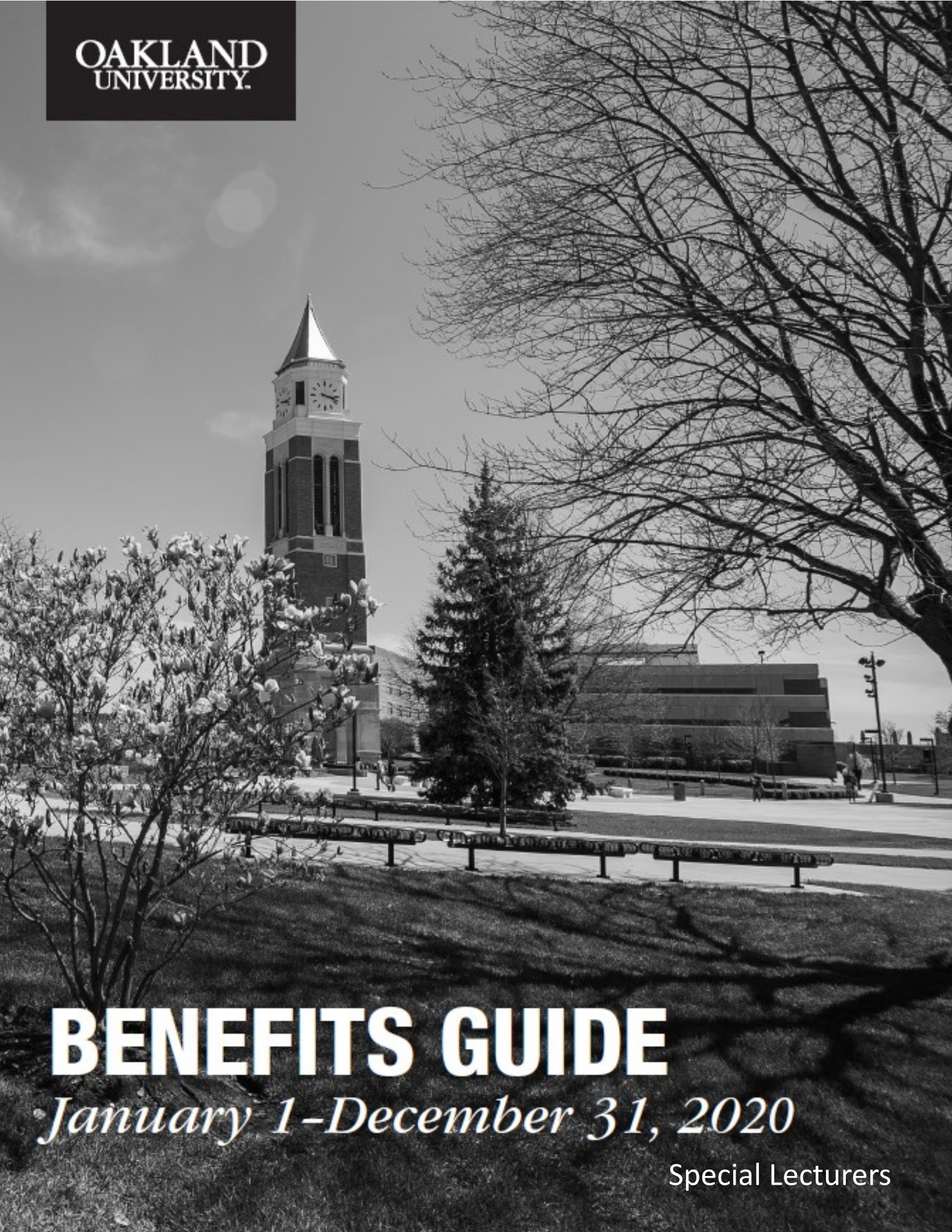
OAKLAND UNIVERSITY



BENEFITS GUIDE

January 1-December 31, 2020

Special Lecturers

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Important Information About Medicare

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 27-28 for more details.

2020 Contributions

Special Lecturers—Monthly Medical Premium Rates (Effective 1/1/20)

	Monthly Total Premium	Monthly OU's Contribution	Average Monthly Employee Contribution	Jan-Apr Employee Contribution	May-Aug Employee Contribution	Sept-Dec Employee Contribution
Blue Cross/Blue Shield—PPO						
Single	$603.00	$326.38	$276.62	$553.24	$0	$276.62
Two Party	$1,447.22	$783.32	$663.90	$1,327.80	$0	$663.90
Three or more	$1,809.02	$979.15	$829.87	$1,659.74	$0	$829.87
Blue Care Network—Healthy Blue Living HMO						
Single	$502.13	$326.38	$175.75	$351.50	$0	$175.75
Two Party	$1,205.11	$783.32	$421.79	$843.58	$0	$421.79
Three or more	$1,506.39	$979.15	$527.24	$1,054.48	$0	$527.24
Priority Health—Choice Buy-Up HMO						
Single	$650.06	$326.38	$323.68	$647.36	$0	$323.68
Two Party	$1,625.16	$783.32	$841.84	$1,683.68	$0	$841.84
Three or more	$1,950.18	$979.15	$971.03	$1,942.06	$0	$971.03
Priority Health—HealthbyChoice Achievements HMO						
Single	$508.21	$326.38	$181.83	$363.66	$0	$181.83
Two Party	$1,270.52	$783.32	$487.20	$974.40	$0	$487.20
Three or more	$1,524.65	$979.15	$545.50	$1,091.00	$0	$545.50
Delta Dental						
Single	$34.77	$22.60	$12.17	$24.34	$0	$12.17
Two Party	$68.81	$44.73	$24.08	$48.16	$0	$24.08
Three or more	$126.69	$82.35	$44.34	$88.68	$0	$44.34
Davis Vision						
Single	$4.89	$3.18	$1.71	$3.42	$0	$1.71
Two Party	$9.78	$6.36	$3.42	$6.84	$0	$3.42
Three or more	$12.22	$7.94	$4.28	$8.56	$0	$4.28
Blue Cross Vision						
Single	$3.90	$2.54	$1.36	$2.72	$0	$1.36
Two Party	$7.80	$5.07	$2.73	$5.46	$0	$2.73
Three or more	$12.95	$8.42	$4.53	$9.06	$0	$4.53

Introduction

It is time for our annual open enrollment. This is when you have an opportunity to reevaluate your benefit choices and make changes for the upcoming plan year. **Any changes you make will be effective January 1, 2020 and will remain in effect through December 31, 2020 unless you experience a qualifying event.**

Any changes or enrollment decisions must be completed online by midnight on Friday, November 1, 2019 for benefit changes to take effect January 1, 2020.

Deductions for your 2020 benefit elections will begin with **your first January paycheck**, with benefits effective on January 1, 2020.

Each medical and Rx plan offered through Blue Cross Blue Shield, Blue Care Network, and Priority Health has a corresponding Summary of Benefits and Coverage document available online. Paper versions are free of charge and are available upon request—please contact UHR for more information.

Oakland University will kick off 2020 Open Enrollment on October 21, 2019, as well as with a Benefit and Wellness Fair in the Oakland University Rec Center on Wednesday, October 23, 2019 from 9:00am to 3:00pm.

Online enrollment closes at midnight on Friday, November 1, 2019. If you have not completed your enrollment by that time, you will remain in your current benefits at the new 2020 rates, with the exception of the flexible spending accounts which will be discontinued.

What's Changing in 2020

Medical Plans:

- The Blue Care Network and Priority Health plans' Out-of-Pocket Maximums will increase to $7,900 for an individual and $15,800 for a family. Please see page 13 for additional information.
- Blue Care Network is implementing a new pharmacy program called Exclusive Specialty for its entire book of business. Currently, BCN members can fill specialty prescriptions at any in-network retail location. When members fill their prescription, their experience will differ based on pharmacy location. Some members may receive counseling from the pharmacist, while some may not. Members who fill specialty medications are often managing complex diseases and should receive coordinated support when filling their prescriptions.
    - Beginning on January 1, 2020, members who fill specialty medications will be required to fill their prescriptions through AllianceRx. Members can pick up their prescriptions at either a Walgreens pharmacy location or utilize the home delivery service.
    - This program is built to support the specialty pharmacy needs of members with care teams of pharmacists, patient care coordinators, and patient financial service experts dedicated to helping patients minimize financial burden.
    - Members will also have access to:

        * Monthly refill reminders
        * Adherence monitoring
        * Proactive side effect management
        * Member education to optimize therapy
        * Prescription expiration notices
        * 24/7 access to a pharmacist or nurse 365 days a year
        * Centers of excellence model to ensure only experts in a given disease state are caring for our sickest members
        * Injection training for newly prescribed members

Introduction

What's Changing in 2020 (continued)

Medical Plans (continued)

- BCBSM PPO members will have access to the Blue Cross Tobacco Coaching program, through WebMD, free of charge. Members will be eligible to participate in the Tobacco Coaching if they are ready to set a quit date within the following 30 days. Members must have used tobacco products within the seven days prior to their initial call to WebMD. Please note the following:
    - The program includes coaching on all tobacco products.
    - Members who participate in the program receive five calls from a specially-trained health coach over the course of 12 weeks. Members will also gain access to online resources and integration with the Digital Health Assistant program.
    - Members can make unlimited inbound calls to a health coach while enrolled in the program.
    - Health coaches are available seven days a week.
    - It is important to note that BCN members and Priority Health members currently have access to similar tobacco cessation programs, free of charge. There are no changes to the BCN and Priority Health programs.
        * Members who participate in the BCN Healthy Blue Living and Priority Health HealthbyChoice Achievements programs and smoke are required to participate in tobacco cessation programs in order to qualify for the Enhanced and Choice programs, respectively. The tobacco cessation programs have different requirements and timelines than the BCBSM Tobacco Coaching program for PPO members.
        * Priority Health HMO Buy-Up members have tobacco cessation support as well, through Priority Health Case Management. There are no changes to this program in 2020.

Flexible Spending Accounts

- The maximum amount you may elect to contribute to the Health Care Reimbursement Account will increase to $2,700, up from $2,650 in 2019. The Dependent Care Reimbursement Account maximum contribution is not changing for 2020 and remains $5,000.

InfoArmor and MetLaw

- Both the InfoArmor program and the MetLaw program have updated enrollment rules. The enrollment rules are summarized as follows:
    - If you are currently enrolled in either InfoArmor or MetLaw, you do not need to go online to re-enroll for 2020. Your participation in these benefits will continue in 2020 at the same level as 2019. This is a change from prior years.
    - If you are not currently enrolled in either InfoArmor or MetLaw, and you would like to enroll for 2020, you do need to go online to enroll for the first time. This is not a change from prior years.
    - You must go online if you choose to terminate either plan for 2020.

Action Steps

This Benefit Guide provides an overview of each plan. We encourage you to review the packet in its entirety. Additional documents can be found by clicking "Open Enrollment Materials" at UHR's benefit website.

Election Form—Online

- ❑ **All Employees must go online and confirm their benefits and covered dependents for 2020, except for Voluntary Life which is done through the UHR offices.**
  - **Even if you are making no changes for your 2020 enrollment, you are highly encouraged to go online and review your covered dependents.**

Flexible Spending Accounts

- ❑ If you want to participate in the Health Care Reimbursement and/or the Dependent Care Reimbursement Accounts in 2020, you must go online and enroll.

Medical

- ❑ Please carefully review the 2020 Medical plan options and HMO qualification requirements found on pages 9-15 of the benefit guide.
- ❑ If you are moving to, or switching between HMOs, you will need to be aware of requirements to qualify for the Enhanced (or Choice) plan.
- ❑ If you're enrolling for the first time in an HMO plan, a default Primary Care Physician (PCP) will be selected for you. You can change your PCP by either calling the carrier (using the number listed on the back of your ID card) or by logging in to the carrier website.

HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Eligibility

Coverage For You

All special lecturers are eligible for benefits on the first day of the month following date of hire.

Coverage For Your Dependents

You can cover yourself and your *eligible* dependents under the benefits offered by Oakland University. Your eligible dependents are:

- Your legal spouse;
- Your eligible children by birth, adoption or legal guardianship, until the end of the calendar year in which they turn 26 for medical coverage;
- For dependent life insurance, dependent children are covered until they reach age 19, or 26 if a full-time student.

You may cover Other Eligible Adults if the other adult satisfies all of the following:

- Resides with the employee and has done so for 18 continuous months prior to the individual's enrollment;
- Is 26 years of age or older;
- Is not a "dependent" of the employee as defined by the Internal Revenue Service;
- Is not married to any other party;
- Is not related by blood (child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin) or marriage;
- Is not the employee's landlord, tenant, or boarder;
- Is not an undocumented immigrant;
- The employee and the Other Eligible Adult are financially interdependent. Financial interdependence may be established by submission of proof of joint bank account, joint home ownership, or some other specified documented proof.

The employee is required to submit a signed Affidavit of Other Eligible Adult. The dependent child(ren) of the Other Eligible Adult is (are) eligible for membership providing all of the eligibility requirements for dependent children are met.

Coverage for Other Eligible Adults is available through BCN, Priority Health, Delta Dental, and Davis Vision.

Employee contributions toward insurance premiums are deducted from your paycheck pre-tax, and it is important to remember that Other Eligible Adults may not be considered tax-eligible dependents based on IRS definitions. If you are adding an Other Eligible Adult, please see the team in the Benefits Office to discuss this process further.

If you have any questions concerning the eligibility of your dependents, contact UHR.

Coverage For Your Dependents (continued)

As you know, we are committed to do all we can to manage the ever-increasing cost of health care. A key to controlling costs is to ensure that our benefit plans are providing coverage only to eligible dependents. To ensure that all of our health care dollars are being spent according to plan eligibility rules, we may conduct a university-wide dependent audit. In the event we do hold a dependent audit, your participation will be required to maintain coverage for your dependents.

We will provide you with notification in the event a dependent audit is held, and please note the following:

- If you are covering a dependent that does not meet the eligibility requirements, you can remove them from coverage during the annual open enrollment.
- We recommend that you start gathering the documents you may need to prove your relationship to your dependents. Acceptable documents are:
    - ⇒ For a spouse or OEA—a valid marriage certificate, a copy of your 2018 filed Federal income tax Form 1040 (just the first page, Social Security numbers and financial information can be blacked out), proof of joint bank account, proof of joint home ownership, or some other specified documented proof.
    - ⇒ For a child—a birth certificate, or a copy of your 2018 filed Federal income tax Form 1040 (just the first page listing your dependent child(ren), Social Security numbers and financial information can be blacked out), or a Qualified Medical Child Support Order, or Court paperwork for legal guardianship.

If you have any questions concerning the eligibility of your dependents, contact UHR.

Annual Elections & Life Status Changes

Pre-Tax Contributions

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year (January 1 – December 31).

Making Mid-Year Life Status Changes

The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

Ordinarily, employees may not change their cafeteria plan elections until open enrollment unless there are qualifying events. But in Notice 2014-55, which took effect Sept. 18, 2014, the Internal Revenue Service (IRS) created two new circumstances when employees may revoke their election for employer-sponsored health coverage under the cafeteria plan.

First, an employee whose hours of service are reduced to an average of less than 30 hours per week, but who still is eligible for group health coverage, may revoke the election for employer-sponsored health coverage to purchase a qualified health plan on one of the health care reform's public exchanges.

Secondly, an employee may cease coverage under the group health plan when he or she has purchased coverage on a public exchange (or marketplace), thus avoiding a period of duplicate coverage under the employer's group health plan and the marketplace coverage or a period of no coverage.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. **If you do not notify UHR within 30 days, you must wait until the next annual enrollment period to make a change.**

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

Annual Elections & Life Status Changes

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). **However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).**

In addition, 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. **However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.**

To request special enrollment or obtain more information, contact UHR.

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee's or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify UHR within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this document.

Medical/Rx Plan Overview

Medical coverage gives you financial protection against the high cost of treating a serious illness or medical condition. The Oakland University Medical/Rx Plans also provide coverage for preventive services, including annual physicals and well child care at no cost to you.

Your medical options are:

- Blue Cross Blue Shield of Michigan (BCBSM) — Community Blue PPO
- Blue Care Network (BCN) — Healthy Blue Living HMO
- Priority Health—Choice Buy-Up HMO
- Priority Health — HealthbyChoice Achievement (HbCA) HMO

PPO Option—Blue Cross Blue Shield of Michigan (BCBSM)

This is a PPO plan that affords you access to the BCBSM PPO network of providers. You don't need to choose a Primary Care Physician with a PPO — you can see any provider you want to see, even a specialist. You may go to any provider, whether they are in the BCBSM network or not.

- You can see non-PPO providers, but your benefits will be reduced and you'll pay more out-of-pocket.
- A participating provider must accept BCBSM's approved amount—they can't balance bill you for more than your deductible and coinsurance. A non-participating provider can balance bill you whatever amount s/he thinks is fair–there's no limit to what you can be charged.

Care at Non-Participating Providers

Coverage at non-participating hospitals (those who do not participate with BCBSM) is limited to care needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital care or care received at non-participating mental health or substance abuse facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

HMO Options — Blue Care Network (BCN) and Priority Health

Blue Care Network Healthy Blue Living (HBL) and Priority Health HealthbyChoice Achievements (HbCA)

The HMO plans provide incentives for our members to practice healthy behaviors.

When you enroll in an HMO, you select a primary care physician who coordinates all aspects of your medical care, including specialist referrals (when required). If you enroll in an HMO plan, you must receive all medical care from HMO doctors and hospitals; out-of-network care is not covered except in extreme emergency situations.

Each of the plans include two different levels of benefits with different cost sharing requirements.

- ***Enhanced (Choice) benefits*** have no deductible and the lowest copay requirements. You must qualify for Enhanced benefits either by meeting the specified qualifications or an alternative standard set by your primary care physician. Please note that Priority Health refers to their Enhanced benefit level as "Choice".
    - Visit the BCN (www.bcbsm.com) and Priority Health (www.priorityhealth.com) websites for more information on their provider networks. You'll also need to access these websites in order to fulfill the online qualification procedures for each plan.
- ***Standard benefits*** cover the same types of expenses as the Enhanced (Choice) plan, but include deductibles and higher copay requirements.

Medical/Rx Plan Overview

Priority Health Choice Buy-Up HMO

Priority Health also offers a "Buy-Up" option which allows employees to purchase Choice level benefits without meeting the qualification requirements. Note that the original HbCA plan is still available with the dual Standard/Choice level benefits at a lower cost to employees.

Prescription Drug Coverage

Prescription drug coverage is included with all the Medical plans. The amount you pay for each prescription depends on which plan you choose, and on whether the drug is a brand-name or generic medication.

Carriers routinely make formulary changes throughout the year. Oakland University has no control over when they make these changes and what changes are made.

Generics Save You Money

Generic utilization is mandatory for all Medical plans. If you choose to fill your prescription with a brand-name medication when a generic is available, you must pay the difference in cost between the approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug, plus your applicable copay (except on the BCBSM plan if your prescriber writes "Dispense as Written (DAW)").

Step Therapy and Prior Authorization

Step Therapy is mandatory for the BCBSM and BCN plans. This applies only to prescriptions being filled for the first time of certain targeted medications. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. If you have already tried the preferred medications, BCBSM or BCN will authorize the brand-name prescription. If you have no record of trying the preferred medication, you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication or your physician obtains prior authorization from BCBSM or BCN A list of select brand-name drugs targeted for step therapy is available at www.bcbsm.com along with the preferred medications.

90-Day Supply

To save money, you may have prescriptions filled for 90-day supply and you will only pay 1-2 times your applicable copay (depending on which plan you choose). Your doctor must write the prescription to be filled as a 90-day supply. You may receive a 90-day supply either at retail stores (through the HMO plans only) or through mail order. The mail order program allows you to obtain a 90-day supply of your prescription delivered right to your door.

BCN Exclusive Specialty

Members who fill specialty medications will be required to fill their prescriptions through AllianceRx. Members can pick up their prescriptions at either a Walgreens pharmacy location or utilize the home delivery service.

Medical/Rx Plan Overview

How To Navigate Your HMO Network

Oakland University's medical and prescription drug plans offered through Blue Care Network *(BCN)* and Priority Health are called Health Maintenance Organizations, or HMOs. BCN and Priority Health contract with physicians, hospitals, and other medical professionals to provide members with a variety of health care services. All of the services provided under BCN and Priority Health HMO plans must be provided by in-network providers, as HMO plans generally do not cover services provided by out-of-network providers.

Within the BCN Network

You must coordinate your care through your Primary Care Physician *(PCP)*, as your PCP is providing or managing all of your care. However, you may need to seek services from other doctors or specialists. This step will require a referral from your PCP, and possibly approval from BCN. You should seek services from your PCP first, and if your PCP cannot treat your condition they can then provide you with a referral to seek services from another doctor or specialist. There are a few exceptions to this rule:

- Women can see any obstetrician/gynecologist, or OB-GYN, in their plan's network for routine services such as Pap tests, annual well-women's visits, and obstetrical care without a referral from their PCP.
- Members can seek behavioral health services from in-network providers without a referral from your PCP.
- If you have an accidental injury or medical emergency, BCN will cover emergency treatment no matter where you go.

Within the Priority Health Network

You do not need to obtain a referral from your PCP in order to receive care from other doctors or specialists. The other doctors or specialists must participate in the Priority Health HMO network in order for those services to be covered under your plan.

Qualifying Members Who Reside Outside of the BCN Service Area

You can seek services in certain situations. Specifically, BCN provides limited services for dependents who are away at school. You must contact BCN to ensure you are properly listed as residing outside of the service area. Please note the following situations and appropriate action steps when needing to seek services within the US but outside of the service area:

- Emergency Care: Call 911 or go to the nearest emergency room.
- Urgent Care: Call BlueCard at 1-800-810-BLUE *(2583)*.
- Follow-up Care *(to treat or monitor a chronic condition)*: Call BCN Customer Service for details about your health benefits and required authorizations.
- Routine Care *(doctor's office for a minor illness)*: Call BlueCard at 1-800-810-BLUE *(2583)*.
- Other Services *(such as elective surgeries, hospitalizations, mental health, preventive care):* Call BCN Customer Service for details about your health benefits and required authorizations.

Qualifying Members Who Reside Outside of the Priority Health Service Area

You can seek the same level of coverage as you would if you lived in Michigan, but only if you utilize a provider that participates in the Cigna network. You must notify Priority Health that you reside outside of the service area and can do this by calling Priority Health customer service at 1-800-446-5674. Members do not have access to the Cigna network inside of Michigan.

Medical/Rx Plan Overview

PPO Benefit Summary

Below is a summary of the PPO plan. This is a benefits highlight sheet, so not all benefits and limitations are shown. For complete detail on the plan design, please review the carrier materials found on UHR's benefit website.

	BCBSM PPO	
	In-Network	Out-of-Network
Calendar Year Deductible (Single/Family)	$250/$500	$500/$1,000
Coinsurance	80%/20%	60%/40%
Calendar Year Coinsurance Max. (Single/Family)	$1,000/$2,000	$3,000/$6,000
Calendar Year Out-of-Pocket Max. (Single/Family)	$6,350/$12,700	$6,350/$12,700
Preventive Care	Covered 100%	Not covered
Office Visits (Med Necessary)	$20 copay	Covered 60% after deductible
Telemedicine Visits	$20 copay	Covered 60% after deductible
Urgent Care	$20 copay	Covered 60% after deductible
Emergency Room	$50 copay	$50 copay
Hospital Services	Covered 80% after deductible	Covered 60% after deductible
Physical, Speech and Occupational Therapy	Covered 80% after deductible, visit limits apply	Covered 60% after deductible, visit limits apply
Chiropractic Care	$20 copay, visit limits apply	Covered 60% after deductible, visit limits apply
Mental/Substance Abuse Treatment		
Inpatient	Covered 80% after deductible	Covered 60% after deductible
Outpatient	Covered 80% after deductible	Covered 60% after deductible
Prescription Drugs (30-day supply)		
Generic	$10 copay	$10 copay plus an additional 25% of the BCBSM approved amount
Preferred Brand	$20 copay	$20 copay plus an additional 25% of the BCBSM approved amount
Non-Preferred Brand	$20 copay	$20 copay plus an additional 25% of the BCBSM approved amount
90-day supply mail-order	2x applicable copay	Not covered

Medical/Rx Plan Overview

HMO Benefit Comparison

Below is a summary comparison of the HMO plans. This is a benefits highlight sheet, so not all benefits and limitations are shown. For complete detail on each plan design, please review the carrier materials found on UHR's benefit website.

	BCN Healthy Blue Living HMO		Priority Health		
	Enhanced	Standard	Choice Buy-Up HMO	HealthbyChoice Achievements HMO	
				Choice	Standard
Calendar Year Deductible (Single/Family)	$0/$0	$200/$400	$0/$0	$0/$0	$200/$400
Coinsurance	100%/0%	80%/20%	100%/0%	100%/0%	80%/20%
Calendar Year Coinsurance Max. (Single/Family)	None	$2,000/$4,000	None	None	$2,000/$4,000
Calendar Year True Out-of-Pocket Max. (Single/Family)	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800	$7,900/$15,800
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Office Visits (Med. Necessary)	$20 copay	$30 copay	$20 copay	$20 copay	$30 copay
Telemedicine Visits	$20 copay	$30 copay	Covered 100%	Covered 100%	Covered 100%
Urgent Care	$20 copay	$30 copay	$20 copay	$20 copay	$30 copay
Emergency Room	$100 copay	$150 copay	$100 copay	$100 copay	$150 copay
Hospital Services	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 100%	Covered 80% after deductible
Physical, Speech and Occupational Therapy	$20 copay, visit limits apply	$30 copay, visit limits apply	$20 copay, visit limits apply	$20 copay, visit limits apply	$30 copay, visit limits apply
Chiropractic Care	$20 copay, referral required	$30 copay, referral required	$20 copay, visit limits apply	$20 copay, visit limits apply	$30 copay, visit limits apply
Inpatient Mental/Substance Abuse Treatment	Covered 100%, when authorized	Covered 80% after deductible, when authorized	Covered 100%, when authorized	Covered 100%, when authorized	Covered 80% after deductible, when authorized
Outpatient	Covered 100%	$30 copay	$20 copay, when authorized	$20 copay, when authorized	$30 copay, when authorized
Prescription Drugs (30-day supply)					
Generic	$7 copay	$10 copay	$7 copay	$7 copay	$7 copay
Preferred Brand	$15 copay	$20 copay	$15 copay	$15 copay	$15 copay
Non-Preferred Brand	$30 copay	$50 copay	$30 copay	$30 copay	$30 copay
90-day supply retail or mail order	2x applicable copay	2x applicable copay	2x applicable copay	2x applicable copay	2x applicable copay

BCN—Healthy Blue Living HMO

You must qualify for the Enhanced level benefits each year. Your spouse/OEA does not have to complete the qualification requirements. This table is a summary of the qualification requirements. **Exact qualification requirements can be found on the BCN Qualification Form available on the UHR's benefit website.**

	BCN—Healthy Blue Living HMO
What plan do you start in?	New enrollees will start in the Enhanced plan. Members already enrolled will stay in the plan they were in at the end of the previous year (Enhanced or Standard).
What is the qualification period?	You have 90 days from your effective date for the initial requirements and 120 days for additional requirements (i.e. Smoking Cessation or Weight Management).
When will you move plans?	If you do not meet the initial qualification requirements within the first 90 days of the plan year, then you will move to Standard benefits as of the 91st day of the plan year. Some employees may need to complete additional requirements. If you fail to do so, you will move to Standard benefits as of the 121st day of the plan year.
What are the qualification requirements?	1. You must complete a confidential, online health assessment. 2. You must have your doctor complete the Qualification Form and return to BCN. 3. You must be tobacco free. 4. Your body mass index (BMI) must be under 30. 5. Your blood pressure must be under 140/90. 6. Your LDL cholesterol must be under 160 or under 100 based on risk factors. 7. Your fasting blood sugar or A1C for on-diabetics FBS must be <126mg/dL. 8. If you have symptoms of depression you must be seeking treatment. You must complete these initial qualifications in the first 90 days of the plan year and receive an A or B. If you use tobacco or have a body mass index of 30 or more, you will be required to enroll in tobacco-cessation programs or a weight management program within 120 days from the plan year's start. You must actively participate through the end of the year, in order to remain in Enhanced benefits. If you receive a "C" or do not pass any of the health measures you will be on the Standard benefits for the remainder of the year. The above summarizes the qualification requirements. See the Qualification Form for additional detail.
Are reasonable alternatives available if you do not pass one of the wellness targets?	If you use tobacco or have a body mass index of 30 or more, you will be required to enroll in tobacco-cessation programs or a weight management program within 120 days from the plan year's start. You must actively participate through the end of the year, in order to remain in Enhanced benefits.

In the event the information provided in this benefit guide deviates from the information provided in the carrier materials, the carrier materials will always rule. Please review the carrier materials carefully before making your benefit election.

Medical/Rx Plan Overview

Priority Health—HealthByChoice Achievements HMO

You and your enrolled spouse/OEA must qualify for the Choice level benefits each year. This table is a summary of the qualification requirements. **Exact qualification requirements can be found on the Priority Health Qualification Form available on the UHR's benefit website.**

	Priority Health—HealthbyChoice Achievements HMO
What plan do you start in?	New enrollees will start in the Choice plan. Members already enrolled will stay in the plan they were in at the end of the previous year (Choice or Standard).
What is the qualification period?	The qualification period for January 1, 2020 open enrollment is 1/1/20 through 3/31/20. If you fail a requirement and need extra time to meet your alternate goal, you will move to Choice effective on the latest date that all goals are met.
When will you move plans?	If you complete and pass the requirements within the open enrollment qualification period of 1/1/20 through 3/31/20, you will be on the Choice plan on 4/1/20. If you do not complete and/or pass the requirements within the open enrollment qualification period of 1/1/20 through 3/31/20, you will move to the Standard plan on 4/1/20.
What are the qualification requirements?	Whether you begin in the Choice or Standard plan you must complete the following requirements within the qualification period in order to be on the Choice plan after the qualification period has concluded: 1. You must complete a confidential, online health assessment. 2. You must have your doctor complete the HealthbyChoice Achievements Qualification Form available online at priorityhealth.com. 3. You must be tobacco free, including e-cigarettes. 4. Your body mass index (BMI) must be under 30 or you must have a waist circumference of <41 inches for a male or <35 inches for a female. 5. Your blood pressure must be under <140/90 or <150/90 for those over 60 years old. With diabetes 140/80 and with CVD 140/90. 6. Your LDL cholesterol must be under 190 or under 100 based on risk factors. 7. Your blood sugar metrics are only required for members with diabetes or heart disease. HbA1c must be lower than 7% if you have diabetes or fasting blood sugar lower than 126 if you have heart disease. The above summarizes the qualification requirements. See the Qualification Form for complete detail.
Are reasonable alternatives available if you do not pass one of the wellness targets?	Yes, depending on the target you miss below are Priority Health's suggested alternative standards: • Quit tobacco (including e-cigarettes) or complete a Priority Health tobacco cessation program. • Body Mass Index (BMI) – reduce your weight by 5%. • Blood Pressure – reduce systolic by 10mm or diastolic by 5mm. • Cholesterol – reduce LDL by 20 mg/dl. • Blood Sugar – improve by reaching normal level, reduce HbA1c by 1%. Your physician can set their own alternative standard for you. If they are not using Priority Health's suggested alterative standards, be sure your doctor enters your specific alternative standard into Priority Health's online system, otherwise it will default to Priority Health's suggested alternative standard. Once you achieve the alternative wellness target you must visit your doctor and have them resubmit the HealthbyChoice Achievements Qualification Form showing the alternative target has been met. You will move to the Choice plan effective on the latest date that all goals and qualification requirements are met.
What happens if I add a spouse mid-year?	Your spouse is added to your contract in the same level that you are in, either Choice or Standard. If you are already enrolled in Choice, your spouse does not have to meet the qualifications until the following renewal. If you are enrolled in Standard, you both have the opportunity to complete and meet the requirements to move into Choice at any time during the year.

Dental Overview

Dental coverage helps with the cost of routine dental care and major services for you and your eligible family members. Coverage is provided through Delta Dental's PPO Point of Service Plan. Your dental coverage is provided to you and your family by Oakland University at no cost to you.

Through Delta Dental there are three types of dentist you can choose to see: a PPO Member dentist, a Premier dentist and a Non-Participating dentist.

Delta Dental PPO Member dentists and Premier dentists agree to accept Delta's fee determination as full payment for covered services. This guaranteed acceptance protects employees from providers who want to bill in excess of what Delta deems "reasonable and customary". If you choose to visit a Non-Participating dentist you will still have coverage but the dentist may bill you directly for any charges in excess of what Delta deems "reasonable and customary".

An online provider directory is available at www.deltadentalmi.com that will enable enrollees to obtain information on PPO Member and Premier dentists. Click on "Consumer Toolkit" to access the online provider directory.

	PPO Member Dentist (accept Delta's fee determination as full payment)	**Delta Premier** (accept Delta's fee determination as full payment)	**Non-Participating Dentist** (do not accept Delta's fee determination as full payment)
Deductible	None		
Annual Maximum (applies to Class I, II and III) *Benefit Year: January 1-December 31*	$1,000 per person		
Lifetime Maximums (applies to Class IV)	$1,500 per person		
Covered Services	**PPO Member Dentist—Plan Pays:**	**Delta Premier– Plan Pays:**	**or Non-Participating Dentist—Plan Pays:**
Class I Benefits			
Exams, Cleanings, X-rays, etc. *(preventive and diagnostic services do not count toward the annual maximum)*	100%	100%	100%
Class II Benefits			
Extractions, Fillings, Root Canals, Relines/Repairs to Bridges and Dentures, etc.	100%	50%	50%
Class III Benefits			
Crowns, Bridges, Implants, Dentures, etc.	50%	50%	50%
Class IV Benefits			
Orthodontics (no age limit)	50%	50%	50%

Did you know visiting your dentist for regular exams is just as important as visiting your medical doctor? We encourage you to take advantage of the two exams covered each year!

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated above.

Vision Overview

Oakland University offers two vision plans:

- Davis Vision
- Blue Cross Blue Shield of Michigan (BCBSM) VSP Vision

Both the Davis Vision and BCBSM Vision plans include ophthalmologists and optometrists in their network. Below is a summary of the two vision plan options:

Davis Vision includes Sam's Club, Costco, and Walmart in its list of participating providers!

	Davis Vision		BCBSM VSP Vision	
	Participating[2]	Non-Participating	Participating[4]	Non-Participating
Eye Exams[1]	$0 copay	Reimbursed up to $30	$5 copay	$5 copay applies to charge
	1 every 12 consecutive months		1 every 24 consecutive months	
Standard Lenses[3]	$0 copay	Reimbursed up to: Single—$25 Bifocal—$35 Trifocal—$45	$7.50 copay	Reimbursed up to: Single—$30 Bifocal—$50 Trifocal—$65
	1 every 24 consecutive months *Lenses can be obtained every 12 months with a 0.5 diopter prescription change		1 every 24 consecutive months	
Frames	$0 copay for Davis Vision Fashion level frames from Davis Vision's collection Reimbursed up to $75 or $125 for non-collection frames	Reimbursed up to $30	$100 allowance less $7.50 copay	Reimbursed up to $70, less a $7.50 copay
	1 every 24 consecutive months (contact lenses or glasses and frames)		1 every 24 consecutive months (contact lenses or glasses and frames)	
Contact Lenses **Medical Necessary**	$0 copay	Reimbursed up to $225	$7.50 copay	Reimbursed up to $210 after $7.50 copay
Elective	Reimbursed up to $105	Reimbursed up to $75	$100 allowance toward contact lens exam and contact lenses	$85 allowance applied toward contact lens exam and contact lenses
	1 every 24 consecutive months (contact lenses or glasses and frames)		1 every 24 consecutive months (contact lenses or glasses and frames)	

[1]If you receive services outside of a routine eye exam you may be required to pay additional costs.

[2]For participating providers, there is a 20% discount on overage for frames and 15% discount on overage for contact lenses. Sign in at www.davisvision.com to find participating providers online (client code is 3217).

[3]If you choose extra options beyond the standards that are covered, you are responsible for the additional cost, paid directly to the providers.

[4]A list of participating BCBSM VSP Network providers can be found here: https://www.vsp.com/find-eye-doctors.html.

Additional Benefits

MetLaw Pre-Paid Legal Overview

This program offers you assistance in IRS Audits, Preventive Legal Services (including legal document review, will preparation and updates), and Motor Vehicle Legal Service. MetLaw requires a one year participant commitment.

The cost for this service is $26.75 (after tax) per month; premiums are paid on a calendar year basis.

Included in the appendix is a brochure for your review. Additional information on MetLaw Pre-Paid Legal can be found at www.info.legalplans.com or by calling (800) 821-6400.

InfoArmor PrivacyArmor Plus Overview

As your partner in Identity Protection, we closely monitor trends and threats in the cyber security realm so you don't have to. Over the past year, the world has seen a dramatic increase in the number of individuals effected by security breaches, in their work and personal lives. As these threats continue to evolve, so do our solutions. InfoArmor is now offering a more robust product to continue to provide you peace of mind – PrivacyArmor Plus:

⇒ **3 Credit Bureau Monitoring:** TransUnion, Equifax and Experian.

⇒ **More Alerts:** Each bureau offers additional alert types to keep your employees secure (27 total alerts compared to only 9 alerts with PrivacyArmor).

⇒ **Financial Transaction Monitoring:** Participants receive additional alert notifications from our expanded data sources for transactions on credit, debit and checking accounts such as new account authorizations, new deposit accounts opened and personal information request changes.

The cost for this service is $9.95 per individual or $17.95 per family per month (after tax) and is completely paid by you.

Included in the appendix is a brochure for your review. Additional information on InfoArmor PrivacyArmor Plus can be found at www.infoarmor.com or by calling (800) 789-2720.

Flexible Spending Account Overview

Flexible Spending Accounts (FSA) let you set aside money from your paycheck before federal, state or city income taxes and Social Security taxes are deducted. When the money is used for eligible expenses incurred by yourself or IRS-eligible dependents, reimbursement is tax-free, too. You pay no taxes on the money you contribute to and receive from either reimbursement account.

There are two types of flexible spending accounts you can elect: a Health Care Reimbursement Account (HCRA) for qualified medical, dental and vision expenses, and a Dependent Care Reimbursement Account (DCRA) for dependent day care expenses incurred while you and your spouse are working or attending school full time.

If you are currently enrolled in a HCRA or DCRA and wish to continue in 2020, you MUST re-enroll during Open Enrollment.

You can set up an HCRA or DCRA by completing the online enrollment. You designate how much you want to contribute into each account annually, and each pay period the amount you specified will be put into your personal account(s) to use in paying for health and/or dependent day care expenses not covered by insurance. The accounts are mutually exclusive. You cannot use HCRA funds for Dependent Care expenses, or vice-versa.

Special Rules for Health Care and Dependent Care Reimbursement Accounts

Because the reimbursement accounts provide significant tax savings, the IRS imposes the following rules:

- Your HCRA and DCRA accounts are completely separate. You may not transfer money from one account to another. In addition, you may not use your HCRA to pay for dependent care expenses, or vice versa.
- If you claim an expense for reimbursement through either account, you may not claim the same expense as a deduction or a credit on your income tax return.
- You can only use HCRA and DCRA monies on IRS-eligible dependents. To determine whether your family member qualifies as an IRS-eligible dependent, visit https://www.irs.gov/help/ita/who-can-i-claim-as-a-dependent to learn more.

Health Care Reimbursement Account (HCRA)

You may set aside any dollar amount from a minimum of $64 to a maximum of $2,700 per year in your HCRA. You may receive your full reimbursement amount for eligible health care expenses at any time during the year. You can use this money to pay for a variety of eligible expenses, such as:

- Deductibles and copays (including prescription costs)
- Expenses not covered by any health plan by which you may be covered
- Expenses in excess of medical or dental coverage limits, such as your share of orthodontia treatment cost
- Expenses for eye exams, contact lenses and eyeglasses
- Over-the-counter drugs when you receive a written prescription from your physician

In most instances, expenses must be incurred between January 1, 2020—December 31, 2020 to be eligible for reimbursement. Call BASIC at 1-800-444-1922 for a copy of all eligible expenses under the HCRA.

Flexible Spending Account Overview

Rollover Rules for your HCRA: If you do not use all your 2019 HCRA funds, up to $500 of your unused funds will automatically rollover into your 2020 account. Please note the following:

- You will have until March 31, 2020 to submit any requests for reimbursement for 2019 claims to BASIC.
- Any amount over $500 will be forfeited.
- The rollover amount will be in addition to the 2020 annual contribution maximum.
- Rollover funds will become available for use in April 2020.
- You do not need to elect a HCRA in 2020 in order to use your 2019 rollover funds, however you do need to be an active Oakland University employee.
- Rollover does not apply to the Dependent Care Account.

Dependent Care Reimbursement Account (DCRA)

You may set aside any dollar amount from a minimum of $64 to a maximum of $5,000 per year in the DCRA. If you are married and your spouse participates in a similar account through his or her employer, you may set aside no more than $5,000 combined per year.

This account is designed to help you pay for dependent care expenses so you, or you and your spouse, can work. You also can use the account to pay dependent expenses if your spouse attends school full-time or is mentally or physically handicapped and unable to care for your children. In order to be eligible for the DCRA, you and your spouse must work or your spouse must be a full-time student.

Eligible dependent care can be provided in your home or in someone else's home, or in a care facility (except for a nursing home). When you submit a claim for expenses, you must show your caregiver's tax identification number (for individuals, this usually is their Social Security number). **The amount you may use from your DCRA is based on the amount in your account when you submit your claim.**

Generally, your dependents include:

- Children under age 13 who qualify as dependents on your federal income tax return.
- Any dependents unable to care for themselves. For example, an incapacitated older child or spouse or an elderly parent who regularly spends at least eight hours a day in your home and otherwise qualifies as a dependent under IRS rules.

Any leftover funds in your DCRA at year-end cannot be returned to you. This means you must plan carefully before deciding to contribute money to the DCRA. Use the worksheet in this workbook to help you plan properly.

You will have until March 31, 2020 to submit any requests for reimbursement for 2019 claims to BASIC.

If you contribute to a Dependent Care Reimbursement Account, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Reimbursements

Reimbursement payments will be sent to you via direct deposit. You will also have the option of using a BASIC debit card to pay for FSA-eligible expenses. If you wish to change your existing bank account for direct deposit, you can download the direct deposit form from the BASIC website and submit it to BASIC.

Flexible Spending Account Overview

How Much Should You Contribute?

Before you set up your HCRA and/or DCRA, you should estimate how much you will spend on eligible expenses during the January 1-December 31 plan year. Use the "Eligible Annual Expense Worksheet" to the right to help calculate your health-care and dependent-care expenses.

Estimate your reimbursement account expenses as accurately as possible and be conservative, because the Internal Revenue Service requires you to forfeit HCRA funds over $500, and any DCRA funds you do not use by the end of the year.

Note, too, that the maximum you can contribute to a FLEX account for health-care expenses is $2,700. The maximum you and your spouse can contribute to a dependent care account is $5,000.

Eligible Annual Expense Worksheet

Health Care Reimbursement Account:

Medical Expenses	
· Deductibles	$_____
· Office Visits, Service Fees	$_____
· Copay	$_____
Dental Copay	$_____
Orthodontic Copay	$_____
Vision Expenses	$_____
Hearing Expenses	$_____
Total Estimated HCRA Expenses	**$_____**

Dependent Care Reimbursement Account:

Dependent Day Care Expenses	
· Child Day Care	$_____
· Adult Day Care	$_____
Total Estimated DCRA Expenses	**$_____**

To determine your Bi-Weekly per pay contribution, divide the total by 26

To determine your Monthly per pay contribution, divide the total by 12

Using Your Flexible Spending Accounts

To receive payment for an eligible health or dependent care expense, simply fill out a Reimbursement Request Form and submit it with your itemized receipt. You may mail or fax your Reimbursement Request Form, or submit it electronically online. You can also submit for reimbursement through the BASIC mobile app, available for download on both Android and iPhone systems.

Reimbursements are processed promptly every day. You will be repaid for the full amount of your Health Care
Reimbursement Account request, up to the total contributions you specified for the year.

You will be reimbursed for expenses up to the amount contributed to your Dependent Care Reimbursement Account at the time your request is submitted. If your reimbursement request is more than the amount available in your account, the remainder will be paid as additional funds are deposited.

Keeping Track of Your Accounts

You can check the status of your Flexible Spending Account(s) by signing in online. You can review claims, submit expenses, and make payments via the online employee portal.

If you have questions about your Oakland University Flex plan, contact the BASIC Health Flexible Benefits Department at 800-444-1922.

Flexible Spending Account Overview

Using Your BASIC Flex Debit Card

Every employee who enrolls in the BASIC Flexible Spending Account will receive two BASIC Visa debit cards. You are not required to use the BASIC debit card, and may continue to use your own form of payment for qualified services and submit for reimbursement via online, mail, fax, or mobile application.

If you use your BASIC debit card, you do not have to submit for reimbursement. When paying with your BASIC debit card, funds will automatically be withdrawn from your HCRA and/or DCRA. BASIC may ask for additional information after you use your BASIC debit card. This process is called "verification." You do NOT have to submit verification unless BASIC requests additional information. You will receive the request for verification via mail or email.

When verification is requested, you can submit the requested information one of the following ways:

- Through the online portal website;
- Upload through the BASIC mobile application ("Benefits by BASIC");
- BASIC's Secure Claim Upload;
- Fax to 800-391-6562;
- Mail to: BASIC 9246 Portage Industrial Dr. Portage, MI 49024.

Any unverified claim amounts which remain at the end of the year will be deducted from your paycheck.

You will need to fill out a BASIC Verification Form, located online in the Forms section. BASIC may request any of the following during the verification process:

- Explanation of Benefits (EOB)
- Itemized Statement
- Prescriptions
- Detailed vision bills from your vision provider
- Letter of medical necessity
- Over-the-Counter prescriptions or letter of medical necessity
- Receipt from day care provider

Debit Card Frequently Asked Questions

Q: *What happens if I forget to submit verification?*

A: If BASIC does not receive documentation within 60 days of purchase as requested, your BASIC debit card will be deactivated. If your card is deactivated, you can have it reactivated by submitting the requested documentation or refund the amount charged. You can still submit for reimbursement while your card is deactivated. BASIC recommends you monitor your transaction status online to ensure your BASIC debit card is never deactivated.

Q: What happens if I purchase an ineligible item?

A: You will receive a letter from BASIC requesting a refund. You can mail a check, payable to Oakland University, to BASSIC at 9246 Portage Industrial Dr. Portage, MI 49024. Once this is received, your account will be credited and the check will be forwarded to Oakland University.

Q: What if I do not have my BASIC debit card and I need to purchase a qualified product or service?

A: Pay your bill with your cash, debit/credit card, or check. Keep your itemized receipt, and submit a request for reimbursement.

Q: Why won't my card work at the pharmacy or retailer?

A: The pharmacy or retailer might not be compliant, you may have outstanding debit card purchases that need to be verified, or you may be trying to purchase an item that is not eligible under IRS regulations.

Flexible Spending Account Overview

Submitting 2019 Claims During the Runout Period

For health care claims or dependent care claims that occurred in 2019, you have 90 days to submit for reimbursement following the end of the plan year on 12/31/19. These claims should be sent to BASIC for processing, and your 2019 funds will be used for payment.

During the runout period, if a provider bills you for dates of service that occurred prior to 1/1/20, you must submit for reimbursement directly with BASIC rather than pay with your BASIC debit card. During the runout period, you CANNOT use your BASIC debit card to pay for claims with dates of service incurred during 2019.

To receive payment for an eligible health or dependent care expense, simply fill out a Reimbursement Request Form and submit it with your itemized receipt. You may mail or fax your Reimbursement Request Form to BASIC, or submit it electronically online.

Reimbursements are processed promptly every week. You will be repaid for the full amount of your Health Care Reimbursement Account request, up to the total contributions you specified for the year.

You will be reimbursed for expenses up to the amount contributed to your Dependent Care Reimbursement Account at the time your request is submitted. If your reimbursement request is more than the amount available in your account, the remainder will be paid as additional funds are deposited.

You can check the status of your Flexible Spending Account(s) online. You can review claims, submit expenses, and make payments via the online employee portal.

If you have questions about the runout period under the Oakland University Flex plan, contact the BASIC Health Flexible Benefits Department at 800-444-1922.

As a reminder:

- Claims with a service date or purchase date beginning January 1, 2019 through December 31, 2019 should be sent to BASIC during the runout period.
    - You have until March 31, 2020 to submit Dependent Care claims.
    - You have until March 31, 2020 to submit Health Care claims.
- Claims with a service date or purchase date beginning January 1, 2020 through December 31, 2020 should be sent to BASIC and can be processed normally. You can also use your BASIC debit card to pay for services incurred in 2020.

If Your Employment Ends Prior to the End of the Plan Year

If you leave the University before the end of the year, you have a run-out period in which to submit claims incurred prior to your termination date. For Health care reimbursement requests, claims can be submitted up to 90 days following termination date, for services incurred from the 1st day of coverage to the last day worked.

Also, if there is a positive balance in your Dependent Care account then Dependent Care reimbursement requests can be submitted through the March 31 runout period deadline, for services incurred from the 1st day of coverage through the last date of prior plan year.

Your BASIC debit card is deactivated when BASIC receives notice of your termination. To receive payment for an eligible health or dependent care expense, simply fill out a Reimbursement Request Form and submit it with your itemized receipt. You may mail or fax your Reimbursement Request Form to BASIC, or submit it electronically online.

Legal Notices

Patient Protection

BCN and Priority Health generally require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. Until you make this designation, the carrier designates one for you. For information on how to select a PCP, and for a list of the PCP providers, contact your carrier.

For children, you may designate a pediatrician as the primary care provider.

For obstetric or gynecological care, you do not need prior authorization from the carrier or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your carrier.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Legal Notices

Coverage Under Michigan's Abortion Insurance Opt-Out Act

Fully insured plans in Michigan can no longer cover elective abortion unless a rider is purchased. Our medical plans, insured by BCBSM, BCN and Priority Health, provide coverage for elective abortion; therefore the rider is included. This rider applies to all plan participants covered by the insured group medical plan; coverage under this rider cannot be declined on an individual basis. An employee's covered dependents may use this coverage without notice to the employee.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

Legal Notices

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/

Legal Notices

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

- U.S. Dept. of Labor, Employee Benefits Security Administration: www.dol.gov/ebsa
  Phone: 1-866-444-EBSA (3272)
- U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: www.cms.hhs.gov
  Phone: 1-877-267-2323, Menu Option 4, Extension 61565

Important Notice from Oakland University About Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oakland University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Oakland University has determined that the prescription drug coverage offered by our medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Oakland University coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Oakland University coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oakland University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oakland University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 15, 2019
Name of Entity/Sender:	Oakland University
Contact--Position/Office	Eric Herppich
Address:	371 Wilson Blvd, Rochester Hills, MI 48309
Phone Number:	248-370-4166

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Legal Notices

DOL Notice for HIPAA Health Contingent Wellness Programs:

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your doctor and they will work with you to find an alternative standard with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program:

Healthy Blue Living and HealthByChoice Achievements is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of for doing so. Although you are not required to complete the HRA , only employees who do so will be moved to the Enhanced/Choice plan. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as walking programs, smoking cessation programs, etc. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Oakland University may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact OU Human Resources.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the practices of the Oakland University Flexible Benefit Plan (called the "Plan" in this Notice) with regard to the Protected Health Information the Plan has about you that relates to your coverage under the Plan, and how the Plan may use and disclose this information. This Notice also describes your rights in your Protected Health Information and how you can exercise those rights. Your rights, and the Plan's responsibilities, apply only to the health care reimbursement account under the Plan.

Protected Health Information ("PHI") includes individually identifiable information that relates to your past, present or future health condition, treatment or payment for health care services, and includes information such as your name, social security number, address and date of birth.

The Plan is required by law to keep PHI that identifies you private, to give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI, notify you following a breach of unsecured PHI that affects you, and to follow the terms of the Notice that is currently in effect. This Notice of Privacy Practices originally became effective on April 14, 2004 and has been amended as of September 23, 2013.

PHI use and disclosure by the Plan is regulated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). This Notice attempts to summarize the regulations, but the regulations will supersede any discrepancy between the information in this Notice and the regulations.

A. Uses and Disclosure of PHI Without Your Permission. The Plan primarily uses and discloses your PHI to evaluate and process requests for coverage and claims for benefits, and to create a record of the health care claims reimbursed under the Plan for Plan administration purposes. The following describes these and other uses and disclosures which may be made without your written authorization, together with some examples:

1. Payment. The Plan may use and disclose your PHI to (1) determine eligibility for Plan benefits, or (2) to facilitate payment for the treatment and services you receive from health care providers. For example, the Plan may share PHI with another entity to assist with the adjudication of health claims.

2. Health Care Operations. The Plan may use and disclose your PHI for other Plan operations. These uses and disclosures are necessary to administer the Plan. For example, the Plan may use or disclose your PHI (1) to conduct quality assessment and improvement activities, (2) for arranging medical review, legal services, audit services, and fraud and abuse detection programs, (3) for business planning and development such as cost management, (4) for business management and general Plan administrative activities.

3. Treatment. The Plan may use or disclose your PHI to facilitate medical treatment or services by providers. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription would have an adverse reaction with prior prescriptions.

4. As Required by Law. The Plan will disclose your PHI when required to do so by law. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose PHI when required by a court or administrative order or subpoena.

5. Workers' Compensation. The Plan may disclose your PHI as authorized by, and to the extent necessary to comply with, workers' compensation or other similar laws.

6. To Business Associates. The Plan may disclose your PHI to business associates the Plan hires to assist the Plan. Business associates, for instance, could be a third party administrator or a consultant. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your PHI.

7. To Plan Sponsor. The Plan may disclose to the Plan Sponsor (Oakland University), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also tell the Plan Sponsor whether you are enrolled in the Plan. The Plan may give your PHI to the Plan Sponsor for plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your PHI. The Plan Sponsor must agree not to use or disclose your PHI for employment-related activities or any other benefit or benefit plans of the Plan Sponsor.

8. For Matters of Public Interest or Safety. The Plan may use or disclose your PHI for matters in the public interest or safety; for example, to avert a serious threat to health or safety.

B. **Uses and Disclosures of PHI Without Objection.** The Plan may disclose your PHI to family members, other relatives or your friends if they are involved in your care or payment for that care, and provided you do not object. For example, a claim determination may be discussed with you in the presence of a relative or friend unless you object. Other than in an emergency or when it is not practical because you are incapacitated, we will provide you with the opportunity to object before such a disclosure is made.

C. Uses and Disclosures of PHI With Your Permission. The Plan will not use or disclose your PHI for any purpose not identified above unless you give the Plan your written authorization to do so. For example, the following uses and disclosures generally require your authorization: (1) uses and disclosures for marketing purposes; (2) uses and disclosures which are a sale of Protected Health Information; and (3) uses and disclosures of psychotherapy notes. If you give the Plan written authorization to use or disclose your PHI for a specific purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all of your PHI the Plan maintains, unless the Plan has taken action in reliance on your authorization.

D. Your Rights. You may make a written request to the Plan to do one or more of the following concerning your PHI:

1. Request Restrictions. To put additional restrictions on the Plan's use and disclosure of your PHI. The Plan does not have to agree to your request.

2. Request Confidential Communications. To communicate with you in confidence about your PHI by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence.

3. Inspect and Copy. To see and get copies of your PHI kept in a "Designated Record Set." A Designated Record Set includes enrollment, payment, billing, claims adjudication, and medical management record systems maintained by or for the Plan that is used to make decisions about individuals. In limited cases, the Plan does not have to agree to your request. The Plan uses or maintains an electronic health record containing your PHI, you may obtain a copy of your electronic PHI in an electronic format and, if you choose, direct the Plan to transmit the electronic copy directly to a person designated by you.

4. Amend. To correct your PHI. A request to correct your PHI must be in writing and you must provide reasons and support for the correction. In some cases, the Plan does not have to agree to your request, in which case you may submit a written response that will be included in future disclosures of your PHI.

5. Accounting of Disclosures. To receive a list of disclosures of your PHI that the Plan and its business associates made for certain purposes for the last 6 years (but not for disclosures before April 14, 2004). This accounting will not include disclosures made for treatment, payment, or health care operations; made to law enforcement personnel; made pursuant to your authorization; or made directly to you.

6. This Notice. To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

NOTE: To exercise your rights, you must submit your request in writing and on the Plan's forms. You may contact the Benefits & Compensation Services Office (contact information is given below) for a copy of any such forms you may need. In some cases, the Plan may charge you a reasonable, cost-based fee to carry out your request.

E. Personal Representative. You may exercise your rights through a personal representative appointed by you or designated by applicable law. The parent of a minor is usually considered that child's personal representative.

F. Changes to This Notice. The Plan must comply with the provisions of this Notice, although the Plan reserves the right to change the terms of this Notice from time to time and to make the revised Notice effective for all PHI the Plan maintains. The Plan will notify you within sixty days of any material changes to this Notice.

G. Questions and Complaints. If you have questions about this Notice or want to file a complaint because you believe the Plan has violated your privacy rights or this Notice, please contact the Plan at:

Benefits and Compensation Services Office
371 Wilson Blvd.
Rochester, MI 48309
Voice: 248/370-4207 Fax: 248/370-4212

You also have the right to complain to the U.S. Department of Health and Human Services. We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

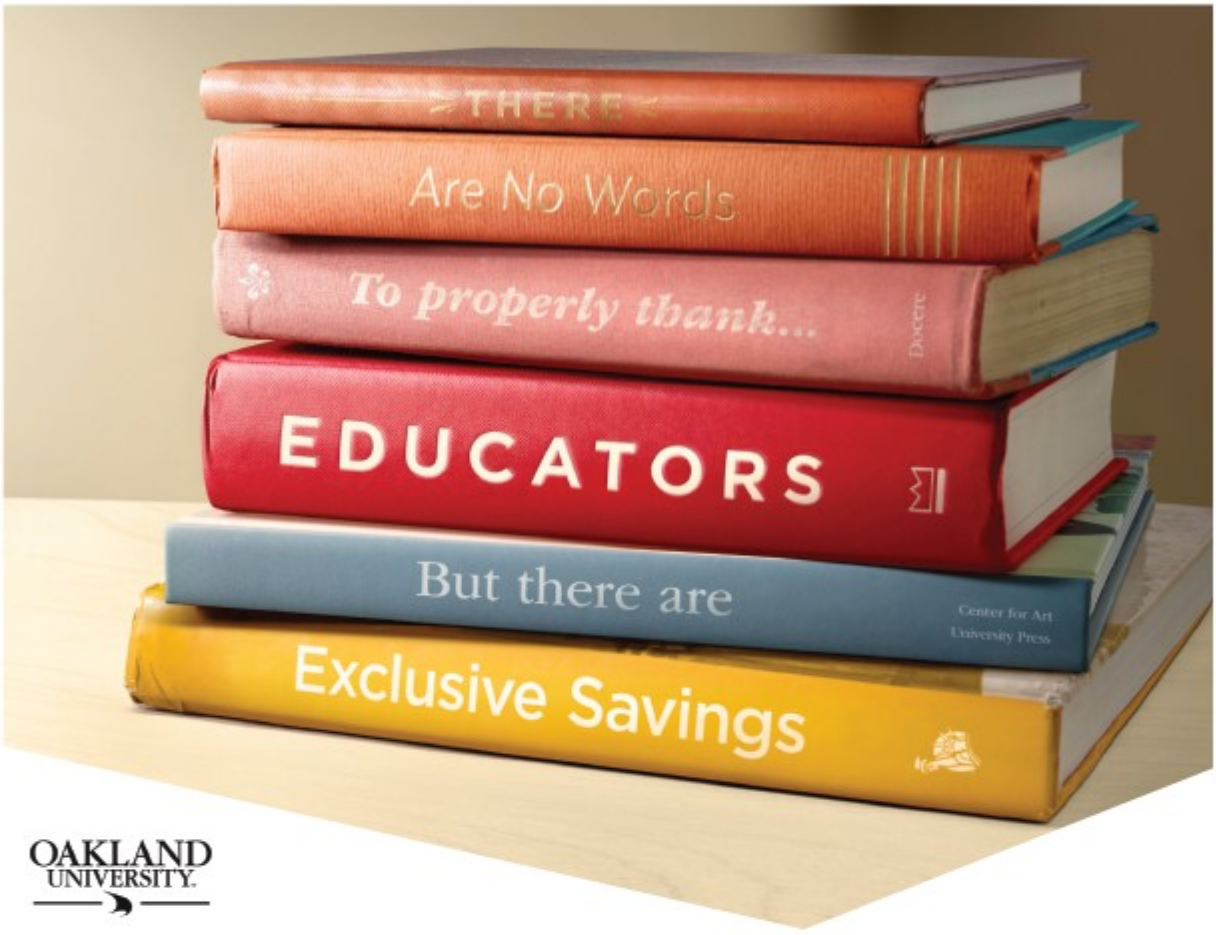
Benefit Contacts

Carrier	Coverage	Contact Information
Blue Cross Blue Shield	Medical/Rx	(877) 790-2583 www.bcbsm.com
Blue Care Network	Medical/Rx	(800) 662-6667 www.bcbsm.com
Priority Health	Medical/Rx	(800) 446-5674 www.priorityhealth.com
Delta Dental	Dental	(800) 524-0149 www.deltadentalmi.com
Davis Vision	Vision	(800) 999-5431 www.davisvision.com
BASIC	Flexible Spending Account	(800) 444-1922 www.basiconline.com
MetLaw	Prepaid Legal	(800) 821-6400 www.legalplans.com
InfoArmor	Identity and Credit Protection	(800) 789-2720 www.infoarmor.com
University Human Resources (UHR) 401 Wilson Hall		(248) 370-4207 www.oakland.edu/uhr

Appendix

- Liberty Mutual
- MetLaw
- InfoArmor

Appendix



OAKLAND UNIVERSITY

Oakland University has partnered with Liberty Mutual Insurance to offer you peace of mind, and significant savings on auto insurance[1] that includes:

Vandalism Loss Protection. If your vehicle is vandalized on school property or during school-related events, there is a $0 deductible

Personal Property Coverage. If your teaching materials or school-owned property is stolen or damaged while in your vehicle, you're covered up to $2,500 per occurrence.

Collision Coverage. There is a $0 deductible if your vehicle is damaged in a collision while you're driving it on school business.

What's more, you'll continue to receive special savings on auto and home insurance.[2]
It's our way of showing appreciation for the difference you make.

Contact me for a free quote or visit libertymutual.com/oakland

Michael J. Meyer, LUTCF
13001 23 Mile Road - Suite 102
Shelby Township, MI48315
586-884-9399
Michael.Meyer@LibertyMutual.com
Client # 110230

To schedule an on campus appointment, reserve your spot by visiting:
http://oakland_libertymutual.timetap.com/

[1]Not available in all states. [2]Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA 02116.

AFF 8300 2015/08 MW

Liberty Mutual. INSURANCE

MetLaw for Oakland University Employees

When life calls for legal help, MetLaw is there for you.

$26.75 per month covers you, your spouse and dependents. Telephone and office consultations are available for an unlimited number of personal legal matters with an attorney of your choice.

Money Matters	- Debt Collection Defense - Identity Theft Defense - Negotiations with Creditors	- Personal Bankruptcy - Promissory Notes	- Tax Audit Representation - Tax Collection Defense
Home & Real Estate	- Boundary & Title Disputes - Deeds - Eviction Defense - Foreclosure - Mortgages	- Property Tax Assessment - Refinancing & Home Equity Loans of Primary, Second or Vacation Home	- Sale or Purchase of Primary, Second or Vacation Home - Security Deposit Assistance - Tenant Negotiations - Zoning Applications
Estate Planning	- Codicils - Complex Wills - Healthcare Proxies - Living Wills	- Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	- Revocable & Irrevocable Trusts - Simple Wills
Family & Personal	- Adoption - Affidavits - Conservatorship - Demand Letters - Garnishment Defense - Guardianship	- Immigration Assistance - Juvenile Court Defense, Including Criminal Matters - Name Change - Parental Responsibility Matters - Personal Property Protection	- Prenuptial Agreement - Protection from Domestic Violence - Review of ANY Personal Legal Document - School Hearings
Civil Lawsuits	- Administrative Hearings - Civil Litigation Defense - Incompetency Defense	- Disputes Over Consumer Goods & Services	- Pet Liabilities - Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your Parents: - Deeds - Leases	- Medicaid - Medicare - Notes - Nursing Home Agreements	- Powers of Attorney - Prescription Plans - Wills
Vehicle & Driving	- Defense of Traffic Tickets[1] - Driving Privilege Restoration	- License Suspension Due to DUI	- Repossession
E-Services	- Attorney Locator - Financial Planning	- Insurance Resources - Law Firm E-Panel	- Self-Help Legal Documents - Work/Life Resources

To learn more, visit **info.legalplans.com** and enter access code: **6091120**
or call our Client Service Center at **1.800.821.6400** Monday-Friday, 8am-8pm (EST Time).

1. Does not cover DUI.

Appendix

MetLife | Legal Services

New portability procedures

If you wish to continue your legal plan benefit after retiring or terminating employment, we offer you the opportunity to continue on as a legal plan member for 12 months through a portable plan.

To apply for portable enrollment:

- Call our Client Service Center at **800.821.6400**, Monday-Friday (8am - 8pm ET) to enroll in your portable plan. A Client Service Center Representative will assist you in the enrollment process. You must enroll within 30 days of your last day of employment.
- Enrollment is prepaid via remittance of a lump sum payment equal to the legal plan's monthly rate times 12 months.
- Upon receipt and approval of payment, we will send you verification of the portable enrollment.
- Portable enrollments will remain effective for a 12 month period and refunds will not be issued.
- Under portable enrollment, dependent definitions are the same as those for active Employees.
- The covered services and exclusions are the same as those under your current plan. Please visit **members.legalplans.com** or call **800.821.6400** for plan details.

Count on us for an exceptional service experience.

Group legal plans are provided by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, OH. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company, Warwick, RI.

Smart. Simple. Affordable.®
Hyatt Legal Plans
A MetLife Company

Hyatt Legal Plans, Inc., a MetLife Company | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

PrivacyArmor

Protect today.
Thrive tomorrow.

Get complete identity protection with PrivacyArmor Plus® so you can focus on what matters most.

- Run your personalized Allstate Digital Footprint and see your digital exposure
- Check your identity health score
- View, manage, and clear alerts in real time
- Monitor your credit scores and reports for any changes or errors
- Receive alerts for cash withdrawals, balance transfers, and large purchases from any linked bank account
- Monitor linked social media accounts for questionable content and signs of account takeover
- Reduce solicitation attempts by opting out of credit card offers, telemarketing calls, commercial mail and email, and unrequested coupons
- Get reimbursed for stolen 401(k) & HSA funds; we'll also advance fraudulent tax returns †

OAKLAND UNIVERSITY™

Please Enroll through Self Service Banner

MyPrivacyArmor.com
Questions?

1.800.789.2720

Plans and pricing

PrivacyArmor Plus
$9.95 per person / month
$17.95 per family / month

†Identity theft insurance underwritten by insurance company subsidiaries or affiliates of Assurant. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policy described. Please refer to the actual policy for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

PrivacyArmor is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

InfoArmor an Allstate company

Appendix

PrivacyArmor by InfoArmor

Summary plan description

Plan features

- Dark web monitoring
- Rapid alerts
- High-risk transaction monitoring
- Financial transaction monitoring
- Tri-bureau credit monitoring
- Unlimited credit reports from TransUnion
- Annual tri-bureau credit report and credit score
- Accounts secured with two-factor authentication
- Human-sourced intelligence
- IP address monitoring
- Social media reputation monitoring
- Digital wallet storage and monitoring
- Deceased family member coverage
- Data breach notifications
- Full-service 24/7 fraud remediation with a dedicated Privacy Advocate
- $1 million identity theft insurance policy
- Credit freeze assistance
- Credit lock (adult and child)
- 401(k) and HSA stolen fund reimbursement
- Tax fraud refund advances

Identity protection:	PrivacyArmor® Plus is a proactive monitoring service that alerts you at the first sign of fraud and fully restores your identity. The PrivacyArmor Plus identity protection plan provides ri-bureau credit monitoring, dark web monitoring, and full restoration and reimbursement services to help detect and recover from identity theft quickly.
Client name:	Oakland University
Policy effective date:	1/1/2020
Policy renewal date:	1/1/2021
Policy number/ client ID:	805
Eligible group(s):	All employees in active employment in the United States with the employer.
Minimum hours requirement:	There is no minimum hours requirement for this plan unless determined by the employer.

page 1 of 2

Waiting period:	Unless determined by employer, there is not a waiting period for this plan.
Participation requirements:	There are no participation requirements for this plan.
Enrollment:	Employees who are eligible may enroll for coverage at any time unless the employer determines enrollment may only take place during a defined enrollment period.
Cancellation:	Employees who are eligible may cancel coverage at any time unless the employer determines cancellations may only take place during a defined period.
Who pays for the coverage:	Employees pay for coverage through payroll deduction, with deduction frequency determined by employer. After 90 days of no payment, coverage will be terminated.
Pre-existing conditions:	Employees have access to full-service identity theft restoration after the effective date, even if the identity theft was discovered prior to the effective date.
Family member definition:	A defined family member is one who is supported financially by the employee or one who lives under the employee's roof. Under this definition, a family member is eligible to enroll as a part of the family plan.
Portability:	If the employee leaves the company, this plan is portable at the same rates offered through payroll deduction. Employees must activate a direct bill relationship with InfoArmor by calling 800.789.2720.
Billing:	Payment method: *Self-bill* Billing cycle: *Bi-Weekly*
Account manager:	**Bobby Irwin** | Birwin@infoarmor.com 480-210-6425 office
Identity theft insurance summary:	If a participant falls victim to identity theft, the $1 million identity theft insurance policy included with PrivacyArmor benefit reimburses many of the participant's out-of-pocket costs. This ensures financial security by covering lost wages, legal fees, medical record request fees, CPA fees, child care costs, and more, while our Privacy Advocates help the participant restore their good name.

InfoArmor

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