OAKLAND
UNIVERSITY.

BENEFITS GUIDE

January 1-December 31, 2021

Special Lecturers

Table of Contents

2021 Contributions 1

Introduction 2

What's Changing in 2021 2

Action Steps 5

Eligibility 6

Annual Elections & Life Status Changes 8

Medical/Rx Plan Overview 10

Dental Overview 18

Vision Overview 19

Additional Benefits 20

- MetLaw Pre-Paid Legal 20
- Allstate Identity Protection Pro Plus 20

Flexible Spending Account 21

Legal Notices 26

Benefit Contacts 39

Appendix 40

Important Information About Medicare

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 37-38 for more details.

2021 Contributions

Special Lecturers—Monthly Medical Premium Rates (Effective 1/1/21)

	Monthly Total Premium	Monthly OU's Contribution	Average Monthly Employee Contribution	Jan-Apr Employee Contribution	May-Aug Employee Contribution	Sept-Dec Employee Contribution
Blue Cross/Blue Shield—PPO						
Single	$567.30	$313.79	$253.51	$507.02	$0	$253.51
Two Party	$1,361.54	$784.47	$577.07	$1,154.14	$0	$577.07
Three or more	$1,701.92	$941.36	$760.56	$1,521.12	$0	$760.56
Blue Care Network—Healthy Blue Living HMO						
Single	$520.81	$313.79	$207.02	$414.04	$0	$207.02
Two Party	$1,249.95	$784.47	$465.48	$930.96	$0	$465.48
Three or more	$1,562.44	$941.36	$621.08	$1,242.16	$0	$621.08
Priority Health—Choice Buy-Up HMO						
Single	$680.50	$313.79	$366.71	$733.42	$0	$366.71
Two Party	$1,701.25	$784.47	$916.78	$1,833.56	$0	$916.78
Three or more	$2,041.50	$941.36	$1,100.14	$2,200.28	$0	$1,100.14
Priority Health—HealthbyChoice Achievements HMO						
Single	$482.75	$313.79	$168.96	$337.92	$0	$168.96
Two Party	$1,206.88	$784.47	$422.41	$844.82	$0	$422.41
Three or more	$1,448.25	$941.36	$506.89	$1,013.78	$0	$506.89
Delta Dental						
Single	$34.77	$22.60	$12.17	$24.34	$0	$12.17
Two Party	$68.81	$44.73	$24.08	$48.16	$0	$24.08
Three or more	$126.69	$82.35	$44.34	$88.68	$0	$44.34
Davis Vision						
Single	$4.89	$3.18	$1.71	$3.42	$0	$1.71
Two Party	$9.78	$6.36	$3.42	$6.84	$0	$3.42
Three or more	$12.22	$7.94	$4.28	$8.56	$0	$4.28
Blue Cross Vision						
Single	$3.52	$2.29	$1.23	$2.46	$0	$1.23
Two Party	$7.04	$4.58	$2.46	$4.92	$0	$2.46
Three or more	$11.69	$7.60	$4.09	$8.18	$0	$4.09

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, 2021 and will remain in effect through December 31, 2021 unless you experience a qualifying event.**

Any changes or enrollment decisions must be completed online by midnight on Friday, October 30, 2020 for benefit changes to take effect January 1, 2021.

Deductions for your 2021 benefit elections will begin with **your first January paycheck**, with benefits effective on January 1, 2021.

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 2021 Open Enrollment on October 19, 2020, as well as with a virtual Benefit and Wellness Fair on Wednesday, October 21, 2020.

Online enrollment closes at midnight on Friday, October 30, 2020. If you have not completed your enrollment by that time, you will remain in your current benefits at the new 2021 rates, with the exception of the flexible spending accounts which will be discontinued.

What's Changing in 2021

Medical Plans:

- The Blue Care Network and Priority Health Out-of-Pocket Maximums will increase to $8,150 for an individual and $16,300 for a family. Please see page 14 for additional information.
- Blue Cross Blue Shield of Michigan is implementing a pharmacy program called Exclusive Specialty for its entire book of business. This pharmacy program was implemented by Blue Care Network last year. Currently, BCBSM members can fill specialty prescriptions at any in-network retail location. When members fill their prescription, their experience will differ based on pharmacy location. Some members may receive counseling from the pharmacist, while some may not. Members who fill specialty medications are often managing complex diseases and should receive coordinated support when filling their prescriptions.
  - Beginning on January 1, 2021, members who fill specialty medications will be required to fill their prescriptions through AllianceRx. Members can pick up their prescriptions at either a Walgreens pharmacy location or utilize the home delivery service.
  - This program is built to support the specialty pharmacy needs of members with care teams of pharmacists, patient care coordinators, and patient financial service experts dedicated to helping patients minimize financial burden.
  - Members will also have access to:
    - Monthly refill reminders
    - Adherence monitoring
    - Proactive side effect management
    - Member education to optimize therapy
    - Prescription expiration notices
    - 24/7 access to a pharmacist or nurse 365 days a year
    - Centers of excellence model to ensure only experts in a given disease state are caring for our sickest members
    - Injection training for newly prescribed members

Introduction

What's Changing in 2021 (continued)

Medical Plans (continued)

- Blue Cross Blue Shield of Michigan and Blue Care Network are implementing a copay assistance program called PillarRx. The goal of the program is to help members afford their medications and adhere to their therapies. Through copay assistance programs, drug manufacturers cover all or some of the member cost-sharing for certain medications.
    - The program is applicable to both BCBSM and BCN members.
    - The copay assistance program is operated by PillarRx Consulting, an independent prescription benefit consulting company.
    - PillarRx will help arrange copay assistance from drug manufacturers for BCBSM/BCN members who purchase certain medications.
    - PillarRx will contact impacted members through letters and phone calls. Please note that letters are co-branded with both the Blue Cross and PillarRx logos.
    - If a member takes one or more medications for which copay assistance is available, s/he can expect a phone call from a PillarRx copay assistance team representative. The representative will help the member to enroll in the discount program.
    - Please note that this program is not optional. If you are contacted by PillarRx, you must participate in the program in order to continue to pay the current Rx copay (or less) for the applicable drug.
- Blue Cross Blue Shield of Michigan is changing its provider network and prior authorization process for Durable Medical Equipment, Prosthetics and Orthotics, and medical supplies (including diabetic supplies). Beginning 1/1/21, members will access these services through the Northwood provider network.
    - This change aligns the BCBSM network and prior authorization process with Blue Care Network.
    - Examples of Durable Medical Equipment include CPAP machines, walkers, and canes. Examples of Prosthetics and Orthotics include body support and custom limb equipment. Examples of medical supplies include diabetic supplies, dressings, ostomy, and urological supplies.
    - BCBSM will be targeting members who are currently utilizing these services with a non-Northwood provider, to notify them of the changes and provide education.
    - The "Find a Doctor" tool located on the member portal will be updated to service members in finding a provider within the Northwood tailored network.
    - BCBSM will be reaching out to all PPO members who fall into one of the three following categories: continuous and purchase users (1), capped rental (2), and non-capped rental (3).
    - Members are responsible for additional costs when any of the following occur: services are not prescribed by a physician, service is outside of the Northwood network without Northwood authorization, and/or quantity received is in excess of established guidelines.

What's Changing in 2021 (continued)

Flexible Spending Accounts

- The maximum amount you may elect to contribute to the Health Care Reimbursement Account will increase to $2,750, up from $2,700 in 2020. The Dependent Care Reimbursement Account maximum contribution is not changing for 2021 and remains $5,000.
- The maximum rollover amount allowed under the Health Care Reimbursement Account (HCRA) is now $550, up from $500. This change is applicable beginning with 2020 funds that rollover into the 2021 plan year, and for all plan years thereafter.
- The Dependent Care Reimbursement Account (DCRA) includes a grace period. A grace period extends the period of time participants have to use DCRA funds on eligible expenses. If you have funds remaining at the end of the plan year on 12/31, you can tap into those funds for an additional 2 1/2 months, through March 15 of the next plan year. See page 22 for more information.

InfoArmor Privacy Armor

- InfoArmor Privacy Armor has changed its name and will now be called Allstate Identity Protection Pro Plus. All benefit options and coverage remain the same.

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 2021, except for Voluntary Life which is done through the UHR offices.**
  - **Even if you are making no changes for your 2021 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 2021, you must go online and enroll.

Medical

- ❑ Please carefully review the 2021 Medical plan options and HMO qualification requirements found on pages 10-17 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.
- ❑ Whether you currently waive coverage or plan on waiving coverage, you **must** complete a new **paper** waiver of coverage form for the 2021 plan year.

HIPAA Privacy Notice

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

Eligibility

Coverage For You

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

Coverage For Your Dependents

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

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

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

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

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

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

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

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

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 2019 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 2019 filed Federal income tax Form 1040 (just the first page listing your dependent child(ren), Social Security numbers and financial information can be blacked out), or a Qualified Medical Child Support Order, or Court paperwork for legal guardianship.

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

Annual Elections & Life Status Changes

Pre-Tax Contributions

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

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

Making Mid-Year Life Status Changes

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

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

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

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

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

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

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

Annual Elections & Life Status Changes

HIPAA Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. **However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.**

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

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

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

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

Medical/Rx Plan Overview

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

Your medical options are:

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

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

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

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

Care at Non-Participating Providers

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

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

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

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

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

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

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

Medical/Rx Plan Overview

Priority Health Choice Buy-Up HMO

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

Prescription Drug Coverage

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

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

Generics Save You Money

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

Step Therapy and Prior Authorization

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

90-Day Supply

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

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. BCBSM, BCN, and Priority Health use Express Scripts for mail order services, and you can obtain the required mail order forms here for BCBSM/BCN and here for Priority Health.

At the link for BCBSM, select "Rx group number BCBSMRX1 mail order form."

At the link for BCN, there is only one listed option.

At the link for Priority Health, 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

How To Navigate Your HMO Network

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

Within the BCN Network

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

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

Within the Priority Health Network

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

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.

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

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.	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	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
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 applicable when services are obtained through the Priority Health member app. Applicable PCP/Specialist copay could apply if telemedicine services are received outside of the app.

Medical/Rx Plan Overview

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. PCP/Specialist member cost-share will apply, along with all other plan provisions.

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. To access virtual care at 100% coverage, you must download the Priority Health app (available in the App Store or Google Play) to get started.

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.

Medical/Rx Plan Overview

Priority Health—HealthByChoice Achievements HMO

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

	Priority Health—HealthbyChoice Achievements HMO
What plan do you start in?	New enrollees will start in the Choice plan. For the 2021 plan year only, members already enrolled in the plan: • Who were in Standard at the end of the previous year will start in the Standard plan. • Who were in Choice at the end of the previous year and met the requirements during the extended qualification period will start in the Choice plan effective 1/1/21. • Who were in Choice at the end of the previous year and did not meet the requirements during the extended qualification period will start in the Standard plan effective 1/1/21.
What is the qualification period?	The qualification period for January 1, 2021 open enrollment is 1/1/21 through 3/31/21. 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 1/1/21 through 3/31/21, you will be on the Choice plan on 4/1/21. If you do not complete and/or pass the requirements within the open enrollment qualification period of 1/1/21 through 3/31/21, you will move to the Standard plan on 4/1/21.
What are the qualification requirements?	Whether you begin in the Choice or Standard plan you must complete the following requirements within the qualification period in order to be on the Choice plan after the qualification period has concluded: 1. You must complete a confidential, online health assessment. 2. You must have your doctor complete the HealthbyChoice Achievements Qualification Form available online at priorityhealth.com. 3. You must be tobacco free, including e-cigarettes. 4. Your body mass index (BMI) must be under 30 or you must have a waist circumference of <41 inches for a male or <35 inches for a female. 5. Your blood pressure must be under <140/90 or <150/90 for those over 60 years old. With diabetes 140/80 and with CVD 140/90. 6. Your LDL cholesterol must be under 190 or under 100 based on risk factors. 7. Your blood sugar metrics are only required for members with diabetes or heart disease. HbA1c must be lower than 7% if you have diabetes or fasting blood sugar lower than 126 if you have heart disease. The above summarizes the qualification requirements. See the Qualification Form for complete detail.
Are reasonable alternatives available if you do not pass one of the wellness targets?	Yes, depending on the target you miss below are Priority Health's suggested alternative standards: • Quit tobacco (including e-cigarettes) or complete a Priority Health tobacco cessation program. • Body Mass Index (BMI) – reduce your weight by 5%. • Blood Pressure – reduce systolic by 10mm or diastolic by 5mm. • Cholesterol – reduce LDL by 20 mg/dl. • Blood Sugar – improve by reaching normal level, reduce HbA1c by 1%. Your physician can set their own alternative standard for you. If they are not using Priority Health's suggested alterative standards, be sure your doctor enters your specific alternative standard into Priority Health's online system, otherwise it will default to Priority Health's suggested alternative standard. Once you achieve the alternative wellness target you must visit your doctor and have them resubmit the HealthbyChoice Achievements Qualification Form showing the alternative target has been met. You will move to the Choice plan effective on the latest date that all goals and qualification requirements are met.
What happens if I add a spouse mid-year?	Your spouse is added to your contract in the same level that you are in, either Choice or Standard. If you are already enrolled in Choice, your spouse does not have to meet the qualifications until the following renewal. If you are enrolled in Standard, you both have the opportunity to complete and meet the requirements to move into Choice at any time during the year.

Dental Overview

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

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

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

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

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

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

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

Vision Overview

Oakland University offers two vision plans:

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

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

BCBSM/VSP Vision now includes Walmart and Sam's Club in its list of participating providers!

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

[1]If you receive services outside of a routine eye exam you may be required to pay additional costs.
[2]For participating providers, there is a 20% discount on overage for frames and 15% discount on overage for contact lenses. Sign in at www.davisvision.com to find participating providers online (client code is 3217).
[3]If you choose extra options beyond the standards that are covered, you are responsible for the additional cost, paid directly to the providers.
[4]A list of participating BCBSM VSP Network providers can be found here: https://www.vsp.com/find-eye-doctors.html.

MetLaw Pre-Paid Legal Overview

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

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

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

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.

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 2021, 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, 2021—December 31, 2021 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 2020 HCRA funds, up to $550 of your unused funds will automatically rollover into your 2021 account. Please note the following:

- You will have until March 31, 2021 to submit any requests for reimbursement for 2020 claims to BASIC.
- Any amount over $550 will be forfeited.
- The rollover amount will be in addition to the 2021 annual contribution maximum.
- Rollover funds will become available for use in April 2021 .
- You do not need to elect a HCRA in 2021 in order to use your 2020 rollover funds, however you do need to be an active Oakland University employee.
- Rollover does not apply to the Dependent Care Account.

Dependent Care Reimbursement Account (DCRA)

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

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

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

Generally, your dependents include:

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

<u>Any leftover funds in your DCRA at year-end cannot be returned to you.</u> 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, 2021—March 15, 2022 to be eligible for reimbursement. You will have until March 31, 2021 to submit any requests for reimbursement for 2020 claims to BASIC.

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

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 year.

Note, too, that the maximum you can contribute to a FLEX account for health-care expenses is $2,750. The maximum you and your spouse can contribute to a dependent care account is $5,000.

Eligible Annual Expense Worksheet

Health Care Reimbursement Account:
Medical Expenses

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

Dependent Care Reimbursement Account:
Dependent Day Care Expenses

· Child Day Care	$_________
· Adult Day Care	$_________
Total Estimated DCRA Expenses	**$_________**

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

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

Using Your Flexible Spending Accounts

To receive payment for an eligible health or dependent care expense, simply fill out a Reimbursement Request Form and submit it with your itemized receipt. You may mail or fax your Reimbursement Request Form, or submit it electronically online. You can also submit for reimbursement through the BASIC mobile app, available for download on both Android and iPhone systems. Reimbursements are processed promptly every day. You will be repaid for the full amount of your Health Care Reimbursement Account request, up to the total contributions you specified for the year.

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

Keeping Track of Your Accounts

You can check the status of your Flexible Spending Account(s) by signing in online. If you have questions about your Oakland University Flex plan, contact the BASIC Health Flexible Benefits Department at 800-444-1922.

Flexible Spending Account Overview

Using Your BASIC Flex Debit Card

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

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

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

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

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

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

- Explanation of Benefits (EOB)
- Itemized Statement
- Prescriptions
- Detailed vision bills from your vision provider
- Letter of medical necessity
- Receipt from day care provider

Debit Card Frequently Asked Questions

Q: What happens if I forget to submit verification?

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

Q: What happens if I purchase an ineligible item?

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

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

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

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

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

Flexible Spending Account Overview

Submitting 2020 Claims During the Runout Period

- Health Care Reimbursement Accounts:
    - For health care claims incurred in 2020, you have 90 days to submit for reimbursement following the end of the plan year on 12/31/20.
    - During the runout period, if a provider bills you for dates of service that occurred prior to 1/1/21, you must submit for reimbursement directly with BASIC rather than pay with your BASIC debit card. During the runout period, you CANNOT use your BASIC debit card to pay for health care claims with dates of service incurred during 2020.
- Dependent Care Reimbursement Accounts:
    - For dependent care claims incurred through March 15, 2021, you have 90 days to submit for reimbursement following the end of the plan year on 12/31/20.
    - During the runout period, you can use your BASIC debit card for expenses incurred both in the prior plan year and in the new plan year.

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

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

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

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

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

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

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

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

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

Legal Notices

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the 2021 Benefits Guide) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Oakland University reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Women's Health and Cancer Rights Act Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' and Mothers' Health Protection Act of 1996

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

Notice of Patient Protection

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

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

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

Coverage Under Michigan's Abortion Insurance Opt-Out Act

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

Legal Notices

DOL Notice for HIPAA Health Contingent Wellness Programs:

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 248-370-4166 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program

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

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

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

Protections from Disclosure of Medical Information

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

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Oakland University sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Oakland University, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Oakland University, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Oakland University HIPAA Privacy Officer or University Human Resources:

Oakland University
Attention: HIPAA Privacy Officer
Benefits and Compensation Services Office
371 Wilson Blvd.
Rochester, MI 48309
Voice: 248/370-4207 Fax: 248/370-4212

Effective Date

This Notice as revised is effective October 19, 2020.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing

with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclo-

sures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Legal Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – MEDICAID
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-916-440-5676
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584
IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740. TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov/
Phone: 1-877-267-2323, Menu Option 4, Extension 61565

Legal Notices

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

Notice of Creditable Coverage

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Oakland University has determined that the prescription drug coverage offered by Oakland University is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Oakland University coverage as an active employee, please note that your Oakland University coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Oakland University coverage as a former employee.

You may also choose to drop your Oakland University coverage. If you do decide to join a Medicare drug plan and drop your current Oakland University coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% high-

er than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 15, 2020
Name of Entity/Sender:	Oakland University
Contact--Position/Office	Eric Herppich, Director of Compensation and Benefits
Address:	371 Wilson Blvd., Rochester Hills, MI 48309
Phone Number:	248-370-4166

Benefit Contacts

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

Appendix

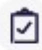
- Liberty Mutual
- MetLaw
- Allstate

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

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

19AFF686950-35 CW 2019/10

Legal Plans

Provides access to legal expertise
for both expected and unexpected events.

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.

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[1] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

Estate planning at your fingertips

Our newly redesigned website provides you with the ability to create wills, living wills and powers of attorneys online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. finalize the documents.[2]

To learn more, visit info.legalplans.com and enter access code 6091120 or call 800.821.6400 Monday – Friday 8:00 am – 8:00 pm (ET).

1. Does not cover DUI.

Group legal plans provided by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and affiliates, Warwick, RI. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife, its affiliates, or plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse/civil union partner or dependents, in which case services are excluded for the spouse/civil union partner and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark, and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. MetLife® is a registered trademark of Metropolitan Life Insurance Company, New York, NY. [ML2]

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

L0520003890[exp0921][All States][DC,PR] © 2020 MetLife Services and Solutions, LLC

Appendix

Identity protection that keeps up with your digital life

With Allstate Identity Protection Pro Plus you'll be able to

- See and control your personal data with our unique tool, Allstate Digital Footprint™
- Monitor social media accounts for questionable content and signs of account takeover
- Check your identity health score
- View and manage alerts in real time
- Catch fraud at its earliest sign with tri-bureau monitoring and an annual tri-bureau credit report and score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- Get help disputing errors on your credit report
- See if your IP addresses have been compromised
- Receive alerts for cash withdrawals, balance transfers, and large purchases
- Get reimbursed for fraud-related losses like stolen 401(k) & HSA funds or fraudulent tax returns with our $1 million identity theft insurance policy†
- Protect yourself and your family (everyone that's "under your roof and wallet")*

Please Enroll Through Self Service Banner

Questions? 1.800.789.2720

Plans and pricing

Allstate Identity Protection Pro Plus

$9.95 per person / month

$17.95 per family / month

It's easy to get started

1. Enroll in Allstate Identity Protection Pro Plus

You're protected from your effective date. Our auto-on credit monitoring alerts require no additional setup.

2. Activate key features

Explore additional features in our easy-to-use portal. The more we monitor, the safer you can be.

3. Live your best life online

In the event of identity theft or fraud, you'll receive an alert as soon as it's detected.