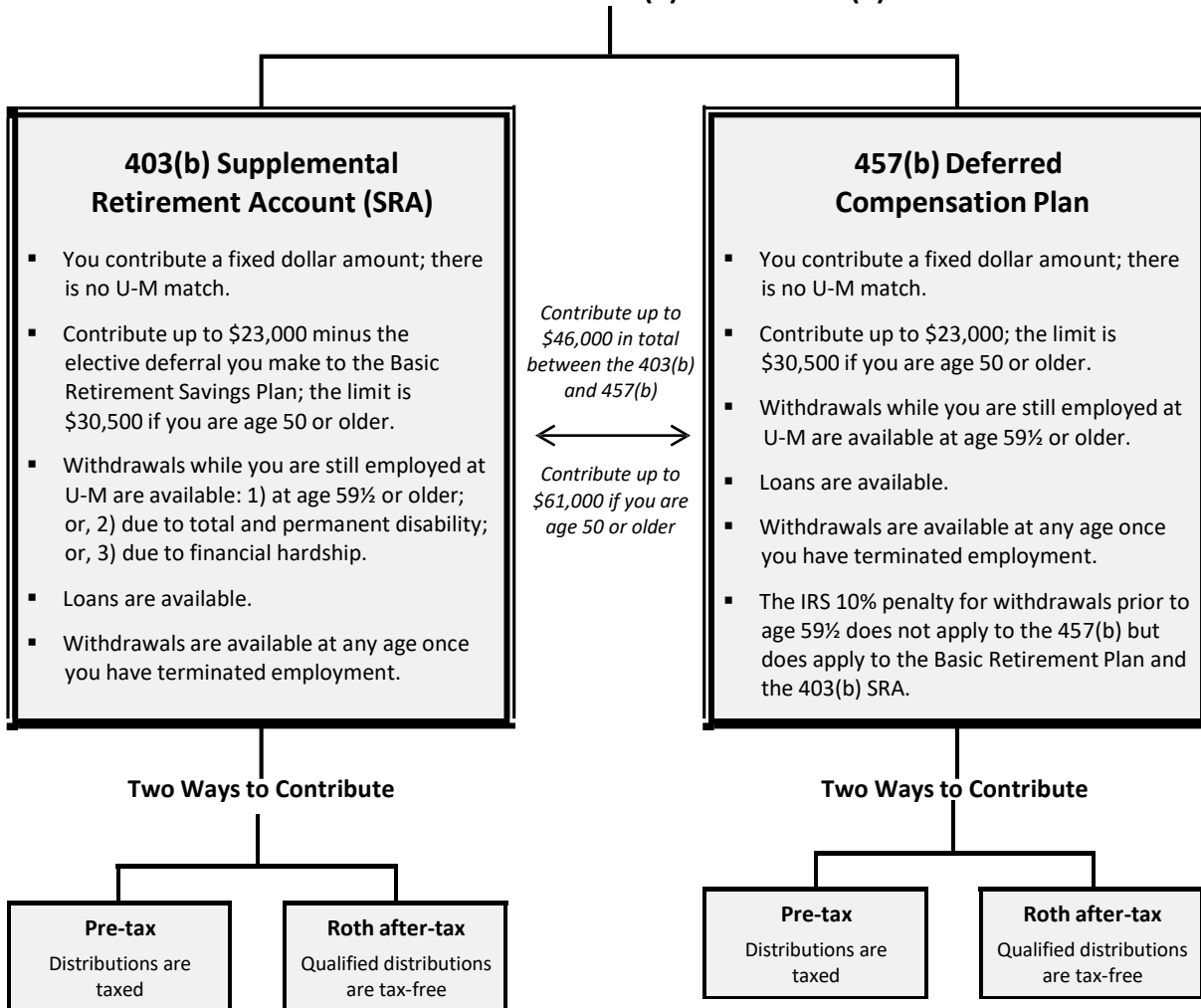
U-M Retirement Savings Plans Overview

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

Basic Retirement Savings Plan

- The U-M Basic Retirement Savings Plan is a 403(b) and 401(a) plan with immediate vesting.
- You contribute 5% of your pre-tax salary and U-M contributes 10% after 1 year of service once you are enrolled in the Basic Plan. If you are subject to a collective bargaining agreement, consult with the terms of the agreement to confirm the contribution rate.
- The Basic Plan does not offer loans and cash withdrawals are not available while you are still employed.
- You may cash out or rollover your contributions at any age after you have terminated employment; U-M contributions may be cashed out or rolled over at age 55 or older once you have terminated.

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



U-M Retirement Savings Plans

Basic Retirement Savings Plan

The University of Michigan Basic Retirement Savings Plan is a tax-deferred defined contribution retirement savings plan with a two-for-one match on earnings up to \$345,000. It is a combination 403(b) plan for employee contributions and a 401(a) plan for university contributions.

Participation and Eligibility

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

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

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

Contribution Rate

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

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

Eligible Compensation

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

- Overtime
- Salary Supplement
- Payout of unused vacation or Paid Time Off (PTO) at termination or retirement
- Annual PTO sell back
- Shift differential
- Administrative Differential
- Added Duties Differential
- Faculty Honor

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

Immediate Vesting

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

Learn More about the U-M Retirement Savings Plans

Website: hr.umich.edu/retirement-savings-plans

Plan book:

hr.umich.edu/retirement-savings-plans-forms-documents

IRS Limits: hr.umich.edu/retirement-savings-plan-limits

hr.umich.edu/retirement-savings-plans

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

What is the waiting period?

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

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

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

How is the waiting period measured?

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

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

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

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

- If your gap in employment or eligibility is one year or greater, you will need to complete the waiting period to become eligible to receive university contributions.
- If your gap in employment or eligibility was less than one year, and you were eligible for university contributions prior to the gap, you do not need to fulfill the waiting period and you will receive university contributions upon enrollment.
- If your gap in employment or eligibility was less than one year, but you were not eligible for university contributions prior to the gap, you will need to complete the waiting period.

- University retirees who are rehired into a title eligible for the Basic Retirement Savings Plan do not need to complete the waiting period if they were eligible for university contributions prior to retirement and will receive university contributions upon enrollment.

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

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

When will the U-M matching contribution begin?

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

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

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

Basic Retirement Savings Plan Contribution Rate Once Enrolled

During first 12 months of eligible service

- You contribute
- U-M does not contribute

After 12 months of eligible service

- You contribute
- U-M provides its matching contribution

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

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

403(b) SRA: hr.umich.edu/403b-sra

457(b): hr.umich.edu/457b-deferred-compensation-plan

Roth 403(b) SRA & Roth 457(b)

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

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

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

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

403(b) and 457(b) Contribution Limits

You may contribute up to \$23,000 to each plan per year if you are under age 50; if you are age 50 or older the limit is \$30,500. This allows you to contribute up to \$46,000 to both plans combined if you are under 50 and up to \$61,000 if you are over age 50.

Do You Have Another Retirement Plan?

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

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

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

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

Visit: hr.umich.edu/retirement-savings-plan-limits

Consult with a Tax Advisor

Consult with a tax advisor to ensure you do not exceed the IRS limits. Call the SSC Contact Center if you have questions on the IRS contributions limits or to report contributions made to another plan that may affect the amount that may be contributed to the U-M plans.

Limits on Cash Withdrawals and Rollovers

Basic Retirement Plan: Employee contributions are not available for cash withdrawals or rollovers until you have terminated employment. University contributions are not available for cash withdrawals or rollovers until you have terminated employment and you are age 55 or older. Loans and in-service cash withdrawals are not available under any circumstance.

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

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

Loans: Available for both the SRA and the 457(b).

Rollovers into U-M

You can rollover assets from another employer's retirement plan into an IRA with TIAA and/or Fidelity to consolidate your assets alongside your U-M retirement plan accounts, and it provides you a single quarterly statement. However, you will not have access to the low-cost share class of mutual funds that are available through the U-M plans. Assets you roll into any of the U-M plans are available for withdrawal while you are working for the university or after you terminate employment. In addition, the 403(b) SRA and 457(b) plans also offer the option to take a loan on your account. Visit: hr.umich.edu/retirement-plan-rollovers-direct-transfers

Compulsory Participation

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

Direct Transfers

You may transfer accumulations between TIAA and Fidelity at any time but you must have an account at the company who will receive the transfer. The transfer application **does not** create your account, which you must do as a separate action. A transfer only moves existing balances. You will need to direct future contributions to the newly chosen investment company or they will continue to be deposited with your current company. Visit:

hr.umich.edu/retirement-plan-rollovers-direct-transfers

Military Leave of Absence

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

How to Enroll as a New Hire

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

403(b) SRA and 457(b) Enrollment

The 403(b) SRA and 457(b) enrollment elections are not available as part of the online new hire enrollment process. You need to create a separate enrollment event to enroll in the 403(b) SRA and the 457(b). Therefore, you will need two separate events to enroll in all three plans. Each enrollment is processed overnight after you finalize your elections; allow up to 24 hours between enrollment elections.

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

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

Effective Date - The Basic Retirement Plan, 403(b) SRA, and 457(b) can all take effect in the current month if your enrollment is completed by certain deadlines. For information on deadlines, synchronizing your plan enrollments to take effect with a specific paycheck and enrollment instructions visit: hr.umich.edu/retirement-enroll-change

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

1. Enroll in the Basic Retirement Plan

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

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

You contribute a fixed dollar amount to the 403(b) SRA and/or 457(b) and you may choose to contribute as traditional pre-tax, Roth after-tax, or any combination of both. You need to create a separate enrollment event to enroll in the 403(b) SRA and/or 457(b) since they are not part of the new hire event that you use to enroll in the Basic Retirement Plan. You may also enroll in, or make changes to any retirement plan throughout the year by creating an enrollment event as follows:

3. Select Your Funds & Designate Your Beneficiary

Your beneficiary and investment fund for the Basic Retirement Plan, 403(b) SRA and 457(b) will be a default until you take action to change them. You can do this through the TIAA and Fidelity websites listed in this packet.

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

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

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

Select Your Funds and Beneficiary

The enrollment process will default your investment fund and your beneficiary for each plan in which you enroll. You may change these at any time after your account has been created, for example, after you receive the welcome packet from the company. You may also create your account online through the TIAA and Fidelity websites listed below.

TIAA Online

You can create your account, select your investment funds and designate your beneficiary online at any time instead of waiting for your welcome packet by going to: tiaa.org/umich

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

By Phone

Call TIAA at 1-800-842-2252, Monday through Friday from 7 a.m. to 9 p.m. and Saturday from 8 a.m. to 5 p.m. (CT). A consultant will help you make the appropriate beneficiary designations for your retirement planning needs and record your investment fund selections.

Fidelity Investments Online

You can create your account, select your investment funds and designate your beneficiary online at any time instead of waiting for your welcome packet by going to: netbenefits.com/uofm

- Select “**Enroll**”
- Click on the type of plan for which you are creating an account: Basic Retirement Plan, 403(b) SRA, 457(b).
 - **NOTE:** *You will need to open an account under two different plans for the Basic Retirement Plan. Open an account under **401(a) Base Plan 86503** for the U-M contribution and open an account under **403(b) Base Plan 72104** for your contribution.*
- Follow the online prompts and enter your selections.

By Phone:

Contact a Fidelity Retirement Services Specialist by calling 800-343-0860, Monday through Friday, 8:00 a.m. to midnight, Eastern Time if you have questions or need assistance.

The Default Investment Fund

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

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

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

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

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

Investment Company Profiles

TIAA

What is TIAA?

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

TIAA received the highest ranking for trust in the financial services and insurance industries by The Harris Poll (2010).

What are my investment choices?

The investment fund is automatically defaulted to an age-appropriate TIAA Lifecycle Index Fund. You may change this at any time. TIAA offers more than 40 fund choices, including mutual funds, and fixed and variable annuities. Domestic and international stock funds, bond funds, money market funds and real estate funds are available, along with a guaranteed fixed annuity and socially responsible funds.

Several Vanguard funds are also available through TIAA.

For a complete list of available investment funds visit:

tiaa.org/umich

TIAA Institutional Class Mutual Funds

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

Where can I find more information?

You can meet with a TIAA investment professional by calling: 1-800-732-8353

tiaa.org/umich

TIAA Telephone Counseling Center

1-800-842-2252

Fidelity Investments

What is Fidelity Investments?

Fidelity Investments was founded in 1946 by Edward C. Johnson II and today is the largest mutual fund company in the world. Fidelity is one of the nation's top providers of 403(b) retirement savings plans for not-for-profit organizations, including colleges and universities, healthcare institutions, foundations, and charitable organizations. The University of Michigan added Fidelity Investments to its retirement plan in 1989.

What are my investment choices with Fidelity?

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

Several Vanguard funds are also available through Fidelity.

For a complete list of available investment funds visit:

netbenefits.com/uofm

Fidelity Freedom Index Funds: Class W

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

Where can I find more information?

You can meet with a Fidelity Investments professional by calling: 1-800-642-7131

netbenefits.com/uofm

Fidelity Retirement Specialists

1-800-343-0860

Fund Management Fees and the U-M Plans

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

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

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

Where to Find More Information

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

You may view an explanation of the types of fund management fees at: hr.umich.edu/fund-fees-and-expenses

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

In addition, you may also provide direction on your investment choices by calling TIAA and Fidelity Investments at the phone numbers listed on page 92 or through their secure websites.

TIAA: tiaa.org/umich

Fidelity Investments: netbenefits.com/uofm

Health Plan Coverage

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

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

If you do not enroll within the deadline, you will not receive health or prescription drug coverage, except House Officers, AFSCME, IUOE POAM, UPAMM, GEO, and MNA members, GSRAs, benefit-eligible fellowship and medical school students who will be enrolled by default into one-person coverage. Research Fellows' default coverage will be determined by university policy.

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

Services Before You Get Your ID Card

Contact your health plan company to find out how to receive services before your health plan ID cards arrive. Phone numbers for plan companies are listed on page 92. Until you receive your health plan cards, you may have to pay for services and/or prescriptions in full. Contact your health plan to find out its reimbursement procedure. Be sure to save all of your receipts.

Prescription Drug Coverage

Prescription drug coverage through Magellan Rx Management is automatically included for everyone who enrolls in a U-M health plan. See page 48 for details.

Physician and Hospital Plan

Participation Contract renewal dates between plans and their doctors and hospitals vary, and renewal is at the option of either party. In the event your primary care physician's (PCP) affiliation with your U-M health plan ends, you will need to select another PCP within your plan's service area. The PPO plan does not require you to designate a PCP. Before enrolling in a PPO or managed care plan, check the provider directory to make sure it includes a doctor and hospital of your choice. You can find provider information on the plan's website, or call the health plan's customer service number. You will not be able to change plans due to a physician's or hospital's disaffiliation with your plan. For more information on U-M health plans, see: hr.umich.edu/health-plans

Understanding Your U-M Health Plan Choices

The university offers health plan choices structured under basic plan designs.

NEW Consumer-Directed Health Plan

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

The CDHP covers the same medical services as other plans, including no out of pocket costs for preventive care and screenings. The CDHP covers the same medical services as other plans, including no out of pocket costs for preventive care and screenings and it uses the national BCBS PPO provider network.

If you are generally healthy and don't need to visit your health care provider often, choosing the CDHP can save you money. While it has the lowest monthly premium cost, you may incur higher out-of-pocket costs depending on the amount of care you need.

Deductible is \$1,600 for single person contracts and \$3,200 for family contracts. maximum. The entire deductible must be met by one or any combination of family members before the plan begins to pay at 90%. The out-of-pocket maximum is \$5,500 for single person contracts and \$9,450 for family contracts. Pharmacy and medical is combined toward the deductible and out-of-pocket maximum.

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. The HSA is managed by HealthEquity, a health savings company. Learn more about how HSAs work, including what qualifies as a medical expense, by visiting the HealthEquity.com.

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
- **IMPORTANT:** Financial hardship created from the costs for the deductible and out-of-pocket maximum is not a qualifying event to change plans.

Health Savings Account Contributions

A Health Savings Account (HSA) lets you put money away for future healthcare costs while saving on taxes. HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too. If you would like, once you have more than \$1,000 in your HSA you can begin investing.

- University HSA Contribution up to: \$800 (\$67 per month) individual, \$1,600 (\$133 per month)
- family
- Minimum Contribution: \$120 individual, \$120 family
- Annual HSA Contribution max for 2024: \$4,150 individual, \$8,300 family
- HSA catch-up if 55+: \$1,000

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 the Michigan Care plan 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 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. Precertification 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 offers the lower costs of an HMO with the flexibility to access a state-wide network of providers if needed. U-M Premier Care is only offered to the University of Michigan community. Members save money when utilizing Network 1 providers, which includes Michigan Medicine 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.**

Dollar-Savings Tip

You can use a Health Care Flexible Spending Account (FSA) for yourself and your dependents for health care expenses beyond what your plan covers. See the Flexible Spending Accounts section (page 56) for details.

ID Cards

Your health plan and prescription drug ID cards will be mailed to you directly from your health plan company and Magellan Rx, not from the Benefits Office, 4-6 weeks after you enroll in your benefits choices and you have received a confirmation statement. Contact your health plan company or Magellan Rx if you have not received your cards on a timely basis.

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

Consider GradCare if:

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

Health Plan Rates

Your individualized health plan rates are available on Wolverine Access through Self Service > Benefits. The page displays rates for all benefits plans for which you are eligible—not just the health plan rates.

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

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

To view your benefits plan rates:

1. Go to Wolverine Access: wolverineaccess.umich.edu
2. Enter “Benefits” in the Search bar
3. Click the **Benefits Self-Service** tile
4. Click the **Display Benefits Plan Rates** tile

Health Plan Resources

Tools and resources are available to help you find the health plan that offers the most advantages to you and your family. To access these resources, visit hr.umich.edu/health-plan-resources.

Coordination of Benefits with Michigan No-Fault Auto Insurance

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

The basic no-fault auto policy has three parts: Personal injury protection (PIP); Property protection insurance (PPI) and Residual bodily injury and property damage liability. The Personal injury protection (PIP) portion of your no-fault policy pays for medical costs if you are hurt in a car accident.

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

Excess or Coordinated Medical Coverage on Auto Insurance Policies

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

Benefits under the University sponsored group health plans will not be reduced because of the existence of coverage under an employee’s coordinated or excess no-fault automobile policy.

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

Primary or Uncoordinated Medical Coverage on Auto Insurance Policies

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

No-Fault and HMO or “Network” Plans

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

University Health Coverage, Medicare and Coordinated No-Fault

Medicare benefits are not payable for any expense that is compensable under an automobile no-fault insurance system. For retirees or disabled employees whose Medicare coverage is primary to their university group plan, the same rules for priority of payment as described MAY apply.

For university retirees or disabled employees covered under a university sponsored BCBSM (BCBSM Community Blue PPO or CMM), PHP (Michigan Care) or BCN (U-M Premier Care) plan, whose Medicare coverage is primary to their university group plan, the same rules for priority of payment as described above will apply. In other words, benefits under the university’s health plan will pay as primary (first) before the retiree’s coordinated no-fault automobile policy. After the university plan has made payment in accordance with the retiree’s benefit plan and the no fault plan has made payment; Medicare will pay as the third carrier for any unpaid charges, if any, in accordance with their terms and conditions for covered services.

Exception to the rule: Fully insured plans maintain the right to uphold their position as secondary to Medicare and will only pay after Medicare has made their payment. Because Medicare benefits are not payable for any expense that is covered under the no-fault plan, Medicare will look to the no-fault plan to pay first. Under this scenario, no-fault auto insurance pays first, Medicare pays second, and the insurance company pays third. Retirees covered under fully-insured plans should consult with their no-fault insurance agent to ensure they have adequate coverage in force.

Questions?

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

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	michiganicare.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 ¹
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

1. Health Savings Account Contributions:

- University HSA Contribution up to: \$800 (\$67 per month) individual, \$1,600 (\$133 per month) family
- Minimum Annual Contribution: \$120 individual, \$120 family.
- Maximum employee contribution is the Annual HSA Contribution (\$4,150/\$8,300) minus university contribution (\$800/\$1,600). Employees 55 and older get an additional \$1,000.
- HSA catch-up if 55+: \$1,000.

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. ³	“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. ^{4,5}	“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.

- Coverage described applies to GradCare Level 1. For details on out-of-network services, call BCN.
- 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-of-network) ^{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 ¹²	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 deductible. 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 ¹²	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 ¹²	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 criteria
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 Management Administers This Plan

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

For more information on U-M Prescription Drug Plan coverage 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 University 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 Prescription Drug Plan provides a consistent benefit and scope of coverage for all members, including:

- **Access to local and national chain pharmacies.** Up to 90-day supplies are available for most medications. Participants can fill prescriptions for 1-to 34-day supplies for one co-pay, 35-to 60-day supplies for two co-pays, or 61-to 90-day supplies for three co-pays.
- **Mail-order pharmacy** is provided by Birdi Rx as an alternative to retail pharmacies. Birdi provides convenient, secure deliveries. This is particularly convenient for participants who take medications on an ongoing basis.

Note: Certain drugs may not be available through mail service because there may be medical reasons for not dispensing large quantities, or because of federal or state laws that prohibit dispensing certain drugs through the mail. Contact Birdi at 877-269-1160 if you have any questions about drugs available through the mail service program. Prescription drugs cannot be mailed outside the United States when using the U-M Prescription Drug Plan.

- **Diabetic insulin, needles, and syringes** are available to all participants in the U-M Prescription Drug Plan. Select insulin products (see hr.umich.edu/formulary), needles and syringes are covered at \$0 copayment for all members.
- **Coverage of diabetic** supplies (injection devices, alcohol swabs, testing strips, lancets, and blood glucose testing monitors) is determined by your health plan. See Contact Information on page 92.

Terms You Need to Know

Formulary -- A formulary is a list of available prescription drugs offered by the plan to serve the pharmaceutical needs of patients requiring self-administered drug therapy on an outpatient basis. In addition, there may be drugs covered but not listed on the formulary. Inclusions (or exclusions) of drugs on the formulary is determined by the clinical judgment of a committee of University of Michigan physicians and pharmacists based on published medical evidence regarding diagnosis and treatment of disease.

Drug lists are subject to change. The U-M formulary can be found at hr.umich.edu/formulary.

Generic Drugs/Tier 1 – The Generic Drug co-pay level offers the opportunity to take advantage of generic drug savings. Generics cost significantly less on average than their counterpart brand-name drugs. Generic drugs are approved by the United States Food and Drug Administration (FDA), contain the same active ingredients as their brand-name equivalents, and must meet the same safety, production, and performance standards. Therefore, generic drugs often offer an effective and safe alternative to help reduce prescription drug costs for both you and the University of Michigan. Approximately 89% of all prescriptions under the U-M Prescription Drug Plan are dispensed as generic drugs. For co-pay amounts for generic drugs, see the Prescription Drug Plan Co-Pays chart on page 50.

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

Generics are always preferred and are your lowest cost option. Preferred brand-name drugs are selected on the basis of therapeutic effectiveness, safety, and cost relative to other brand-name drugs used to treat the same conditions. Physicians are encouraged, but not required, to prescribe from the PDL when appropriate for the patient's condition. Approximately 13% of all prescriptions filled under the U-M Prescription Drug Plan are dispensed with \$0 co-pay. For co-pay amounts for preferred brand-name drugs, see the Prescription Drug Plan Co-Pays chart on page 50.

Non-Preferred Drugs (Brand-Name)/Tier 3 – Drugs on the third co-pay tier are FDA-approved drugs that 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 Prescription Drug Plan Co-Pays chart on page 50.

Select medications as defined by the Affordable Care Act with a prescription from your doctor are covered at zero (\$0) co-pay for drug plan participants 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 specialty medications are covered up to a 90-day supply. More information is available at hr.umich.edu/specialty-drugs or call the Michigan specialty pharmacy's toll free number, 855-276-3002.

Dollar Saver Tip

You can use a Health Care Flexible Spending Account (FSA) for yourself and your dependents to pay for prescription drug expenses beyond what the plan covers, including co-pay amounts and some over-the-counter medications if you have a written order from your physician. See pages 56-60 for more information on FSAs.

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

2024 Prescription Drug Plan Co-pays					
Group	Drug Type	Retail Pharmacy Co-pay ^{1, 2, 3, 4}			Mail-Order Co-pay ^{2, 3,}
		1- to 34-day supply	35- to 60-day supply	60- to 90-day supply	Birdi Rx Up to 90-day supply (Compare to 61- to 90-day supply at Retail Pharmacy)
Active Employees (see below for variance by collective bargaining agreement)	Generic Drugs/Tier 1	\$10	\$20	\$30	\$20
	Preferred Brand Name Name/Tier 2	\$20	\$40	\$60	\$40
	Non-Preferred Brand Name Drugs/Tier 3	\$75	\$150	\$225	\$150
MNA Active and LTD members (per contract)	Generic Drugs/Tier 1	\$7	\$14	\$21	\$14
	Preferred Brand Name Name/Tier 2	\$15	\$30	\$45	\$30
	Non-Preferred Brand Name Drugs/Tier 3	\$30	\$60	\$90	\$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 annual 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 doctor 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.

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

U-M Prescription Drug Plan information:
hr.umich.edu/prescription-drug-plan

Mail order pharmacy service:
umich.birdirx.com

Expanded Long-Term Disability

The Expanded Long-Term Disability (LTD) plan pays up to 65% of your covered pre-disability base salary when you become totally disabled and your claim is approved.

The maximum covered annual base salary is \$424,615. Income benefits from the plan are coordinated with income from public programs, such as Social Security. The plan also pays the cost to continue most of the benefits you have at the time of disability.

Eligibility

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

Expanded LTD is available to faculty, staff, MNA, POAM, UPAMM, COAM, Trades, IUOE, LEO and LEO-GLAM members including Lecturer I with two years of service; however, Supplemental Faculty, Graduate Students, House Officers, Professional Specialists, AFSCME members, and Research Fellows are not eligible for this plan.

Enrollment

You can enroll in this plan within 30 days of your service date or newly eligible appointment. If you miss the 30-day deadline, you can still enroll if you submit a satisfactory statement of good health. Both the enrollment form and the health statement are available from the Human Resources website or by request from the SSC.

Your Years of Service Count

- You pay for coverage on your full salary the first two years of service at the university. You must have at least a 50% appointment for eight continuous months.
- If your appointment drops below 50% or below eight continuous months during the first two years of service, you are no longer eligible for the benefit, but you do not lose your current benefit eligibility date. When your appointment again reaches 50% and the expected duration is for eight months or more, you are newly eligible to enroll.

- At two years of service in an eligible career/job family with at least a 50%, eight-month continuous appointment or more, you are automatically enrolled. The university pays for your coverage on up to \$69,800 of annual salary. If you enrolled in coverage on your full salary during your first two years of service, you will pay for coverage only on salary over \$69,800. If you did not enroll in coverage on your full salary during your first two years of service, you must submit a satisfactory statement of good health for coverage on salary over \$69,800. Both the enrollment form and the health statement are available at hr.umich.edu/ltd-forms-documents or the SSC Contact Center.
- At three years of service in an eligible career/job family with less than a 50%, eight-month continuous appointment or more, you are automatically enrolled. The university pays for your coverage up to \$69,800 of annual salary. You can elect to pay for coverage above that amount. If you do not enroll within 30 days of eligibility, you must submit a satisfactory statement of good health to elect coverage on salary over \$69,800. Both the enrollment form and health statement are available at hr.umich.edu/ltd-forms-documents or the SSC Contact Center.
- You are not eligible for the LTD plan if you are not eligible for the Basic Retirement Savings Plan.

If You Become Disabled

Participants who qualify for LTD benefits receive:

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

How to Apply for Expanded LTD Benefits

If you believe you may need to apply for Expanded LTD benefits, you should contact Work Connections at: 734-615-0643. Work Connections will work with you to obtain the necessary information. If it appears you may qualify for Expanded LTD benefits, Work Connections will coordinate the application process with the Benefits Office and the external LTD Claims Administrator. For more information on Work Connections, see page 90.

Definition of Disability

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

Leaves Affect Coverage

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

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

Cost of Expanded LTD Coverage

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

For information on the cost of coverage after you have two years of service, refer to the section “Your Years of Service Count” on the previous page. To calculate your monthly cost for the Expanded LTD plan, visit

hr.umich.edu/expanded-ltd-cost-calculator

Should You Enroll in this Plan?

Below are questions to consider when making your decision.

- What is your plan for medical insurance if you are unable to work? Can you go to a spouse’s plan? Do you have coverage from another company? If you do not have another source of medical insurance for you and your dependents, the Expanded Long-Term Disability (LTD) plan could meet your needs.
- If you are unable to work, what will be your source of financial support? Do you have a spouse, partner, parents, or foreign government that would offer financial support? If not, you may want the Expanded LTD plan.
- What are your plans for retirement income for you your spouse or partner? If you become disabled and contributions to your retirement plan stop, are you and your spouse financially prepared for your retirement years? If not, you may need the Expanded LTD plan.
- Do you have long-term disability coverage through a professional group? Does it provide medical insurance and retirement contributions? If not, you may want to enroll in the Expanded LTD plan.

Basic Long-Term Disability

The Basic Long-Term Disability (LTD) Plan is available to AFSCME members only, after four years of service. The Basic LTD plan pays up to \$1,200 per month, when you become totally disabled. The plan also pays the cost to continue most of the benefits you have at the time of disability. Income benefits from the plan are coordinated with income from public programs, such as Social Security. The maximum combined benefit you can receive from the Basic LTD plan and a public program is the greater of 75% of your pre-disability base salary or your pre-disability net income. In any case, the maximum payable income benefit under the provisions of the Basic LTD plan is \$1,200 per month.

Eligibility

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

Enrollment

At four years of service, AFSCME members will be automatically enrolled in the Basic LTD plan. The university pays the cost of this plan for you.

If You Become Disabled

Participants who become disabled receive:

- 50% salary replacement up to \$1,200 per month, or
- 75% salary replacement coordinated with income from a public program up to the monthly \$1,200 maximum. For AFSCME staff members, the pre-disability net monthly base income is used for coordination if it is more than 75% of your gross monthly pre-disability base salary. For example, if your pre-disability net monthly income is \$2,000 and you receive monthly Social Security disability income in the amount of \$800, the Basic LTD plan will pay \$1,200 per month ($\$2,000 - \$800 = \$1,200$), and

- Basic Retirement Savings Plan contributions
- Payment of premiums for the following benefits in which you and your dependents are actively enrolled prior to the disability, such as:
 - Health Plan
 - Prescription Drug Plan
 - Dental Plan Option 1
 - Group Life Insurance (employee only)

How to Apply for Basic LTD Benefits

If you believe you may need to apply for Basic LTD benefits, you should contact Work Connections at: 734-615-0643. Work Connections will work with you to obtain the necessary information. If it appears you may qualify for Basic LTD benefits, Work Connections will coordinate the application process with the Benefits Office and the external Claims Administrator. For more information on Work Connections, see page 90.

Definition of Disability

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

Leaves Affect Coverage

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

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

Cost of Basic LTD Coverage

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

Flexible Spending Accounts

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.

For a list of covered FSA expenses, visit the Inspira Financial website, inspirafinancial.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 Inspira Financial website, inspirafinancial.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, Inspira Financial, provides an online FSA Calculator to help you determine how much to contribute to your FSA account, and lets you know how much you can save by using pre-tax dollars to pay for eligible health care, dental/vision, and/or dependent care expenses. The 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, Inspira Financial, will process claims for reimbursement from your 2024 FSA account.

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

- Mail your claims directly to Inspira Financial. The mailing address is:
Inspira Financial
P.O. Box 8396
Omaha, NE 68108-0396
- Or fax to Inspira Financial toll-free at (855) 703-5305
- Submit claims online: Login at inspirafinancial.com, enter your claim information and fax or upload your receipts.
- File Claims using the Inspira Financial 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 inspirafinancial.com.
- Inspira Financial pays claims on a daily basis
- Check your account balance and view transactions, and claim histories at: inspirafinancial.com.
- Inspira Financial can directly deposit your reimbursements to your bank account.
- View inspirafinancial.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 Inspira Financial website at: inspirafinancial.com and review the Flexible Spending Account Eligible Expense Guide. Contact Inspira Financial at (877) 343-1346 if you have questions about whether a particular expense is eligible.

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, 2024. Your balance must be \$0.00. Otherwise, you will not be eligible for HSA contributions until Apr. 1, 2025.
 - 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 Inspira Financial FSA Calculator at inspirafinancial.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 Inspira Financial 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 2024 FSA and you wish to participate in 2025, 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 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 Inspira Financial at: 877-343-1346, or visit inspirafinancial.com

Tax Savings

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

University HR website:

hr.umich.edu/flexible-spending-accounts

Business Travel Accident Insurance & Travel Assistance

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

Plan Summary

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

Travel Assistance

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

Filing a Claim

Your department representative or a family member should call the SSC Contact Center to file a claim by calling 734-615-2000 or 1-866-647-7657 (toll free).

Travel Registry

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

Visit global.umich.edu for more information on business travel abroad.

hr.umich.edu/business-travel-accident-insurance

Group Term Life Insurance

MetLife Administers These Plans

The university offers three group term life insurance plans to eligible faculty and staff:

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

Plan Highlights

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

University Life Insurance Plan

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

Optional Life Insurance Plan

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

- If you are a nonsmoker, you receive a discount on the Optional Plan premium. A nonsmoker is defined as a person who has not smoked for 12 months.
 - You will be defaulted to the higher standard (e.g. smoker) rate unless you update your smoker status.
- To find your smoker status, visit wolverineaccess.umich.edu > Employee Self-Service > Benefits > Display Benefits Plan Rates > Life Plan Rates
- If your coverage is based on your salary, under the

Optional Plan, the amount of coverage you choose and its cost may increase when your salary increases. Your cost may increase similarly when you move into a higher age bracket.

- If you are enrolled in the Optional Plan, you are eligible for simple will preparation services provided by attorneys who participate in the MetLife Legal Plan Network.
- You may cancel at any time, but if you wish to re-enroll you will be required to furnish evidence of insurability (a health statement) that is satisfactory to MetLife Insurance Company of America. MetLife may also require a physical examination.

How to Enroll in the Optional Plan

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

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

Application Form

The application form is available from the University HR website: hr.umich.edu/life-insurance-forms-documents or by request from the SSC Contact Center.

What You Pay for Your Optional Life Insurance Plan Coverage

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

Calculate your monthly rate using the rate table.

- If you choose a flat dollar amount of coverage, multiply your rate by the amount of coverage you choose and divide by 1,000 to get your monthly rate.
Example:
Age 30-34, Non-Smoker, \$50,000 of coverage
 $(\$0.023 \times \$50,000) / 1,000 = \$1.15$ monthly rate
- If you choose coverage based on a multiple of salary, multiply your rate by your annual salary, then multiply by the level of coverage you choose (1 to 8). Divide by 1,000 to get your monthly rate.
Example:
Age 30-34, Non-Smoker, \$20,000 salary, 4 x salary coverage
 $(\$0.023 \times \$20,000 \times 4) / 1,000 = \1.84 monthly rate

Health Statement

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

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

You will need to submit a health statement if you:

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

Effective Date

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

2024 Monthly Rate Per \$1,000 of Coverage		
AGE	STANDARD	NON-SMOKER RATE
<30	\$0.021	\$0.010
30 - 34	\$0.023	\$0.021
35 - 39	\$0.028	\$0.025
40 - 44	\$0.043	\$0.037
45 - 49	\$0.074	\$0.063
50 - 54	\$0.122	\$0.104
55 - 59	\$0.191	\$0.162
60 - 64	\$0.296	\$0.269
65 - 69	\$0.531	\$0.448
70 & older	\$0.952	\$0.620

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

Your Beneficiary

When you elect life insurance coverage of any kind for the first time, you must complete the beneficiary designation on the MetLife website at: metlife.com/mybenefits

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

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

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

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

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

Beneficiary Changes

You may change your beneficiary at any time. When your family status changes, you may wish to change your beneficiary. If you are not sure whom you have named as your beneficiary, you may want to update your designation by submitting a beneficiary change on the MetLife website at: metlife.com/mybenefits

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

Beneficiary Confidentiality

To protect your privacy, the Benefits Office, the Shared Service Center, and MetLife cannot tell you the names of your beneficiary designations over the phone.

Your Coverage in Retirement

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

- The amount for which you were insured on your date of retirement from the university, or
- The amount applicable to your age and your completed years of continuous service (find the age and years of service that applies to you in the "Amounts of Insurance" chart below).

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

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

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

Dependent Plan

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

Spouse or Other Qualified Adult

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

Dependent Children

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

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

Your dependent child may remain enrolled in the Dependent Plan as long as he/she is under age 26, unmarried, and supported by you.

Beneficiary

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

Continuation of Coverage

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

Terminating Coverage

You can terminate dependent coverage at any time. To do so, complete a Group Life Insurance Withdrawal Form available from the University HR website or the Shared Service Center.

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

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

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

Dependent Life Insurance Coverage Options and Monthly Rates		
COVERED DEPENDENT	COVERAGE AMOUNT	2024 COST PER MONTH
Spouse/OQA	\$10,000	\$1.56
Spouse/OQA	\$25,000	\$3.90
Spouse/OQA	\$50,000	\$7.80
Spouse/OQA	\$100,000	\$15.60
Children	\$2,000 per child	\$0.10
Children	\$5,000 per child	\$0.26

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

Dental Plan

Delta Dental of Michigan Administers This Plan

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

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

Three Dental Plan Options Available

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

If you enroll in Options 2 or 3, Delta will pay toward restorative and major services. Even greater savings are reached by using a Delta PPO or Delta Premier participating dentist. Please refer to the benefit comparison chart on pages 69–70 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 the University HR website.

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 Work?

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

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

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

Delta Dental will pay the PPO dentist directly for covered services based on his or her submitted fee or the amount in the local Delta Dental's PPO dentist schedule, whichever is less.

If the PPO dentist schedule amount is lower than the dentist's submitted fee, the dentist cannot charge you the difference. This means you will be responsible only for your copayments and deductible, if any, when you go to a PPO dentist for covered services (see the coverage comparison chart on pages 69-70). PPO dentists will also fill out and file your claim forms.

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

Delta Dental will pay the Premier dentist directly for covered services based on his or her submitted fee or the local Delta Dental maximum approved fee, whichever is less. If the maximum approved fee is lower than the dentist's submitted fee, the dentist cannot charge you the difference.

As with PPO dentists, this means you will be responsible only for your copayments and deductible, if any, when you go to a Premier dentist for covered services (see the coverage comparison chart on pages 69-70). And, like PPO dentists, Premier dentists will fill out and file your claim forms for you.

What if I go to a Nonparticipating Dentist?

If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier, you will still be covered (see the coverage comparison chart on pages 69-70). However, you could save more of your out-of-pocket expenses if you go to a dentist that participates with Delta Dental. Delta Dental will pay you directly for covered services based on the dentist's submitted fee or the local Delta Dental's nonparticipating dentist fee, whichever is less. You will be responsible for paying the dentist whatever he or she charges.

How Can I find a Participating Dentist?

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

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

The University of Michigan School of Dentistry and Community Dental Center provide dental service to the general public and participates with Delta Dental for insurance coverage. To confirm the Delta Dental network participation level, call the Dental School Patient Business Office at (734) 647-8383. Visit the School of Dentistry website for more information: dent.umich.edu/patients

ID Card

Delta Dental does not require ID cards. When visiting a Delta Dental dentist, simply provide your eight-digit UMID

or your Social Security number. The dental office can use that information to verify your eligibility and benefits through Delta Dental's website or toll-free number. If you still would like an ID card, you can print a customized ID card on demand using Delta Dental's Consumer Toolkit online.

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

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

Preauthorization

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

Where Can I find Additional Information Regarding the Dental Plan?

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

- View the Dental Plan section on the University HR website: hr.umich.edu/dental-plan
- Call Delta Dental Customer Service at: 800-524-0149.
- Register and log onto Delta Dental's Consumer Toolkit. See below for instructions on how to access and use the Toolkit.

Delta Dental Consumer Toolkit toolkitsonline.com

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

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

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

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

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

Summary of Dental Plan Benefits

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

Delta Dental PPO (Point-of-Service) Program									
University of Michigan Group No. 5970	Option 1			Option 2			Option 3		
Sub Group Numbers: Active Employees	1001			2001			3001		
Sub Group Numbers: LTD, COBRA, Retirees & Survivors	1099			2099			3099		
Delta Dental Network Participation Level	PPO	Premier	NonPar	PPO	Premier	NonPar	PPO	Premier	NonPar

Class I

Diagnostic and Preventive Services —Used to diagnose and/or prevent dental abnormalities or disease. Includes prophylaxes, including periodontal prophylaxes, and routine oral examinations/evaluations payable twice in a calendar year. (People with certain high-risk medical conditions or with a documented history of periodontal disease may be eligible for two additional prophylaxes.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Radiographs —Including one set of bitewing x-rays in a calendar year and either a panoramic film or one set of full mouth x-rays once in any five-year period.	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sealants —Sealants are payable on permanent bicuspid and molars once per tooth per lifetime to age 16.	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatment —Preventive fluoride treatments are payable once in a calendar year for people up to age 19. (People over age 19 with certain high-risk medical conditions may be eligible for additional prophylaxes or fluoride treatment.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Space Maintainers —Space maintainers are payable for people up to age 19.	100%	100%	100%	100%	100%	100%	100%	100%	100%

Class II

*Emergency Palliative Treatment —Used to temporarily relieve pain.	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Occlusal Guards —Payable once in a five-year period.	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Periodontal Scaling & Root Planing	100%	100%	100%	100%	100%	100%	100%	100%	100%
*Periodontal Maintenance —Two additional prophylaxes or periodontal maintenance procedures will be covered for individuals with a documented history of periodontal disease. (No more than four prophylaxes [cleanings] and/or periodontal prophylaxes or maintenance procedures will be payable in a calendar year.)	100%	100%	100%	100%	100%	100%	100%	100%	100%
All Other Periodontics —Used to treat diseases of the gums and supporting structures of the teeth	0%	0%	0%	100%	60%	60%	100%	100%	100%
Oral Surgery —Extractions and dental surgery, including preoperative and post-operative care.	0%	0%	0%	100%	60%	60%	100%	100%	100%
Minor Restorative Services —Used to repair teeth damaged by disease or injury (for example, fillings).	0%	0%	0%	100%	60%	60%	100%	100%	100%
Endodontics —Used to treat teeth with diseased or damaged nerves (for example, root canals).	0%	0%	0%	100%	60%	60%	100%	100%	100%

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

IMPORTANT

This chart is intended to provide basic information about services covered by the University of Michigan Dental Plan. It is not intended to be a full description of the plans offered by the University of Michigan. If you choose a dentist who does not participate in either the PPO or Premier program, you will be responsible for any difference between Delta Dental's allowed fee and the Dentist's submitted fee, in addition to any applicable copayment or deductible. Other limitations and exclusions apply. For additional plan information, 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	<ul style="list-style-type: none"> There is no calendar year maximum dollar amount applied to covered Class I and II services under Option 1. A \$1,500 per person total lifetime maximum applies to covered orthodontic Class IV Benefits. This is a combined maximum under all plan options, even if you change dental plan options from year to year. 	<ul style="list-style-type: none"> \$1,250 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 plan information, details on how claims are paid, exclusions and limitations for the dental program, visit 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 dental care when they are outside of the United States through the AXA Assistance worldwide network of dentists and dental clinics.

How to find a Dentist

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

What Dental Services are Covered

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

Filing Claims

When you receive dental care outside the U.S., you pay the dentist and file a claim for reimbursement with Delta Dental when you return from your trip. Be sure to get an itemized receipt for all dental services you receive. The receipt should include the dentist's name and address, the services performed, and an indication of which tooth or teeth received treatment. It should also note if the dentist's charges were billed in U.S. dollars or the local currency. Claim forms are available from the University HR website. 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

How the Vision Plan Works

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

To access plan information and find a provider:

1. Go to metlife.com/mybenefits
2. Select "Find a Vision Provider"
3. Choose "Davis Vision by MetLife"
4. 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. The reimbursement form can be downloaded from the University HR website.

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

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

Davis Vision by MetLife provides a comprehensive eye exam, including a review of your case history, health status of the visual system, refractive status evaluation, binocular function, diagnosis, treatment, and dilation as professionally indicated. Davis Vision by MetLife also provides a materials benefit providing you access to eyeglasses or contact lenses. 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 Davis Vision by MetLife Plan brochure and at hr.umich.edu/vision-plan.

Laser Vision Correction Services

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating provider's normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please 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 Davis Vision at 833-393-5433 to speak to a representative. For details, visit hr.umich.edu/vision-plan.

Eye Exams

Your health plan may cover your vision exam. See Vision Care on the chart on page 44 and/or contact your health plan office directly to ask if your plan covers vision exams.

\$ Saver Tip

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

No ID Card for the Vision Plan

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

Warranty

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

Summary of Benefits

The Vision Care Plan Benefits Description is available on the University HR website 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.

The Vision Plan covers the following services once each calendar year.		
Service/supply plan benefits ¹	Davis Vision Provider Maximum Benefit Payment	Non-Davis Vision Provider Maximum Benefit Payment
Comprehensive eye exam²	Covered in full	\$30
Single-vision lenses	Covered in full	\$25
Bifocal lenses	Covered in full	\$35
Trifocal lenses	Covered in full	\$45
Eyeglass frames	Fashion, designer, and premier collections covered in full or receive a \$50 wholesale credit toward a network provider's own frame.	\$30
Scratch-resistant coating	Covered in full	N/A
Blended invisible bifocals	Covered in full	N/A
Ultraviolet (UV) coating	Covered in full	N/A
Contact lenses in lieu of eyeglasses^{3,4} Davis Vision Contact Lens Collection (Includes evaluation, fitting, follow-up): <ul style="list-style-type: none"> ▸ Standard/Daily: one pack of lenses. ▸ Disposable: Four boxes/multi pack ▸ Non-Plan contact lenses 	Covered in full In lieu of Davis Vision Contact lenses, a \$105 retail credit will be applied toward contact lenses from the provider's own supply of contact lenses, evaluation, fitting and follow-up care	\$75 N/A

- ¹ Benefits include oversize lenses, blended invisible bifocals, certain fashion frames and sun tinting of plastic lenses, gradient tints, glass gray #3 prescription sunglasses, and initial lenses following cataract surgery. Materials carry a one-year warranty against breakage. Discounts are available for additional prescription glasses. Ask your provider if they are willing to extend a discount on non-prescription eyewear.
- ² Your health plan may cover your vision exam. See Vision Care on the chart on page 44 and/or contact your health plan office directly.
- ³ Contact Davis Vision to verify the applicable co-pay and that your brand of contacts is covered before you enroll.
- ⁴ Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. Routine eye examinations may not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

metlife.com/insurance/vision-insurance

Legal Services Plan

MetLife Legal Services Administers This Plan

Low-cost Help with a Variety of Legal Matters

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

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

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 Services attorney will give you a written fee agreement in advance. That means you will know from the start what those services will cost you. To obtain a fee schedule, call MetLife.

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

info.legalplans.com

MetLife Legal Plan

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

Legal Plan Book

For more information, view the Legal 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 Services are Covered through U-M Optional Life Insurance

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

3. Graduate Student Benefits

Review the charts on pages 9-15 to identify the benefits available to your graduate student group and for details on dependent benefits eligibility.

For all eligible graduate students, application for benefits must be made within 30 days of your date of hire or newly eligible status. If you do not elect to enroll or do not waive medical and/or dental, you will be automatically enrolled in the GradCare health plan and the Dental Option I plan at single person coverage. You will be notified by email when you are eligible to enroll. You will enroll using Self Service> Benefits as instructed in the email message.

A Change in Appointment

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

Spring/Summer Continuation

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

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

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

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

Summer Coverage

To learn about continuation of GradCare through the summer, view the GradCare information on the University HR website at hr.umich.edu/gradcare or call the SSC Contact Center.

Effects of Changes on Health Care Eligibility

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

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

Assignments Outside the GradCare Service Area

If your assignment takes you off campus, download the form from the University HR website at: hr.umich.edu/gradcare or call to request a form from the SSC Contact Center. Your department must authorize and submit the form to BCN.

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

See the University HR website for information on continuing your GradCare health plan coverage.

Visit the BCN website to designate or change your primary care physician, update your address with BCN, or request a replacement ID card:

mibcn.com

4. Changes to Your Benefits

Qualified Family Status Change

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

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

Different qualifying events allow different benefit changes. Any change you make mid-year must be consistent with your change in status and the event must affect eligibility for coverage under the plan. For example, if you get married, you can add your new spouse to your health coverage, but you cannot drop your children from your health coverage. For more information, visit hr.umich.edu/life-events

Moving Out of a Managed Care Plan Service Area

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

Dependents of International Students/Scholars Entering the Country

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

If your F-2 or J-2 dependents intend to join you later, you need to add them to your health coverage within 30 days of their arrival in the U.S. Remember that they must have health insurance too. You will be asked to provide a copy of your F-2 or J-2 spouse and dependents' flight ticket/confirmation or their admission stamp, or paper or print-out of electronic Form I-94 as documentation of their arrival date. Call the SSC Contact Center at 734-615-2000 locally, or 1-866-647-7657 (toll-free for off-campus long-distance calling within the U.S.) for assistance.

Deadline for Reporting Changes in Family Status

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

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

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

Removing Dependents Who Lose Eligibility

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

Further, failure to notify the Shared Services Center or the SSC Benefits Transaction Team within 60 days of the dependent's loss of eligibility will result in forfeiture of that dependent's COBRA continuation rights. In providing this notice, you must use the form entitled "Notice of COBRA Qualifying Event." You may obtain a copy of this form at no charge by calling the SSC Contact Center, or you can download the form from the at hr.umich.edu/health-plan-forms-documents

Refer to page 85 for information concerning COBRA. In addition, information regarding your rights under COBRA is available on the University HR website at: hr.umich.edu/cobra

Ex-Spouse

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

Age 26 Dependent Child

Children who turn age 26 in 2024 will be automatically removed from coverage at the end of the month they turn 26, and offered COBRA.

Questions?

If you have any questions about your dependent's eligibility for benefits or making changes to your coverage, call the SSC Contact Center at: 734-615-2000 locally, or 866-647-7657 (toll-free for off-campus long-distance calling within the U.S.), 8 a.m. – 5 p.m., Monday - Friday.

Change in Your Appointment

If at any time your hours decrease to less than 50%, you become ineligible for health, life insurance, dental, and prescription drug benefits (does not apply to House Officers, Research Fellows, GSIs, GSSAs, or GSRAs).

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

hr.umich.edu/esr-for-employees. Expanded Long-Term Disability ceases if you have less than five years of service.

Leaves of Absence

Questions about leaves should be directed to the Office of Recruiting and Employment Services or Michigan Medicine Human Resources. Leaves of absence are approved by your department and staff HR rep. There are several kinds of leaves, and the effect on your benefits may vary. When your leave is approved, you will receive information about benefits continuation at your home address.

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

Address Update

As a university employee, it is your responsibility to keep your address updated with the university. See "Update Your Address Listing," page 5.

COBRA information will be mailed to you at your last known home address.

If your employment terminates for any reason, contact the SSC Contact Center before you leave to make sure your address is correct.

Change Forms

Forms for making changes to your benefits are available on the University HR website at: hr.umich.edu/benefits-wellness

When You Leave the University

Your Benefits When Your Employment Ends

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

Health, Dental, and Vision Plans

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

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

Following your termination, COBRA enrollment materials will be sent to your last known home address. Update your address with the university before your employment end date. See Update Your Address Listing on page 5.

Long-Term Disability

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

Group Life Insurance

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

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

Basic Retirement Savings Plan

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

You may withdraw or rollover your employee contributions and earnings at any age after you have terminated your employment. The university contribution and earnings are available at age 55 or older after you have terminated. Contact TIAA and Fidelity when you wish to make a withdrawal.

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

403(b) SRA and 457(b)

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

Legal Services Plan

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

Health Care Flexible Spending Account

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

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

Dependent Care Flexible Spending Account

Dependent Care Flexible Spending Account participants may continue to submit reimbursement requests for eligible expenses incurred before the end of the calendar year. Payment of claims will be based on the balance in the participant's account. Any balance remaining in your Health Savings Account when you leave the university is yours to keep. The university will no longer contribute to your HSA and you will be responsible for all account maintenance fees. Contact [HealthEquity.com](https://www.healthequity.com) for more information.

Important Deadline

You have only 60 days following your loss of eligibility for benefits to elect COBRA coverage. If you do not receive your COBRA information within a reasonable length of time (no longer than 14 days from your last day of benefits coverage), you need to call the SSC Contact Center immediately.

Update Your Address

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

- Change it online in Wolverine Access at: wolverineaccess.umich.edu, or
- Call the SSC Contact Center at: 734-615-2000 or 866-647-7657 (toll free). SSC unavailable daily from 1 – 2 p.m.

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

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

Your Benefits When You Retire

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

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

Retirement Eligibility Point System

Retirement eligibility is determined by a point system. The number of points you have at a given time is equal to your age plus your years of continuous eligible service at the university. From now on, 80 points will be required to retire. For example, if Robert is age 65 in 2024 and has worked at U-M for 15 continuous years, he will have 80 points and will be eligible to retire ($65 + 15 = 80$).

Visit the University HR website for more information on service requirements to retire and associated benefits. Go to hr.umich.edu/retirement-planning

Individuals who belong to a union or bargaining unit should check with the terms of the collective bargaining agreement regarding eligibility to retire.

Determination of Years of Service

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

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

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

If You Retire Under Age 62

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

Date of Service Prior to January 1, 2013 and Retire on or after January 1, 2021

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

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

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

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

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

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

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

Your Benefits After You Retire

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

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

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

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

Under specific conditions, these benefits, except group life insurance, can continue for a surviving spouse and eligible dependents.

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

How Medicare Affects Your Coverage After You Retire

Medicare becomes the primary coverage for you and any covered dependents age 65 years of age or older, or disabled once you have retired. On the first day of the month that you turn age 65, your coverage with the university will be changed so that the university's coverage will not pay for anything that Medicare Parts A and B would have paid for. You can phone 800-772-1213 (TTY 1-800-325-0778) to schedule an appointment with a Social Security counselor at an office near you or to request the enrollment forms by mail.

Retirees and their dependents must enroll in Medicare Parts A and B benefits when first eligible. If you or a dependent who is eligible for Medicare fail to enroll when first eligible, your benefits will be drastically reduced until you are enrolled. U-M health care plan will not pay for services that would have been paid primarily by Medicare if Medicare enrollment had occurred. There may be a penalty for late Medicare enrollment of 10% a year for each year you could have been enrolled.

Your U-M coverage becomes secondary or supplementary to Medicare.

All services must be submitted to Medicare first for payment.

Waiving Coverage

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

Individuals with a service date on or after July 1, 1988 who have to pay the full cost of benefits because they retire under age 62 may choose to waive U-M coverage at retirement. Such individuals who choose to waive coverage are eligible for re-enrollment in U-M medical and/or dental coverage at age 62 providing the retiree maintains continuous comparable medical and/or dental coverage through another source and requests re-enrollment by contacting the SSC Contact Service Center within 30 days of turning 62 years of age. Certification that

comparable coverage has been maintained will be required. Effective the first of the month after reaching age 62, the university will provide its contribution toward the cost of benefits.

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

Maintaining Comparable Medical and Dental Coverage

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

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

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

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

Loss of Comparable Coverage

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

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

the other medical or dental coverage is involuntarily lost and provide satisfactory evidence as requested by the Benefits Office that all requirements for reenrollment have been satisfied. Coverage will go into effect the day following the termination of the other coverage.

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

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

1. You and/or your spouse or dependents were eligible for medical and dental insurance at the time of your retirement from the university;
2. Coverage has been continuously maintained in another group medical or dental plan; that is, there has been no lapse in coverage between the time you waived university coverage and later apply for coverage;
3. A completed and signed Request to Waive Retiree Coverage form is submitted to the SSC Benefits Transaction Team within 30 days of the date you request waiver of your retiree benefits;
4. You must request enrollment within 30 days after

5. Important Federal Notices

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 38-46, a document called a Summary of Benefits and Coverage (SBC), is also available on the University HR website.

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

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 the Health Care Reform website at: 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 medical and/or dental benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a limited period of time.

If you need to remove ineligible dependents from your benefits, do not remove them when you make your Open Enrollment elections. If you do, continuation of

benefits under the federal COBRA law will not be available to them. Your dependent children who become ineligible due to age limits will be automatically dropped from your group health coverage and will be sent information on coverage under COBRA provisions at that time. If dependents become ineligible for reasons other than age ineligibility, you must complete and return a Notice of Qualifying Event form to SSC Benefits Transactions within 60 days of the loss of eligibility. The form is available on the University HR website at: hr.umich.edu/cobra 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 out-side 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 University HR website at: hr.umich.edu/forms, 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 call toll free 866-647-7657.

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

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. (For a list of participating states, visit healthcare.gov) 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-KIDSNOW or visit insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

HIPAA Privacy and Security

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

Please read U-M’s Commitment to HIPAA Compliance and the Privacy Notice, which explains how the Benefits Office and the university use and protect PHI, at:

hr.umich.edu/hipaa

Read the information carefully and call 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 in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers 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-of-network services toward your deductible and out-of-pocket limit.

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

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

6. Workplace Resources

Faculty and Staff Counseling and Consultation Office (FASCCO)

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

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

Services include:

- Counseling
- Supervisory Consultations
- On-Going Support Groups
- Mental and Emotional Health Presentations
- Personalized Coaching Services

What to Expect When Contacting FASCCO

Since the FASCCO counseling staff are licensed mental health professionals everyone will be required to complete some brief intake forms and review and complete a "Statement of Understanding" that provides an overview of Confidentiality policies and guidelines.

In the initial assessment session(s) with a FASCCO counselor will include the following.

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

Phone 734-936-8660
Email fascco@umich.edu

Michigan Medicine Office of Counseling and Workplace Resilience

The Office of Counseling and Workplace Resilience is an assessment, referral, consultation and short-term counseling service for the employees of Michigan Medicine.

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

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

- Mental Health Concerns
- Crisis Resolution
- Marital/Family/Partner Issues
- Grief/Loss
- Financial Concerns
- Alcohol Use and Other Drugs
- Work Relationships
- Unit or Department Reorganization or Change
- Job Stress

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

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

Phone 734-763-5409
Email counseling@med.umich.edu
Web counseling.med.umich.edu

Mediation Services for Faculty and Staff

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

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

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

Phone 734-763-0235

Email mediation.services@umich.edu

Web ecrt.umich.edu/resolution-options/mediation/

Work Connections

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

The program will:

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

Phone 734-615-0643

Toll Free 877-869-5266

Fax 734-936-1913

Email work.connections@umich.edu

Web workconnections.umich.edu

Child and Family Care

Child and Family Care (formerly Work-Life Programs) provides information and resources to support your personal life while maintaining your professional responsibilities. Resources for the university community include:

- Child care resources including databases of all state-licensed centers and homes
- U-M Children's Centers information and apply to the waitlist online
- Additional child care options and Care.com access, webinars, and Care Talks
- Campus Child Care Homes
- Kids Kare at Home occasional backup child care
- Family Helpers Posting Board
- Lactation resources including Campus and Michigan Medicine lactation rooms
- Elder care resources and adults and children with disabilities resources
- Connecting the Dots annual virtual conference

By advocating for enlightened policies, practices, and services, Child and Family Care contributes to the recruitment and retention of the highest-quality faculty, staff, and students.

Phone 734-936-8677

Email worklife@umich.edu

Web hr.umich.edu/worklife

Emergency Hardship Program

Sometimes, unforeseen and unavoidable circumstances such as sudden illness, family crisis, or natural disaster can result in a traumatic or emergency financial crisis for University of Michigan employees. The Emergency Hardship Program provides financial support to employees who are experiencing a qualifying financial hardship.

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

Email MHealthyResourceCoach@med.umich.edu

Web hr.umich.edu/emergencyhardship

7. 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 Savings 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
Inspira Financial	877-343-1346	inspirafinancial.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	

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).

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

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

Kent Seckinger
Director of Operations for Benefits

University of Michigan Board of Regents:

Jordan B. Acker
Michael J. Behm
Mark J. Bernstein
Paul W. Brown
Sarah Hubbard
Denise Ilitch
Ron Weiser
Katherine E. White
Santa J. Ono (*ex officio*)

A Non-discriminatory, Affirmative Action Employer.

Title IX Notice: Sex discrimination is prohibited by federal law through Title IX of the Education Amendments of 1972. The University of Michigan does not discriminate on the basis of sex in the education programs or activities that it operates, including admissions and employment. Title IX also prohibits retaliation against reporters of sex discrimination, including reports of sex discrimination against administrators and other employees, and the University of Michigan will investigate alleged retaliation for participation in the Title IX process. Inquiries concerning the application of Title IX may be made to the Title IX Coordinator and/or the Assistant Secretary of the United States Department of Education. Reports of sex discrimination, including sexual harassment, may be made to the Title IX Coordinator at (734) 763-0235, TTY (734) 647-1388 or ecrtooffice@umich.edu.

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

© 2023 Regents of the University of Michigan, Ann Arbor, Michigan 48109