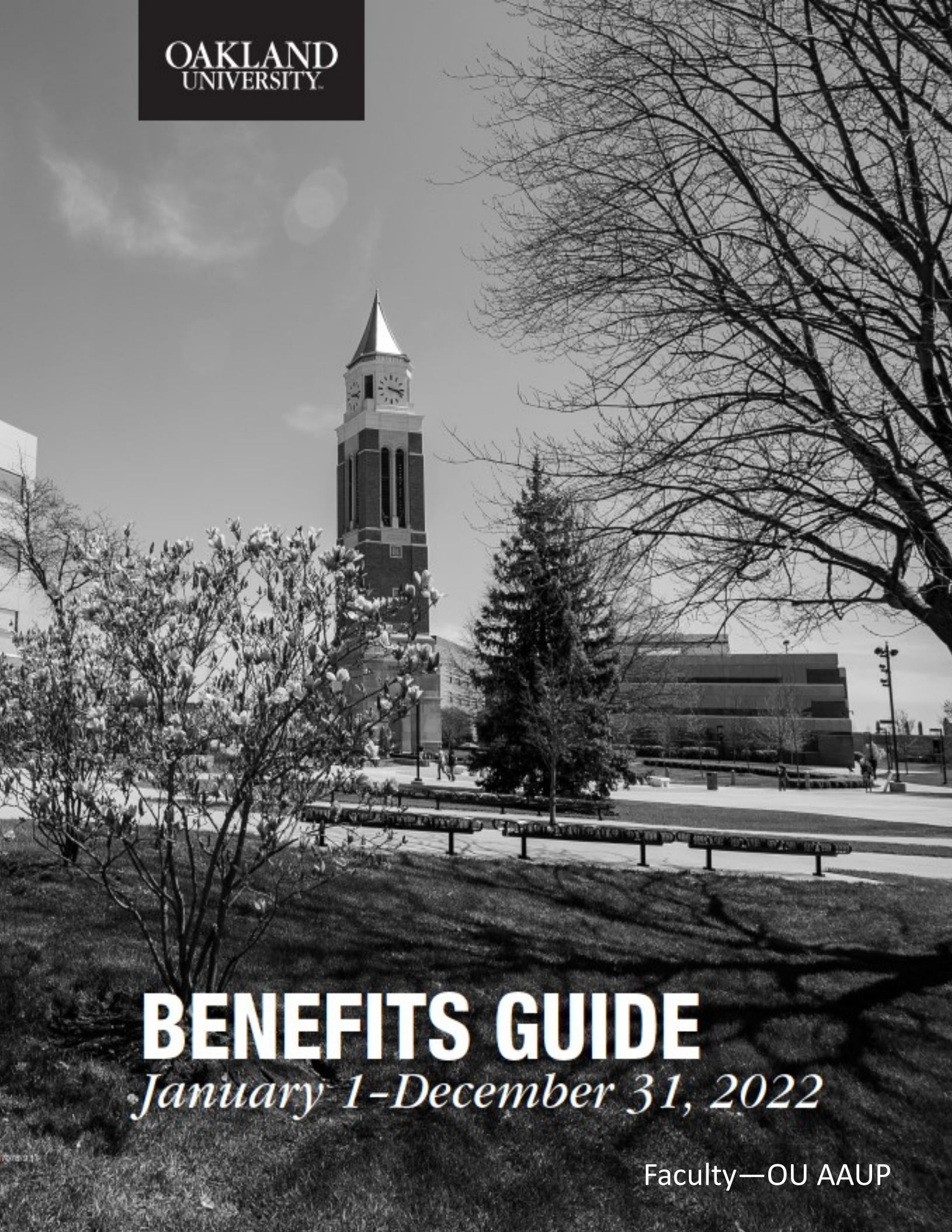
OAKLAND
UNIVERSITY
BENEFITS GUIDE
January 1-December 31, 2022
Faculty—OU AAUP

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2022 Contributions

Faculty - Monthly Medical Premium Rates (Effective 1/1/22)

	Total Premium	OU's Contribution	Employee Contributions
Blue Cross/Blue Shield—PPO			
Single	$639.30	$490.17	$149.13
Two Party	$1,534.31	$1,225.43	$308.88
Three or more	$1,917.90	$1,470.51	$447.39
Blue Care Network—Healthy Blue Living HMO			
Single	$601.15	$490.17	$110.98
Two Party	$1,442.77	$1,225.43	$217.34
Three or more	$1,803.46	$1,470.51	$332.95
Priority Health—Choice Buy-Up HMO			
Single	$601.68	$490.17	$111.51
Two Party	$1,504.20	$1,225.43	$278.77
Three or more	$1,805.04	$1,470.51	$334.53
Priority Health—HealthbyChoice Achievements HMO			
Single	$515.97	$490.17	$25.80
Two Party	$1,289.93	$1,225.43	$64.50
Three or more	$1,547.91	$1,470.51	$77.40

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, 2022 and will remain in effect through December 31, 2022 unless you experience a qualifying event.**

Any changes or enrollment decisions must be completed online by midnight on Friday, October 29, 2021 for benefit changes to take effect January 1, 2022.

Deductions for your 2022 benefit elections will begin with **your first January paycheck**, with benefits effective on January 1, 2022.

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 2022 Open Enrollment on October 18, 2021, as well as with a Benefit and Wellness Fair in the Oakland University Rec Center on Wednesday, October 20, 2021 from 9:00am to 1:00pm.

Online enrollment closes at midnight on Friday, October 29, 2021. If you have not completed your enrollment by that time, you will remain in your current benefits at the new 2022 rates, with the exception of the flexible spending accounts which will be discontinued.

What's Changing in 2022

Medical Plans:

- The Priority Health Out-of-Pocket Maximum will increase to $8,550 for an individual and $17,100 for a family. The Blue Care Network Out-of-Pocket Maximum will not change in 2022. Please see page 15 for additional information.
- As a result of the Consolidated Appropriations Act, all Blue Cross Blue Shield, Blue Care Network, and Priority Health subscribers will receive new ID cards for the 2022 plan year. The act requires that member ID cards include amounts of in– and out-of-network individual and family deductibles, and out-of-pocket maximums for pharmacy and medical services.

Flexible Spending Accounts:

- The COVID-19 national emergency spurred government relief applicable to Health Care Reimbursement Accounts (HCRA) and Dependent Care Reimbursement Accounts (DCRA) in 2020 and 2021. Because the government relief specifically impacted plan years ending in 2020 and 2021, as of 1/1/22 the following will occur:
    - In 2020 and 2021, government relief increased HCRA carryover amounts from $550 to unlimited. For the 2022 plan year, the carryover amount will return back to $550. This means that any remaining funds in 2021 HCRAs will carryover into 2022. However, if you have any funds remaining in your 2022 HCRA, the maximum amount you can carryover into the 2023 plan year is $550.
    - In 2021, government relief increased DCRA contribution maximums from $5,000 to $10,500. For the 2022 plan year, the DCRA contribution maximum will return to $5,000.
    - In 2020 and 2021, government relief extended the DCRA grace period from 2.5 months to 12 months. This means that plan participants have until 12/31/21 to incur expenses and use 2020 funds to pay for those expenses, and plan participants have until 12/31/22 to incur expenses and use 2021 funds to pay for those expenses. For the 2022 plan year grace period, plan participants will have until 3/15/23 to incur expenses and use 2022 funds to pay for those expenses.

Introduction

What's Changing in 2022 (continued)

Flexible Spending Accounts (continued):

- In 2020 and 2021, government relief allowed employees to join or cancel participation in a HCRA and DCRA at any time and for any reason. For the 2022 plan year, all HCRA and DCRA enrollments must occur either during Open Enrollment (effective 1/1/22) or within 30 days of a Qualified Life Event. For the 2022 plan year, all HCRA and DCRA changes must occur within 30 days of a Qualified Life Event.
- In 2021, government relief allowed terminated HCRA participants to incur expenses through 12/31/21 and use funds contributed while employed to pay for those expenses. For the 2022 plan year, HCRA terminated participants can use contributed funds to pay for expenses incurred up to their termination date, and will have 90 days post-termination to submit for reimbursement.

Prescription Drug Coverage:

- As of January 1, 2022 the Pharmacy Benefit Manager (PBM) at Blue Cross Blue Shield of Michigan and Blue Care Network will change from Express Scripts to OptumRx. A PBM is an internal partner that helps BCBSM and BCN to support the administration of pharmacy claims, manage rebate contracting with pharmaceutical manufacturers, manage retail pharmacy networks, and provide mail-order dispensing.
- What **IS NOT** changing?
  - Member benefits, including copays.
  - AllianceRx and Walgreens will continue to be the preferred provider of specialty pharmacy drugs.
  - Pharmacy and medical utilization review (includes step therapy and quantity limits).
  - Prior authorization review, approval, and denial.
  - PillarRx and Sempre Health programs.
  - Formulary management.
  - Opioid management.
  - Site of care.
  - Oncology management.
- We've put together a list of common questions and answers for your review:

Question	Will there be any pharmacy network disruption as a result of the PBM transition?
Answer	In short, yes but we expect minimal disruption. Blue Cross is working with OptumRx to minimize any pharmacy network disruption. OptumRx will contact pharmacies that are currently in the Blue Cross network but not in the OptumRx network. If efforts are unsuccessful, impacted members will be notified at least 45 days in advance of January 1, 2022.
Question	Will members have to start over on step therapy or obtain a new prior authorization for medications that require those?
Answer	No. Blue Cross will continue to manage all clinical programs as they do today. Previously approved prior authorizations and member status in step therapy will not change.

What's Changing in 2022 (continued)

Prescription Drug Coverage (continued):

Question	Will there be any drug list disruption as a result of the PBM transition?
Answer	Blue Cross typically makes changes to their drug lists throughout the year. So, there will be minor changes to the Blue Cross drug lists effective 1/1/22 but these changes are not as a result of the PBM transition and occur as a normal part of the Blue Cross formulary management process.
Question	Will members need new ID cards as a result of the PBM transition?
Answer	All members will receive new ID cards, and new cards will begin to be mailed in late 2021. This means that if you are enrolled in a Blue Cross plan in 2021, you will receive new ID cards in late 2021 and based on your 2021 enrollment which can be used beginning 1/1/22. ID cards will mail out from October 3-December 15. Since the new ID cards associated with the PBM change will be sent separate to any plan changes that you make during open enrollment, if your open enrollment change requires you receive new ID cards, you will receive those ID cards separately. Members will be able to access their up-to-date digital ID cards at any time through their online accounts or the BCBSM/BCN mobile app. The Rx BIN number on member ID cards is changing as a result of the PBM transition to OptumRx. In addition, information will be added to member ID cards as a result of the Consolidated Appropriations Act of 2021. This act requires that member ID cards include amounts of in– and out-of-network individual and family deductibles, and out-of-pocket maximums for pharmacy and medical services.
Question	Who will be the home delivery pharmacy for BCBSM and BCN?
Answer	OptumRx will be the new home delivery pharmacy starting January 1, 2022. Blue Cross will automatically transfer most prescriptions to OptumRx for members currently using home delivery. Controlled substances, expired prescriptions, and prescriptions without refills cannot be transferred. In those cases, members will need to talk to their doctors to get new prescriptions sent to OptumRx January 1, 2022 or thereafter. Members will receive detailed communications from Blue Cross, as well as a letter and phone call from OptumRx, to ensure a smooth transition to OptumRx for home delivery. AllianceRx and Walgreens will continue to be the preferred provider of specialty pharmacy drugs.
Question	How will Blue Cross notify members about the change?
Answer	Blue Cross is creating a communication plan that will include sending information directly to members about the changes that may affect them. We will share additional information in advance of member mailings planned for this fall.

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

- ❑ **It is recommended that employees go online and confirm their benefits and covered dependents for 2022, except for Voluntary Life which is done through the UHR offices.**
  - **Even if you are making no changes for your 2022 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 2022, you must go online and enroll.

Medical

- ❑ Please carefully review the 2022 Medical plan options and HMO qualification requirements found on pages 10-18 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.
- ❑ If you plan on waiving coverage for the first time, you **must** complete a **paper** waiver of coverage form for the 2022 plan year. If you waived coverage in 2021, your waiver will remain in effect until it is changed or revoked, or until expiration of the current OU-AAUP collective bargaining agreement.

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.

Voluntary Life

- ❑ No action is required to maintain your current coverage.
- ❑ You and/or your dependent spouse or Other Eligible Adult (OEA) may increase your Voluntary Life, however EOI may be required.
- ❑ **Contact UHR by October 29, 2021 if you would like to increase your Voluntary Life coverage effective 1/1/22.**

Eligibility

Coverage For You

All full-time, faculty members are eligible to enroll 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 the end of the month in which they reach age 19, or end of the month in which they turn 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.

Eligibility

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 2020 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 2020 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 they have 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 they lose 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
- Opt-Out

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 they think 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 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 BCBM 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 a 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.

BCBSM and 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.

BCBSM and BCN Pillar Rx

Members who fill certain high-cost medications will be required to utilize available copay assistance cards through Pillar Rx.

BCBSM, BCN, and Priority Health Rx Mail Order

You have the option to fill many medications* through mail order. For mail order services, BCBSM and BCN use OptumRx and Priority Health uses Express Scripts.

For BCBSM and BCN participants, the OptumRx mail order form will be available on January 1, 2022.

For Priority Health participants, you can obtain the required mail order form here. At the link, select "Order prescriptions delivered to your home."

*Note: BCBSM & BCN specialty drug mail order is handled through the Exclusive Specialty pharmacy program.

Medical/Rx Plan Overview

Medical Opt-Out

Employees who are eligible to receive group medical insurance coverage through Oakland University may waive that coverage for themselves and their dependents. In order to waive coverage for the first time, employees must submit a completed and signed Oakland University Waiver of Medical Insurance Coverage form ("Waiver Form") to the Benefits office in 401 Wilson Hall. If you waived coverage in 2021, your waiver will remain in effect until it is changed or revoked, or until expiration of the current OU-AAUP collective bargaining agreement. Completed Waiver Forms must be submitted during the applicable enrollment period. Employees who waive group medical insurance coverage for themselves and their tax dependents are eligible to receive a pre-tax Waiver Payment (currently $1,000 per calendar year or $83.33 per month) for each calendar year during which coverage has been waived if the employees:

- Satisfy the Waiver Payment requirements in any applicable collective bargaining agreement, personnel policy manual or individual contract; and
- Except as otherwise provided in an applicable collective bargaining agreement, submit a Waiver Form each calendar year attesting that they, and all of their tax dependents, have or will have minimum essential health insurance coverage (other than an individual policy) during the period for which coverage has been waived.

A Waiver Payment will not be made if Oakland University knows or has reason to know, that an employee or any of their tax dependents do not have, or will not have, minimum essential health insurance coverage during the period for which coverage has been waived. In addition, Waiver Payments will be pro-rated for partial years (e.g., employees who start or end their employment during a calendar year).

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.

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.

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.

Outside of the Priority Health Service Area

Priority Health provides services for dependents who are away at school or reside outside of the service area, however you must contact Priority Health to ensure you are properly listed as residing outside of the service area. Additionally, Priority Health utilizes the Cigna Open Access Plus network outside of the state of Michigan. You can notify Priority Health that you live outside of the service area by calling Priority Health customer service at 1-800-446-5674. If you are not a dependent residing outside of Michigan, you are only covered outside the service area for emergent/urgent care, or prior approved services. 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)	$8,150/$16,300	$8,150/$16,300	$8,550/$17,100	$8,550/$17,100	$8,550/$17,100
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

*100% telemedicine coverage is applicable when billing indicates the service was conducted virtually. Applicable PCP/Specialist copay will apply if a telemedicine claim is billed without indicating the service was conducted virtually.

How to Use the Telemedicine Benefit

Oakland University's medical plans offered through BCBSM, BCN and Priority Health offer coverage for telemedicine services. Each carrier offers its own proprietary platform that can be utilized for telemedicine services, and many individual providers offer telemedicine services. Below we've outlined the different forms in which you can utilize telemedicine services through your medical plans.

Telemedicine Services Outside of Proprietary Platforms

Many doctors offer telemedicine services, across all specialties including behavioral health. If a service is conducted virtually, commonly called "telemedicine" services, and that service is normally considered a covered benefit if conducted in-person, then it will also be covered if conducted virtually. For BCBSM and BCN subscribers, the PCP/Specialist member cost-share will apply. For Priority Health subscribers, 100% of your costs will be covered for telemedicine visits if your provider submits the claim to Priority Health indicating that the visit was conducted virtually. If the provider does not indicate that the visit was conducted virtually, the PCP/Specialist member cost-share will apply. All other plan provisions will apply.

BCBSM/BCN Online Visits—proprietary platform

For medical care, you can use BCBSM Online Visits when you're traveling , at home, or when your primary care doctor isn't available. Visits usually last about 10 minutes, although doctors will spend as much time as needed. You can see a doctor on-demand or by appointment, 24 hours a day, seven days a week. For behavioral health care, online visits give you more choices for behavioral health care. Talk to therapists about life's challenges from the comfort of your own home. Therapy visits include psychologists, licensed clinical social workers, marriage and family therapists, and professional counselors. Psychiatry appointments are also available.

Sign up via the following ways:

- Mobile: Download the BCBSM Online Visits app
- Web: Visit bcbsmonlinevisits.com
- Phone: Call 1-844-606-1608

Note: PCP/Specialist member cost-share applies to all telemedicine services.

Priority Health Spectrum Health Now and MD Live—proprietary platforms

Virtual care gives you access to board-certified doctors on nights, weekends, and even holidays for health issues that aren't an emergency. Virtual care connects you with a doctor over the phone, through video, or simply by filling out an online questionnaire. Depending on your condition and the type of virtual care you choose, a doctor can prescribe a medication and send it to your preferred pharmacy, develop a treatment plan, notify your primary care doctor with current information, and make follow-up recommendations, including referrals to see a specialist.

Virtual care is great for non-emergencies, like cough, cold, flu, fever, nausea, vomiting, sinus problems, pink eye, allergies, bites, and stings, rash, hives, and more. You can download the Priority Health app (available in the App Store or Google Play) to get started.

Medical/Rx Plan Overview

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, or the beginning of the plan year, for the initial requirements. You have 120 days from your effective date, or the beginning of the plan year, to complete additional steps depending on your qualification form results (i.e. enroll in a tobacco cessation coaching program or a weight management program).
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?	Within the first 90 days of the plan year, log into your online BCBSM account to complete a personal health assessment, Also, schedule an appointment with your primary care physician for a health evaluation to check: • Body mass index • Tobacco use (cotinine test required) • Blood pressure • Blood sugar • Depression Your doctor must complete the qualification form and return it to BCN. You must complete these initial qualifications in the first 90 days of the plan year and receive an A or B score on your qualification form. If you receive a "C" on any of the health measures you will move to the Standard benefits for the remainder of the year. Depending on the results of your qualification form, you may have additional steps to complete within the first 120 days of the plan year to maintain the enhanced benefit level. You must actively participate through the end of the year in order to remain in Enhanced benefits. • If your qualification form shows a BMI of 30 or higher, you need to enroll and participate in a BCN-sponsored weight management program. • If your qualification form shows you use tobacco, you need to enroll and participate in a tobacco cessation coaching program. The above summarizes the qualification requirements. See the Qualification Form or Healthy Blue Living Member Guide 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.

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, 2022 open enrollment is 1/1/22 through 3/31/22. 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 1/1/22 through 3/31/22, you will be on the Choice plan on 4/1/22. If you do not complete and/or pass the requirements within the open enrollment qualification period of 1/1/22 through 3/31/22, you will move to the Standard plan on 4/1/22.
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

These plans are offered to you and your family by Oakland University at no cost to you. 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		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.

Life Insurance Overview

Employee Life Insurance Overview

Oakland University provides company-paid Basic Life insurance, which provides payment to your beneficiaries in the event of your passing.

Basic (employer-paid) benefit: One times your basic annual pay to a maximum of $250,000.

You may purchase Voluntary Life insurance (employee-paid) in addition to the Basic Life provided by OU.

Voluntary (employee-paid) benefit: Choice of $50,000, $100,000, $150,000 or $200,000.

During Open Enrollment, you can increase your current Voluntary Life benefit by one level without submitting EOI.

During Open Enrollment, if you want to increase your current Voluntary Life benefit by more than one level, EOI is required.

What is EOI?

EOI stands for Evidence of Insurability. Insurance companies use this to confirm that you are in good health. It is an application process in which you provide information on the condition of your or your dependents health in order to obtain coverage.

If you declined enrollment in Voluntary Life upon your initial eligibility but wish to enroll during Open Enrollment, you are required to submit EOI for any benefit amount greater than $50,000.

Important Notes

- You must be actively at work for your Life insurance to take effect.
- Basic and Voluntary Life benefits reduce the first of the month after you reach age 65, 70, and 75:
  - At age 65, benefits reduce to 67% of the principal amount
  - At age 70, benefits reduce to 45% of the principal amount
  - At age 75, benefits reduce to 30% of the principal amount
- Life benefits terminate when employment ends.

Voluntary Employee Life rates vary based on your age. Rates change on the first of the month following your birthday if you enter into a new age band. See the below chart of the Voluntary Employee Life rates:

Employee Age	Employee Rate Per $1,000	Employee Voluntary Life Options and Monthly Cost			
		Option #1	Option #2	Option #3	Option #4
		$50,000	$100,000	$150,000	$200,000
<29	0.050	$2.50	$5.00	$7.50	$10.00
30-34	0.060	$3.00	$6.00	$9.00	$12.00
35-39	0.080	$4.00	$8.00	$12.00	$16.00
40-44	0.130	$6.50	$13.00	$19.50	$26.00
45-49	0.210	$10.50	$21.00	$31.50	$42.00
50-54	0.330	$16.50	$33.00	$49.50	$66.00
55-59	0.510	$25.50	$51.00	$76.50	$102.00
60-64	0.770	$38.50	$77.00	$115.50	$154.00
Employee benefits reduce to 67% at age 65; 45% at age 70; and 30% at age 75.					
65-69	1.190	($33,500) $39.87	($67,000) $79.73	($100,500) $119.60	($134,000) $159.46
70-74	3.000	($22,500) $67.50	($45,000) $135.00	($67,500) $202.50	($90,000) $270.00
75+	3.000	($15,000) $45.00	($30,000) $90.00	($45,000) $135.00	($60,000) $180.00

Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate/benefit booklet for details.

Life Insurance Overview

Dependent Life Insurance Overview

Voluntary Dependent Life insurance provides coverage on the lives of your spouse or Other Eligible Adult (OEA) and eligible dependent children. Voluntary Dependent Life insurance is 100% employee-paid.

If you declined enrollment in Voluntary Spouse Life upon your initial eligibility but wish to enroll during Open Enrollment, you are required to submit EOI for the $20,000 benefit level. EOI is not required for the $5,000 benefit level.

EOI is never required for dependent children, however dependent children can only be added during Open Enrollment or due to a qualifying life event.

Spouse/OEA Voluntary benefit: Choice of $5,000 or $20,000
Dependent Child(ren) Voluntary benefit: $4,000

Important Notes

- Voluntary Spouse/OEA Life rates are based on their age, and rates are adjusted on the first of the month following the birthday they enter into the new age band. Benefits also reduce at the following ages:
    - At age 65, benefits reduce to 67% of the principal amount
    - At age 70, benefits reduce to 45% of the principal amount
    - At age 75, benefits reduce to 30% of the principal amount
- Voluntary Spouse/OEA Life benefits terminate when your employment ends.
- Spouse and child: coverage is delayed if in the hospital or totally disabled.

Eligible Dependents

Under this benefit, your spouse, your OEA and your unmarried children are considered to be your eligible dependents. Children are covered from live birth to the last day of the month in which the child turns age 19, or age 26 if they are full-time students. The definition of children also includes legally adopted children, stepchildren who live with you and children for whom you are the legal guardian, who are living with you and are dependent on you for support.

Spouses/OEAs that work at OU are not eligible for coverage under the Spouse Life benefit. If both the employee and Spouse/OEA work at OU, their eligible children may only be covered under one policy.

Life Insurance Overview

Dependent Life Insurance Overview (continued)

Spouse/OEA Age	Spouse/OEA Rate Per $1,000	Spouse/OEA Voluntary Life Options and Monthly Cost	
		Option #1	Option #2
		$5,000	$20,000
<29	0.050	$0.25	$1.00
30-34	0.060	$0.30	$1.20
35-39	0.080	$0.40	$1.60
40-44	0.130	$0.65	$2.60
45-49	0.210	$1.05	$4.20
50-54	0.330	$1.65	$6.60
55-59	0.510	$2.55	$10.20
60-64	0.770	$3.85	$15.40
Spouse benefits reduce to 67% at age 65; 45% at age 70; and 30% at age 75.			
65-69	1.190	($3,350) $3.99	($13,400) $15.95
70-74	3.000	($2,250) $6.75	($9,000) $27.00
75+	3.000	($1,500) $4.50	($6,000) $18.00

The Child Voluntary Life rate is $0.40 per month, regardless of the number of children enrolled.
Maximum benefit per child is $4,000.

Voluntary AD&D Overview

Oakland University offers an employee-paid Voluntary Accidental Death and Dismemberment (AD&D) plan that protects against any covered accident including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile, etc. You are covered on a worldwide basis, 24 hours a day, 365 days a year.

Employee Eligibility: All active employees domiciled in the United States working a minimum of 20 hours per week. To be eligible, persons that are not U.S. citizens must have Lawful Permanent Residency (a green card) or a valid and active I-129 work visa and their legal status must be verified by payroll deduction.

Dependent Eligibility: Your spouse, your OEA and your unmarried children are considered to be your eligible dependents. Children are covered to age 19, or age 26 if they are full-time students. The definition of children also includes:

- Legally adopted children
- Your stepchildren

No eligible person may be covered more than once under this Policy. If they are covered as an Employee, they cannot also be covered as a dependent of another Employee.

Benefit Options

Employee: Employees may elect $10,000 - $500,000 in increments of $10,000. Any amounts over $250,000 are subject to a limit of 10 times your annual salary.

Family Coverage:

1. Employee and Spouse/OEA with dependent children: Spouse/OEA's benefit is 50% of the employee's and each child's benefit is 10% of the employee's principal sum.
2. Employee and Spouse/OEA with no dependent children: Spouse/OEA's benefit is 60% of the employee's principal sum.
3. Employee and Dependent children with no Spouse/OEA: Each child's benefit is 20% of the employee's principal sum.

Cost of Voluntary AD&D Benefit

Employee: 0.023 per $1,000 of benefit
Family: 0.031 per $1,000 of employee benefit

This is a summary of the Voluntary AD&D benefits. Complete benefit, definition and exclusionary details can be found in the carrier Policy. Should there be any discrepancy between the Policy and this outline, the Policy will prevail.

Voluntary AD&D Overview

Below are the monthly costs for Voluntary AD&D coverage. Under this plan, your election must be a multiple of $10,000.

Voluntary AD&D Options	Employee Per $1,000 $0.023	Employee Plus Family Per $1,000 $0.031
$10,000	$0.23	$0.31
$20,000	$0.46	$0.62
$30,000	$0.69	$0.93
$40,000	$0.92	$1.24
$50,000	$1.15	$1.55
$60,000	$1.38	$1.86
$70,000	$1.61	$2.17
$80,000	$1.84	$2.48
$90,000	$2.07	$2.79
$100,000	$2.30	$3.10
$110,000	$2.53	$3.41
$120,000	$2.76	$3.72
$130,000	$2.99	$4.03
$140,000	$3.22	$4.34
$150,000	$3.45	$4.65
$160,000	$3.68	$4.96
$170,000	$3.91	$5.27
$180,000	$4.14	$5.58
$190,000	$4.37	$5.89
$200,000	$4.60	$6.20
$210,000	$4.83	$6.51
$220,000	$5.06	$6.82
$230,000	$5.29	$7.13
$240,000	$5.52	$7.44
$250,000	$5.75	$7.75

Voluntary AD&D Options	Employee Per $1,000 $0.023	Employee Plus Family Per $1,000 $0.031
$260,000	$5.98	$8.06
$270,000	$6.21	$8.37
$280,000	$6.44	$8.68
$290,000	$6.67	$8.99
$300,000	$6.90	$9.30
$310,000	$7.13	$9.61
$320,000	$7.36	$9.92
$330,000	$7.59	$10.23
$340,000	$7.82	$10.54
$350,000	$8.05	$10.85
$360,000	$8.28	$11.16
$370,000	$8.51	$11.47
$380,000	$8.74	$11.78
$390,000	$8.97	$12.09
$400,000	$9.20	$12.40
$410,000	$9.43	$12.71
$420,000	$9.66	$13.02
$430,000	$9.89	$13.33
$440,000	$10.12	$13.64
$450,000	$10.35	$13.95
$460,000	$10.58	$14.26
$470,000	$10.81	$14.57
$480,000	$11.04	$14.88
$490,000	$11.27	$15.19
$500,000	$11.50	$15.50

This is a summary of the Voluntary AD&D benefits. Complete benefit, definition and exclusionary details can be found in the carrier Policy. Should there be any discrepancy between the Policy and this outline, the Policy will prevail.

Long Term Disability Overview

Oakland University provides Long Term Disability insurance through Unum, at no cost to you.

Long Term Disability replaces a portion of your income in the event you are disabled for an extended period of time and you are unable to work. Benefits for approved claims begin after you have been disabled for 180 days.

Definition of Disability:	The employee is considered disabled if, solely because of injury or sickness, they are unable to perform the material duties of their regular occupation, or unable to earn 80% or more of their indexed earnings from working in their regular occupation. After disability benefits have been paid for 24 months, the insured is considered disabled if, solely due to injury or sickness, they are unable to perform the material duties of any occupation for which they are, or may reasonably become, qualified based on education, training or experience, or unable to earn 80% or more of their indexed earnings.
Elimination Period:	180 Days
Monthly Benefit:	60% of basic monthly earnings to a maximum of $5,000
Pre-Existing Condition:	Any injury or sickness for which the employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 3 months before their most recent effective date of insurance.
Pre-Existing Limitation:	No benefits are payable for a disability that begins in the first 12 months after your effective date of coverage for a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to your effective date of coverage.

This information is a high-level summary of some of the key terms and conditions found in the Unum insurance policy. Please refer to the employee booklet certificate for a complete and accurate breakdown of the terms and conditions of your Insurance policy. Note that to the extent there are any discrepancies between the content of this enrollment guide and Oakland University's Unum policy, Unum is not responsible to pay any benefits in excess of what the policy terms mandate.

Additional Benefits

MetLife 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. MetLife 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 MetLife Pre-Paid Legal can be found at www.info.legalplans.com or by calling (800) 821-6400.

Allstate Identity Protection Pro 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. Allstate Identity Protection Pro Plus *(formerly InfoArmor PrivacyArmor)* offers a robust product to continue to provide you peace of mind:

⇒ **3 Credit Bureau Monitoring:** TransUnion, Equifax and Experian. Also get help disputing errors on your credit report.

⇒ **Fraud Reimbursement:** Get reimbursed for fraud-related losses like stolen 401(k) funds or fraudulent tax returns with a $1 million identity theft insurance policy.

⇒ **Financial Transaction Monitoring:** Participants receive additional alert notifications from our 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 Allstate Identity Protection Pro Plus can be found at www.myaip.com or by calling (800) 789-2720.

Unum & Health Advocate Employee Assistance Program (EAP)

The Oakland University and Unum partnership provides an additional benefit to members, which is an Employee Assistance Program offered through a third-party company called Health Advocate. Your EAP is provided at no cost to you in conjunction with your employer-paid Life Insurance policy.

It is important to note that the EAP services are available to all eligible employees, spouses/OEAs, dependent children, parents, and parents-in-law.

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for **confidential** access to a Licensed Professional Counselor who can help you.

A Licensed Professional Counsel can help you with:	
Stress, depression, anxiety	Family and parenting problems
Relationship issues, divorce	Anger, grief, and loss
Job stress, work conflicts	And more

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of the Work/Life Specialists can answer your questions and help you find resources in your community.

Ask the Work/Life Specialists about:	
Child care	Financial services, debt management, credit report issues
Elder care	Reducing your medical/dental bills
Legal questions, identity theft	And more

Accessing help is easy!

⇒ Online/phone support: Unlimited, confidential, 24/7.
⇒ In-person: you can get up to three visits **at no additional cost to you** with a Licensed Professional Counsel. Your counsel may refer you to resources in your community for ongoing support.
⇒ Call toll-free 1-800-854-1446 (multi-lingual).
⇒ Get online to find out more and access care.

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 2022, 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 $2,750 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 and menstrual products

In most instances, expenses must be incurred between January 1, 2022—December 31, 2022 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 2021 HCRA funds, all of your unused funds will automatically rollover into your 2022 account. Please note the following:

- Normally, any amount over $550 is forfeited. Due to COVID-19, the government has allowed that all of your unused funds will automatically rollover into 2022.
- The rollover amount will be in addition to the 2022 annual contribution maximum.
- Rollover funds will become available for use in April 2022.
- You do not need to elect a HCRA in 2022 in order to use your 2021 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 their 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.

Your DCRA includes a grace period, which extends the period of time you have to use your DCRA funds on eligible expenses. In most instances, expenses must be incurred between January 1, 2022—March 15, 2023 to be eligible for reimbursement from 2022 plan year funds.

- The grace period does not impact the amount of time you have to file claims/submit documentation for expenses.
- The extension does not impact the next plan year. You can still elect up to the full maximum annual election.

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.

Flexible Spending Account Overview

Reimbursements

Reimbursement payments will be sent to you via the BASIC debit card and a service called MyCash. You can also direct BASIC to deposit reimbursement payments into the bank account of your choosing, or receive a paper check. You will also have the option of using a BASIC debit card to pay for FSA-eligible expenses. To view or change your existing bank account for direct deposit, you can download the direct deposit form from the BASIC website and submit it to BASIC.

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 $550, and any DCRA funds you do not use by the end of the grace period.

Note, too, that the maximum you can contribute to a HCRA account for health-care expenses is $2,750. The maximum you and your spouse can contribute to a DCRA 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. 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

MyCash Account by BASIC

MyCash is an individual cash account that securely holds your reimbursement funds until you spend or move them. The MyCash account is available through your BASIC debit card - it is not a separate card.

On the occasion when you do not use your BASIC debit card to pay for an eligible expense, you can request reimbursement through your BASIC account or the BASIC mobile app. Requests are processed daily and approved reimbursements are deposited directly into your MyCash account. The typical reimbursement is available within 24-48 hours, which is often a faster turn-around than direct deposit.

There are no restrictions on how you use your MyCash funds. These are your reimbursement funds and can be spent like cash everywhere MasterCard is accepted. You can also withdraw MyCash funds from an ATM, or transfer the funds to your personal bank account via the website or mobile app.

All new BASIC participants will receive reimbursement payments via MyCash, unless direct deposit is established. If direct deposit is not already established, you can follow these steps to establish a recurring direct deposit for all reimbursements:

- Sign into your BASIC account or open the BASIC mobile app.
- Click the MyCash balance menu and select schedule a balance transfer.
- Select a frequency (weekly, every two weeks, monthly).
- Choose your bank account or link a new one.
- Choose the transfer date.

Manage your MyCash account

- It's easy to view and manage your MyCash funds online or via the BASIC mobile app.
- View recent MyCash reimbursement transfers, ATM withdrawals, and/or BASIC debit card transactions.
- View BASIC debit card information, reissue a card, request a PIN, request a dependent debit card, and view debit card history.
- Save bank account details to easily schedule transfers from MyCash to a personal bank account.
- Schedule a transfer to a personal checking or savings account.

Verification

If you use your MyCash debit card, you do not have to submit for reimbursement. BASIC may ask for additional information after you use the debit card, and this process is called "verification." When verification is requested, you can submit the requested information one of the following ways:

- Through the online portal website;
- BASIC's Secure Claim Upload;
- Fax to 269-327-0716;
- Mail to: BASIC CDA Department PO Box 6278, Monona, WI 53716.

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, and/or receipt from day care provider.

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

Flexible Spending Account Overview

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 BASIC at BASIC CDA Department PO Box 6278, Monona, WI 53716. 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.

Signing into your BASIC online account

The first time you access the Consumer Driven Accounts (CDA) system, you need to sign up. Login to the BASIC website by following this link: https://cda.basiconline.com/login. Under "First time here?" click the sign up link you you will then be directed to enter an email address. For your first login you should use your Oakland University work email address, and then create a password.

Once you have signed up, use the sign-in function to access your account going forward. Select sign-in, enter your email address, and click next. On the next screen, enter your password and select sign-in.

It is important to use your Oakland University work email address for your first login to the BASIC website. If the one you entered is not recognized, please contact BASIC Customer Service at 1-800-444-1922 for assistance.

Flexible Spending Account Overview

Important Information Regarding COVID-19 and its impact on HCRAs and DCRAs

The COVID-19 national emergency spurred government relief applicable to Health Care Reimbursement Accounts (HCRA) and Dependent Care Reimbursement Accounts (DCRA).

This government relief impacts the runout period and grace period as follows:

- Submitting 2021 Claims During the Runout Period and Grace Period:
  - Runout Period: Government relief has paused the runout period, which is the deadline you have following the end of the plan year to submit for reimbursement. Normally, for claims incurred in 2021, you would have 90 days to submit for reimbursement following the end of the plan year on 12/31/21. This deadline is paused, and we do not know when the pause will end and the normal deadline will apply. So, we recommend that you adhere to the 90-day deadline that is applicable outside of the COVID-related government relief.
  - Grace Period: Government relief has extended the grace period, which is applicable to DCRAs and is an additional amount of time you have to incur claims and use the prior year's funds to pay for those claims. Normally, the DCRA allows for a grace period of 2.5 months which would mean that you could incur DCRA claims through March 15, 2022 and use 2021 funds to pay for those expenses. However, due to the COVID-related government relief, the 2021 plan year grace period has been extended to 12 months. This means that you can incur DCRA claims through 12/31/22 and use 2021 funds to pay for those expenses.

This government relief impacts carryover rules and contribution maximums as follows:

- In 2020 and 2021, government relief increased the HCRA carryover amount from $550 to unlimited. For the 2022 plan year, the carryover amount will return back to $550. This means that any remaining funds in 2021 HCRAs will carry over into 2022. However, if you have any funds remaining in your 2022 HCRA, the maximum amount that you can carry over into the 2023 plan year is $550.
- In 2021, government relief increased the DCRA contribution maximum from $5,000 to $10,500. For the 2022 plan year, the DCRA contribution maximum will return to $5,000.

This government relief impacts election rules as follows:

- In 2020 and 2021, government relief allowed employees to join or cancel participation in a HCRA and DCRA at any time and for any reason. For the 2022 plan year, all HCRA and DCRA enrollments must occur either during Open Enrollment (effective 1/1/22) or within 30 days of a qualified life event.
- In 2021, government relief allowed terminated HCRA participants to incur expenses through 12/31/21 and use funds contributed while employed to pay for those expenses. For the 2022 plan year, normal rules will resume. So, HCRA participants can use contributed funds to pay for expenses incurred up to their termination date and will have 90 days post-termination to submit for reimbursement. Normal rules for DCRA have always allowed terminated participants to use contributed funds to pay for services incurred through the last date of prior plan year.

If you have questions about the runout period, grace period, or any of the government relief related to COVID-19, contact the BASIC Health Flexible Benefits Department at 800-444-1922.

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
Unum	Life/AD&D	(800) 275-8686 www.unum.com
Unum	Short-Term and Long-Term Disability	(800) 275-8686 www.unum.com
BASIC	Flexible Spending Account	(800) 444-1922 https://cda.basiconline.com/login
MetLife	Prepaid Legal	(800) 821-6400 www.legalplans.com
Allstate Identity Protection	Identity and Credit Protection	(800) 789-2720 www.myaip.com
Unum/Health Advocate	Employee Assistance Program	(800) 854-1446 www.unum.com/lifebalance
University Human Resources (UHR) 401 Wilson Hall		(248) 370-4207 www.oakland.edu/uhr

Appendix

- Liberty Mutual
- MetLife
- Allstate

Appendix

There are no words to properly thank educators, but there are **special savings.**

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.[2]

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

Collision Coverage
There is a $0 deductible if your vehicle is damaged in a collision while you're driving it on school business.[2]

You'll also enjoy many other benefits, like Accident Forgiveness[3], Better Car Replacement[4], and 24-Hour Road Assistance[5]. It's our way of saying thank you for the difference you make.[1]

Contact me for your free quote.

Michael Meyer
Executive Sales Representative
13001 23 Mile Rd, Ste 102
Shelby Township, MI 48315
(586) 884-9399
Michael.Meyer@LibertyMutual.com
Client #110230

OAKLAND UNIVERSITY | Liberty Mutual INSURANCE

AUTO | HOME | RENTERS | UMBRELLA | MOTORCYCLE | CONDO | WATERCRAFT

[1]Discounts and savings are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. [2]Not available in all states, and may vary by state. [3]ACCIDENT FORGIVENESS NOT AVAILABLE IN CA. Terms and conditions apply. [4]Optional coverage in some states. Availability varies by state. Eligibility rules apply. [5]Coverage is provided on the optional Towing & Labor Coverage endorsement. May vary by state. Applies to mechanical breakdowns and disablements only, and may be subject to limits. Policy provisions apply. Coverage provided and underwritten by Liberty Mutual Insurance Company or its subsidiaries or affiliates, 175 Berkeley Street, Boston, MA 02116. Equal Housing Insurer. ©2019 Liberty Mutual Insurance 12837280

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MetLife | Legal Plans

| FOR OAKLAND UNIVERSITY EMPLOYEES

OAKLAND UNIVERSITY

Legal experts on your side, whenever you need them

For **$26.75 a month**, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms, when using a network attorney for a covered matter. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

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	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of 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	• Disputes Over Consumer Goods & Services • Incompetency Defense	• 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[2] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[3]

To learn more about your coverages and see our attorney network, create an account at **legalplans.com** or call **800.821.6400** Monday – Friday 8:00 am to 8:00 pm (ET).

1. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.
2. Does not cover DUI.
3. Digital notary and signing is not available in all states.

Navigating life together

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

Appendix

Allstate IDENTITY PROTECTION

Pro Plus Overview

As your partner in Identity Theft and Fraud 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 affected by security breaches in their work and personal lives. As these threats continue to evolve, so do our solutions. Allstate Identity Protection Pro Plus (formerly InfoArmor Privacy Armor) offers a robust product to continue to provide you peace of mind.

What is identity theft protection?

There are many types of programs out there claiming to provide identity theft protection. The only feature that all of them have in common is some form of credit monitoring — and for some, that's all they do.

Identity theft isn't the problem; it's fixing it

It's about how a thief could make use of your information to exploit other accounts and areas of your life. It's about using personal information and known passwords to unlock other accounts. It's about learning enough about you and your habits that someone else could use your identity for their own gain. It's easy to provide FAQ sheets, forums, and educational content. Providing human support for guidance and Q&A makes the difference. AIP provides support advocates who are available 24x7 and offer full service remediation to ensure the participant is restored to pre-theft status.

- **3 Credit Bureau Monitoring:** TransUnion, Equifax, and Experian. Also get help disputing errors on your credit report.
- **Fraud Reimbursement:** Get reimbursed for fraud-related losses like stolen 401(k) funds or fraudulent tax returns with a $1 million identity theft insurance policy.
- **Financial Transaction Monitoring:** Participants receive additional alert notifications from our data sources for transactions on credit, debit, and checking accounts such as new account authorizations, new deposits, accounts opened, and personal information request changes.

AIP vs. Credit Monitoring

Credit Monitoring	Allstate Identity Protection
Credit file activity at one bureau	Tri-bureau credit report monitoring
Daily credit report	Tri-bureau credit scores
Identity Theft Insurance	Credit based account monitoring and alerts
Identity Restoration	Solicitation reduction
	Social media monitoring- suspicious links
	Dark web monitoring
	Recovery insurance for stolen funds
	Customer support 24/7/365 Based in Arizona
	401(k)/HSA reimbursements
	High-risk transaction monitoring/threshold
	Financial activity monitoring- checking/ savings
	Lost wallet protection
	Digital exposure reports
	Data breach notifications
	Allstate Digital Footprint
	Sex offender Registry
	Mobile app
	IP address Monitoring

OAKLAND UNIVERSITY

Please Enroll Through Self Service Banner

Questions? 1.800.789.2720
www.myaip.com

Plans and pricing

Allstate Identity Protection Pro Plus

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