



WAYNE STATE
UNIVERSITY
Human Resources



Active Employee Benefits Handbook

Please note: The descriptions contained in this handbook are only a summary and are not meant to be the controlling legal document or contract of employment between the employee and the university. If there are any conflicts between the handbook and the official plan documents, the official plan documents will control the administration of the plans. The benefit information in this handbook may be subsequently updated due to changes in the law and policies. Additional information about your Wayne State University benefits is available at hr.wayne.edu/tcw/benefits.



Total Rewards • Human Resources

Address: 5700 Cass Ave., Suite 3638, Detroit, Michigan 48202

Telephone: 313-577-3000 • Fax: 313-577-0637

Email: askhr@wayne.edu

Hours: Weekdays, 8:30 a.m. - 5:00 p.m.

Table of Contents

Welcome	1	Wellness Warriors Program	39
Benefits Resource Directory	2	Life Advisor Employee Assistance Program (EAP)	40
Benefits Eligibility	7	Voluntary Benefits	41
Medical, Dental, Vision and Life Insurance Benefits	10	COBRA	42
• How to Enroll, Change or Cancel Benefits	10	Glossary	45
• Life Events	13	Frequently Asked Questions	48
• Benefit Costs	14	Legal Notices	53
Medical Insurance	15	• Providing False Information	
Cash in Lieu of Medical	16	• Disclaimer	
Dental Insurance	22	• Women’s Health and Cancer Rights Act	
Vision Insurance	25	• Creditable Coverage Notice (Medicare Part D)	
Life Insurance	27	If you 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.	
Family and Medical Leave Act (FMLA)	30	• Notice of Privacy Practices	
Michigan Paid Medical Leave Act (PMLA)	31	• HIPAA Notice of Special Enrollment Rights	
Americans with Disabilities Act (ADA)	32	• Coverage Under Michigan’s Abortion Insurance Opt-Out Act	
Long-Term Disability (LTD) Insurance	33	• CHIP Notice	
Flexible Spending Accounts (FSAs)	34		
Retirement Savings Plans	36		
Tuition Assistance Programs	38		

Wayne State University – Warrior Strong

Our mission

We will create and advance knowledge, prepare a diverse student body to thrive, and positively impact local and global communities.

Our vision

We will be a pre-eminent, public, urban research university known for academic and research excellence, success across a diverse student body, and meaningful engagement in its urban community.

Our values

While our vision and mission show where we want to go, our values guide us on the way. They cut across organizational boundaries, bind us culturally, and permeate our strategic and tactical initiatives. They are the defining traits of the Wayne State community.

- Collaboration: When we work together, drawing upon various talents and perspectives, we achieve better results.
- Integrity: We keep our word, live up to our commitments and are accountable to ourselves and each other.
- Innovation: We are unafraid to try new things and learn by both failure and success.
- Excellence: We strive for the highest quality outcomes in everything we do.
- Diversity and Inclusion: We value all people and understand that their unique experiences, talents and perspectives make us a stronger organization and better people.

Welcome to Wayne State University Employee Benefits!

Wayne State University is committed to your overall health and well-being. Our benefits are competitive and structured to provide high quality health care and financial protection for you and your family. Your total compensation is comprised of both your salary and the array of benefits offered to you as a benefits-eligible employee while at Wayne State University.

Take a moment to invest in yourself and review the description of benefits available to you. The options you choose will be tailored to your needs. Review the information contained in this book, take notes and schedule appointments to meet with the appropriate resources. The cost of medical, dental, vision, and life insurance benefits are shared by you and the university, with a significant portion paid by Wayne State.

While this handbook features important information about our benefit programs, more comprehensive details are located on our website at hr.wayne.edu.

Attending a new hire orientation session for a formal Human Resources presentation can be very helpful to learn about everything offered to you as a Wayne State University employee. Contact your hiring manager for more information on how to attend.

Please always contact us if you have any questions or concerns about your benefits.

To your health,

Total Rewards

Human Resources

The benefits offered to you are designed to be:

- Accessible and easy to use
- Adaptable - multiple plan options
- Affordable



Benefits Resource Directory

Contact	Phone (hours) and Address	Website, Email and App (download free mobile apps listed below through the App Store or Google Play)
Wayne State University		
For general Human Resources and benefits questions:		
HR Service Center	313-577-3000 (Mon–Fri 8:30am–5pm) fax: 313-577-0637	web: hr.wayne.edu/tcw email: askhr@wayne.edu
	24/7 Employee Self-Service	web: academica.wayne.edu
Medical, Dental and Vision		
For information about:		
<ul style="list-style-type: none"> • Eligibility to participate in a benefit plan • Enrolling in and changing coverage in a benefit plan • Changing personal information (including dependent information) 		
Businessolver - Wayne State Benefits Center	888-907-1433 (Mon-Fri 8am-8pm)	web: mywaynebenefits.com app: MyChoice Mobile
For:		
<ul style="list-style-type: none"> • Participating providers • Covered and non-covered expenses • ID cards (for Medical and Vision) • Claims 		
Medical Plans		
Health Alliance Plan HMO Group #: 10000664	800-422-4641 (Mon–Fri 8am–7pm)	web: hap.org app: HAP OnTheGo
Priority Health HMO Group #: 796653	800-446-5674	web: priorityhealth.com app: Priority Health Member Portal
Blue Care Network HMO Group #: 00111308	800-662-6667 (Mon–Fri 8am–5:30pm)	web: bcbsm.com app: BCBSM
BCBSM PPO Group #: 007002779	877-354-2583 (Mon–Fri 8am–5:30pm)	web: bcbsm.com app: BCBSM
Blue Cross Blue Shield of Michigan Group #: 007002779	877-354-2583 (Mon–Fri 8am–5:30pm)	web: bcbsm.com app: BCBSM
Virtual Doctor Visits (visit a board-certified doctor via smartphone or computer 24/7)		
HAP – American Well	844-733-3627 (every day, 24 hours)	web: hap.amwell.com email: support@amwell.com app: Amwell: Doctor Visits 24/7 Service Key: HAPMi
Priority Health – Spectrum Health Now	844-322-7374	web: priorityhealth.com app: Spectrum Health
Blue Care Network, BCBSM PPO & Blue Cross Blue Shield - Teledoc Health	800-835-2362 (every day, 24 hours)	web: bcbsm.com/virtualcare app: Teledoc Health

Benefits Resource Directory

Contact	Phone (hours) and Address	Website, Email and App (download free mobile apps listed below through the App Store or Google Play)
Home Delivery Pharmacy Service (free shipping, 90-day supply, licensed pharmacists)		
HAP – Pharmacy Advantage	800-456-2112	web: pharmacyadvantagerx.com app: HAP OnTheGo
Priority Health – Express Scripts	888-378-2589 (every day, 24 hours)	web: express-scripts.com/ app: Express Scripts
Blue Care Network, BCBSM PPO & Blue Cross Blue Shield – OptumRx	844-642-9087 (every day, 24 hours)	web: bcbsm.com
Dental		
Delta Dental Group #: 0007544	800-482-8915 (Mon–Fri 8am–8pm)	web: deltadentalmi.com app: Delta Dental Mobile
Vision		
EyeMed Group #: 9730953	866-939-3633 (every day, 7am–11pm)	web: eyemed.com (“Select” Network) app: EyeMed Members
Life Insurance		
<ul style="list-style-type: none"> • Enrollment • Beneficiary designation 		
Businessolver - Wayne State Benefits Center	888-907-1433 (Mon-Fri 8am-8pm)	web: mywaynebenefits.com app: MyChoice Mobile
<ul style="list-style-type: none"> • Coverage questions • To file death claims 		
HR Service Center	313-577-3000 (Mon–Fri 8:30am–5pm) fax: 313-577-0637 5700 Cass Ave., Suite 3638 Detroit, MI 48202	web: hr.wayne.edu/tcw/health-welfare/life-insurance email: askhr@wayne.edu
<ul style="list-style-type: none"> • Questions after a claim has been paid or denied • Conversion coverage administration • Portability coverage administration 		
Sun Life Financial	800-247-6875 (Mon–Fri 8am–8pm) One Sun Life Executive Park Wellesley Hills, MA 02481	web: sunlife.com/us email: usweb_general_information@sunlife.com app: Sun Life Benefit Tools

Benefits Resource Directory

Contact	Phone (hours) and Address	Website, Email and App (download free mobile apps listed below through the App Store or Google Play)
Family Medical Leave (FMLA)		
<ul style="list-style-type: none"> • Request a leave • Check eligibility • Check leave status • Learn regulations 		
FMLASource	877-GO2-FMLA (Mon–Fri 7:30am–10pm) fax: 877-309-0218 455 N. Cityfront Plaza Drive 13th Floor Chicago, IL 60611-5322	web: fmlasource.com app: FMLASource Now
Long-Term Disability (LTD)		
<ul style="list-style-type: none"> • Claim filing • Coverage questions 		
HR Service Center	313-577-3000 (Mon–Fri 8:30am–5pm) fax: 313-577-0637 5700 Cass Ave., Suite 3638 Detroit, MI 48202	web: hr.wayne.edu/tcw/health-welfare/longterm-disability email: askhr@wayne.edu app: Wayne State University
<ul style="list-style-type: none"> • After filing claims 		
New York Life Group Benefit Solutions	800-362-4462 888-842-4462 (Mon–Fri 7am–5pm) PO Box 709015, Dallas TX 75370-9015	web: mynylgbs.com app: MyCigna
Flexible Spending Accounts (FSAs)		
<ul style="list-style-type: none"> • Enrollment 		
Businessolver - Wayne State Benefits Center	888-907-1433 (Mon-Fri 8am-8pm)	web: mywaynebenefits.com app: MyChoice Mobile
<ul style="list-style-type: none"> • Eligible/covered expenses • Current account balance • Rejected claims • Required receipts 		
WEX	866-451-3399 (Mon–Fri 6am-9pm, central) PO Box 2926 Fargo, ND 58108-2926	web: wexinc.com app: Benefits by WEX

Benefits Resource Directory

Contact	Phone (hours) and Address	Website, Email and App (download free mobile apps listed below through the App Store or Google Play)
Health & Wellness Programs <ul style="list-style-type: none"> • Employee wellness programs • Employee assistance programs 		
Wellness Warriors Program		
Total Rewards	313-577-3000 (Mon–Fri 8:30am–5pm) fax: 313-577-0637 5700 Cass Ave., Suite 3638 Detroit, MI 48202	web: wellness.wayne.edu email: wellness@wayne.edu
Wellness Warriors Free Services		
<ul style="list-style-type: none"> • Flu shots & other immunizations 		
Campus Health Center	313-577-5041 (Mon–Fri 9am–5:30pm) fax: 313-577-9581 5285 Anthony Wayne Drive, Suite 115 Detroit, MI 48202	web: health.wayne.edu email: campushealth@wayne.edu
<ul style="list-style-type: none"> • Gym Memberships • Personal training • Exercise classes • Fitness assessments 		
Mort Harris Recreation and Fitness Center	313-577-2348 (Mon–Fri 5:30am–11pm) (Sat–Sun 10am–7pm) fax: 313-577-5843 5210 Gullen Mall Detroit, MI 48202	web: rfc.wayne.edu email: campusrec@wayne.edu
<ul style="list-style-type: none"> • Wellness coaching • Well-being portal • Health Assessment 		
Ulliance	888-699-3554 (Mon–Fri 8am–5pm)	Wellness Warriors Portal: wsu.lifeadvisorwellness.com app: Ulliance Life Advisor EAP
Employee Assistance Program (EAP)		
<ul style="list-style-type: none"> • Confidential • Crisis intervention • Work-stress related issues 		
Ulliance Life Advisor EAP	800-448-8326 (every day, 24 hours)	web: lifeadvisorereap.com app: Ulliance Life Advisor EAP

Benefits Resource Directory

Contact	Phone (hours) and Address	Website, Email and App (download free mobile apps listed below through the App Store or Google Play)
Retirement Savings Plans		
• Enrollment		
Retirement@Work Portal	24/7 Employee Self-Service	web: academica.aws.wayne.edu/link/6ug
• Investment options		
Fidelity Investments	800-343-0860 (Mon–Fri 8am–12am) PO Box 770001 Cincinnati, OH 45277-0018 Overnight Mail 100 Crosby Parkway KC1E Covington, KY 41015	web: netbenefits.com/waynestateuniversity app: NetBenefits
Fidelity Investments 1-on-1 counseling	800-642-7131 (Mon–Fri 8am–12am)	web: fidelity.com/atwork/reservations
TIAA	800-842-2252 (Mon–Fri 8am–10pm) (Sat 9am–6pm) PO Box 1268 Charlotte, NC 28201-1268 Overnight Mail 8500 Andrew Carnegie Blvd Charlotte, NC 28262	web: tiaa.org/wayne app: TIAA
TIAA 1-on-1 counseling	800-842-2044 (Mon–Fri 8am–10pm)	web: tiaa.org/wayne
Voluntary Benefits		
• Claims processing		
Liberty Mutual – Home & Auto	800-699-5298	web: libertymutual.com/wsu app: Liberty Mutual Mobile
PetPartners	800-956-2495	
Trustmark – Long-Term Care Insurance	800-918-8877 (Mon–Fri 7am–6pm) 400 Field Drive Lake Forest, IL 60045	web: trustmarksolutions.com/ email: customercare@trustmarksolutions.com
COBRA		
• COBRA enrollment and billing		
Businessolver	888-907-1433 (8am–8pm EST)	web: mywaynebenefits.com email: clientcare@businessolver.com

Benefits Eligibility

Employee Eligibility

You are eligible for benefits if you are classified in a benefits-eligible position (verify your classification with your HR Consultant or hiring manager) and your appointment percentage is 50% or greater. If your appointment percentage decreases below 50%, you will no longer be eligible to be enrolled in benefits as an active employee (however, COBRA may be an option for continuation of coverage).

You are not eligible for benefit enrollment if your classification does not meet the criteria stated above. For example, Student Assistants, college work study, temporary employees and employees represented by the Building Trades are not benefits-eligible. However, part-time faculty who meet the eligibility requirements defined by their Collective Bargaining Agreement may be eligible to enroll in voluntary dental and/or vision plan(s), being 100% employee paid.

If both you and your spouse/other eligible person are employed by Wayne State University, neither you nor your spouse/OEP can be covered as **both** an employee and a dependent under any of the Wayne State University benefit plans. Additionally, any eligible dependents of yours or your spouse/OEP cannot be covered by both parties under any of the WSU benefit plans.

Do you meet the eligibility requirements for benefits? When to enroll:

- Within 45 days of your hire date or when you become newly eligible for benefits.
- Within 30 days of experiencing a qualifying Life Event.
- During the annual Open Enrollment period (October and November), with changes effective the following January 1.



Dependent Eligibility

You can enroll your eligible dependents in medical, dental, vision and dependent life insurance benefits.

Eligible dependents include:

- Legal spouse (There is no dual coverage for WSU employees married to WSU employees.)
- Other Eligible Person (OEP) – If you do not already enroll a spouse for medical, dental or vision insurance benefits, you may enroll one other eligible person (OEP) if you and your OEP meet **all** the following requirements:
 - An adult, age 26 or older; and
 - Currently resides in the same residence as the employee and has done so for 18 continuous months prior to the individual's enrollment, other than as a tenant; and
 - Not a dependent of the employee as defined by the IRS; and
 - Not related by blood or marriage.
 - Not a spouse, child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin, landlord, renter, boarder or tenant of employee.
- Your children or the children of your spouse/OEP, defined as:
 - Children by birth or adoption (or placed in your home for final adoption).
 - Children by legal guardianship.
 - Stepchildren.
 - Under age 26.
- Principally supported children (Blue Cross Blue Shield and Blue Care Network only), defined as:
 - Not your child by birth or marriage until the end of the month in which they reach age 26.
 - Principally supported by you for at least six consecutive months (nine months for BCBS).
 - Related to you by blood or marriage.
 - Claimed as your dependents on your most recent income tax return.
- Unmarried disabled dependent children who:
 - Became disabled before reaching age 26, and are incapable of self-sustaining employment by reason of mental or physical handicap.
 - Have reached the end of the month in which they turned 26.
 - Are dependent on you for support and maintenance.

- Your sponsored dependent (Blue Care Network and Priority Health only), defined as:
 - An adult, age 26 or older.
 - Dependent on your financial support.
 - Claimed on your most recent income tax return.
 - Resides with you permanently.

You have 45 days from your date of hire or 30 days from a Life Event to enroll dependents, otherwise you must wait until the annual Open Enrollment period, with coverage taking effect the following January 1.

Dependent Documentation

In order to enroll dependents, there are documentation requirements that must be met. A list of **required** dependent documentation is available at hr.wayne.edu/tcw/benefits/dependents



If You Enroll an Ineligible Dependent

If you enroll a dependent who does not meet the dependent eligibility requirements, or you do not cancel coverage within 30 calendar days of when a dependent ceases to meet the dependent eligibility requirements, he or she will be considered an ineligible dependent and coverage may be rescinded retroactive to the date on which your dependent no longer qualified as an eligible dependent. The university has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded.

Examples of ineligible dependents:

- Ex-spouse or Ex-OEP
- Dependents not covered by court order
- Dependents over age 26
- A dependent already covered under a Wayne State University benefit plan

Medical, Dental, Vision and Life Insurance Benefits

How to Enroll, Change or Cancel Benefits

You can enroll, change or cancel your benefits:

- Within 45 days of becoming eligible as a new employee or becoming benefits-eligible due to a change in your employee classification, or
- Within 30 days of a Life Event (see Life Events section on page 13 for more details), or
- During the annual Open Enrollment period, with changes taking effect January 1st of the following year.

How to Enroll in Benefits

After 45 days as a new employee, you can only enroll or make changes to your medical, dental, and vision benefits during the annual Open Enrollment period, unless you have a Life Event during the year. Please note: After your date of hire, you can also enroll in additional benefits such as retirement savings plan(s), flexible spending account(s), tuition assistance, employee wellness programs, group home and auto insurance, and universal life insurance. Additional details regarding these benefits are found within this handbook.

You can enroll yourself and/or your dependents in benefits as a new employee, during a Life Event or during the annual Open Enrollment period.

- **As a New Employee:** Your enrollment election must be made within 45 days of your hire date and your date of coverage is the first of the month coincident with or following your date of hire. (Example: if you're hired on the first, your coverage will begin on the first of the month. If you're hired on the second, your coverage will begin the first of the following month.)
- **During a Life Event:** Make changes within 30 days of the event.
- **During Open Enrollment:** Follow the directions below.

When enrolling in your employee benefits, remember to:

- Choose a medical plan that meets your needs and is affordable to you.
- Decide which of your eligible dependents you wish to cover, if any.
- Upload the required dependent documentation to enroll eligible dependents.
- Select a Primary Care Physician, if enrolling in an HMO.
- Select vision and dental options.

To Enroll: Log into Academica

Click 'Employee Resources'

Click 'Employee Self-Service'

Click 'Benefit Plan Enrollment & Changes'

How to Make Changes to Benefits



Interlocking (Matching) Enrollments

Medical, dental and vision enrollment levels must be the same for each plan (single, two-person or family). If you elect WSU medical insurance, vision insurance is bundled (automatically comes with) and enrollment levels must match.

Voluntary Enrollments

If you waive WSU medical insurance and elect Cash in Lieu of Medical, dental and/or vision insurance is only available as a voluntary election and you will pay 100% of the cost.

You can make changes to your and/or your dependent's benefits during a Life Event or during the annual Open Enrollment period.

- **During a Life Event:** Make changes within 30 days of the event.
- **During Open Enrollment:** Follow the directions below.

To Make Changes: Log into Academica

Click 'Employee Resources'

Click 'Employee Self-Service'

Click 'Benefit Plan Enrollment & Changes'

How to Cancel Benefits

You can cancel your and/or your dependent's benefits during a Life Event or during the annual Open Enrollment period.

To Cancel: Log into Academica

Click 'Employee Resources'

Click 'Employee Self-Service'

Click 'Benefit Plan Enrollment & Changes'

Your participation in any voluntary benefits, including flexible spending accounts, ends the date your employment with the university ends. For more information and any applicable exclusions to this rule, visit our website.

For information about continuation of coverage, see the COBRA section on page 41.

When Coverage Begins

The date coverage for you and/or your eligible dependents begins depends on the event and when you log in to make changes/submit required supporting documentation.

For the following event:	If you log in to make changes/submit required supporting documentation:	The coverage change effective date is:
Newly hired or newly eligible	Within 45 days	First of the month following date of hire or first of the month if date of hire is on the first of the month.
Open Enrollment	During the annual Open Enrollment period	The following January 1.
Adding coverage due to loss of coverage, including those needing coverage due to divorce or spouse's loss of benefits	Within 30 days from loss of coverage	First of the month following loss of coverage date or if loss of coverage date is on the first of the month, the loss of coverage date.
Acquiring a new dependent <ul style="list-style-type: none"> • Newborn child • Adoption/pending adoption • Spouse after new marriage • Other eligible person after new partnership 	Within 30 days from date of birth, adoption, date of marriage or partnership	Date of acquiring new dependent.
Acquiring a child by legal guardianship	Within 30 days from date of guardianship	Date of acquiring child. Cannot change carriers at this point.
Acquiring a principally supported child (subject to eligibility guidelines)	Within 30 days from date the eligibility requirement is satisfied (9 months for BCBS) or during Open Enrollment if eligibility requirement has been satisfied	First of the month following date eligibility requirements are met.
Acquiring sponsored dependents (subject to eligibility guidelines)	Only during Open Enrollment	January 1 if enrolled during open enrollment.
Eligible dependent moves to United States or the plan service area	Within 30 days from the date of the individual's arrival within the United States or the plan service area	First of following month.

Return from leave or layoff to an active eligible appointment Reappointment within 30 days of original termination	Within 30 days of your official return date notify the HR Service Center	Benefits resume on the 1st of the month following your return to work in an eligible appointment.
When Coverage Ends: Divorce or termination of partnership Death of an active employee Dependent's loss of eligibility	30 days from date of final divorce, termination of partnership or loss of eligibility	End of the month following divorce or termination of partnership, death or loss of eligibility.

Life Events

You can enroll, make changes to, or cancel your and/or your dependent's benefits within 30 days of a Life Event, as defined by Section 125 of the IRS. The coverage election must be consistent with your change in status (for example: you cannot make a coverage change for financial reasons or because a provider stops participating in a network).

Life Events may include:

- Your marriage, divorce or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption or placement for adoption;
- A Qualified Medical Child Support Order that requires you to provide medical coverage for a child;
- A change in employment status by you or your eligible dependent that affects eligibility;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent's status;
- You and/or your eligible dependents become eligible for (and enroll in) or lose eligibility for Medicare or Medicaid;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and
- You or your eligible dependents have a significant change in benefits or costs, such as benefits from another employer, etc.

If you do not report the Life Event within 30 calendar days of the event date, you will not be able to enroll, change, or cancel benefits until the next annual Open Enrollment period and the change will not take effect until January 1st of the following year.

Benefit Costs

You and the university share in the cost of medical, dental and vision coverage. The cost of coverage for yourself and your eligible dependents is based on the benefit option(s) and level of coverage you elect. Your cost for coverage is automatically deducted from your paycheck on a before-tax basis, which means that your taxable pay is lower — and so is the amount you pay for Social Security and Medicare taxes, federal income tax and, in most areas, state and local income taxes. Your enrollment authorizes the deductions to be taken from your paycheck on a before-tax basis.

Each plan has different costs. Please review the bi-weekly rate schedule found at hr.wayne.edu/tcw/health-welfare/medical-rates prior to your selection. Rates are listed on a per-paycheck basis. There are two no-deduction pay periods each year in which you do not have medical, dental, vision or life insurance benefit deductions taken from your pay.

The university reserves the right to recover any underpayments by the employee or eligible dependent, made through error or otherwise, by offsetting future payments or invoicing the affected participant.



Imputed Income – Taxable Benefits

Medical, dental and vision benefits provided to Other Eligible Persons (OEP) may require taxation of the value of the coverage provided to the OEP. This tax will be deducted from your bi-weekly paycheck and can significantly add to the cost of the coverage.

Medical Insurance

Wayne State University offers five medical plan options to choose from. The benefits provided under each of the medical plans are summarized in the Comparison of Medical Benefits chart that begins on page 18. Additional information on what medical expenses are covered can be found in each of the plan's *Summary of Benefits and Coverages* documents, located on our website.

Effective January 1, 2022, the university has two medical plan designs. The plans are organized as follows:

Plan 1 - All Non-academic Represented Union employees

Plan 2 - AAUP, GEOC, Stipends and Non-Represented employees

Your Options

Health Maintenance Organization (HMO)

An HMO is a type of managed health plan where members choose their physicians from a list of approved providers and facilities. When electing an HMO, you must select a primary care physician who will serve as your health advocate and will help you find the best treatment for your health concerns.

You have three health maintenance organizations to choose from:

- *Health Alliance Plan*
- *Blue Care Network*
- *Priority Health*

Each HMO operates in the following Michigan counties:

Health Alliance Plan:

Arenac, Bay, Genesee, Hillsdale, Huron, Iosco, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw, and Wayne Counties

Blue Care Network:

All Lower Peninsula Counties

Priority Health:

Wayne, Oakland, Macomb, Livingston, Washtenaw and St. Clair Counties

Note: Canadian residents who live outside of the city of Windsor are not eligible for enrollment in the HMO plans.

Preferred Provider Organization (PPO) - BCBSM PPO (formerly Community Blue)

BCBSM PPO is administered by Blue Cross Blue Shield. BCBSM PPO is a type of plan that combines advantages of a national network of providers with the option to use physicians and facilities outside the network, but at a higher cost.

Traditional "Fee for Service" Plan - Blue Cross Blue Shield Traditional (BCBS)

Our traditional fee-for-service plan is administered by Blue Cross Blue Shield. This option may interest you if you want complete flexibility in choosing physicians. BCBS covers inpatient hospitalization, surgical fees, emergency care, and many outpatient procedures including diagnostic office visits and prescription drugs. An annual deductible and copays apply. Please see the important note on the following page regarding BCBS's payment for services at non-participating hospitals and facilities and alternatives to hospital care providers.

Important Note: BCBSM PPO and BCBS Traditional Plan

Blue Cross Blue Shield's payment for services received at non-participating hospitals and facilities, and alternatives to hospital care providers, is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means that you will need to pay the charges yourself, and your bill could be substantial.

Virtual Doctor Visits

Virtual doctor visits are provided by each of the medical plan options. This service provides medical consultation via telephone for minor illnesses such as cold/flu symptoms, allergies and ear infections. Virtual doctor visits are available 24 hours a day, seven days a week. Physicians who consult virtually can issue prescription drugs for a variety of immediate care items, and can call the prescription in to the pharmacy you choose for easy pickup. Virtual consultations cost about the same as an office visit, without the limitation of office hours and the inconvenience of travel time. See page 2 for contact information.

Home Delivery Pharmacy Service

Home delivery pharmacy service (mail order) is available with each of the medical plan options to save you time and money. Generally, you can obtain a three-month supply of your medication for the cost of one copay (may vary based on the medication prescribed). Please note: Priority Health HMO offers a three-month supply of certain medications for the cost of two copays. For names and contact information for the individual services, see the Benefits Resource Directory on page 3. For more information on how retail prescription drugs are covered, see the Comparison of Medical Benefits chart on pages 20-21.

Cash in Lieu of Medical

If you are covered by a non-Wayne State University health insurance plan, you may decline medical, dental, and vision coverage, and, in return, have \$50 applied to your pay each pay period (except the two non-deduction pays per year). Graduate Assistants receive \$30 per pay. Your withheld taxes will increase because the Cash in Lieu of Medical payment is subject to FICA, federal, state and city taxes. The amount deducted for taxes depends on individual tax circumstances.

To Enroll: Log into [Academica](#)

Click 'Employee Resources'

Click 'Employee Self-Service'

Click 'Benefit Plan Enrollment & Changes'

When you decline WSU medical benefits, you will not have dental or vision insurance unless you elect voluntary dental or vision plan enrollment.

The following applies to the AAUP, GEOC and Non-Represented employee groups: If you elect Cash in Lieu of Medical, you may elect dental and/or vision insurance and pay 100% of the cost. If you waive both medical insurance and Cash in Lieu of Medical, you may elect subsidized dental and/or vision insurance.

The following applies to the 517M, Operating Engineers, Public Safety, Staff Association, P&A, AFSCME, and HERE 24 Janitors employee groups: If you elect Cash in Lieu of Medical, you may elect subsidized dental insurance. If you waive both medical insurance and Cash in Lieu of Medical, you may elect subsidized dental insurance.



Comparison of Medical Benefits

The Comparison of Medical Benefits on the following pages contains a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained therein 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.

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.

Benefit Plan Comparison - Plan 1	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Inpatient Hospital							
Hospital Services	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible (non-emergency services must be rendered in a participating hospital)	Covered in full (non-emergency services must be rendered in a participating hospital)	80% after out-of-network deductible (non-emergency services must be rendered in a participating hospital)
Medical Care							
Office Visits: In Person	\$20 copay	\$20 copay	\$20 copay	\$40 copay	\$20 copay	\$20 copay	80% after out-of-network deductible
Telemedicine/Virtual Visits	\$20 copay	\$20 copay	Covered in full	Covered in full	\$20 copay	\$20 copay	Not covered
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Not covered
Vision and Hearing Examinations	\$20 copay	Vision exam not covered; Hearing exam covered	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Not covered	Vision exam not covered; Hearing exam covered	Vision exam not covered; Hearing exam covered at participating providers
Urgent Care	\$20 copay	\$20 copay	\$20 copay	\$40 copay	\$20 copay	\$20 copay	\$20 copay
Emergency Room Services	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	\$100 copay (waived if admitted). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.
Laboratory, Pathology and Radiology (X-Ray) Services	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible (preventive services excluded)	Covered in full	80% after out-of-network deductible
Allergy Testing and Injections	Covered in full	Covered in full	Covered in full	Covered in full	\$20 copay	Covered in full	80% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy	Covered in full (up to 60 combined visits per year)	Office visit copay applies (up to 60 visits per medical episode per year)	\$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	\$40 copay after deductible; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible	Covered in full (up to 60 visits per year combined with out of network)	80% after out-of-network deductible at participating providers
Durable Medical Equipment	Covered in full for approved equipment	Covered in full	Covered in full	50% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	Covered in full
Chiropractic Services/ Spinal Manipulation	Not covered	Office visit copay applies (referral required)	\$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	\$40 copay after deductible; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible (up to 38 visits per year)	Covered in full (up to 24 visits per year)	80% after out-of-network deductible (up to 24 visits per year)
Reproductive Care							
Pre-Natal Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	80% after out-of-network deductible
Delivery and Routine Nursery Care	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Infertility Services	Coverage is limited to services for diagnosis, counseling, and treatment of bodily disorders causing infertility	Coverage is limited to diagnosis, counseling and treatment of infertility. Coverage includes artificial insemination for the treatment of infertility	Coverage is limited to diagnostic, counseling, and planning services for treatment of the underlying cause of infertility		Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility
Voluntary Sterilization	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full (female only)	Covered in full	80% after out-of-network deductible

Benefit Plan Comparison - Plan 1	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Mental Health and Substance Abuse							
Outpatient Care: In Person	\$20 copay	\$20 copay	\$20 copay	\$40 copay	Plan pays 90% after deductible	Covered in full (approved facilities)	Covered in full (approved facilities)
Telemedicine/Virtual Visits	Not covered	\$20 copay	Covered in full	Covered in full	Plan pays 90% after deductible	\$20 copay	80% after out-of-network deductible
Inpatient Care	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Prescription Drugs							
Prescription Drugs	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for same cost as above.	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for same cost as above.	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for 2 times the above cost.	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for same cost as above.	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for same cost as above.	\$5 generic drugs \$20 preferred brand drugs \$45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available for same cost as above.	75% of approved amount less plan copay. Limited to one month supply. Includes contraceptive medications.
Other Services							
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered - contact carrier for details	Covered - contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-ocular surgery	Covered following cataract or intra-ocular surgery	Not covered	Not covered	Covered following cataract or intra-ocular surgery, accidental injury, or certain non-routine diagnoses. Plan pays 90% after deductible.	Covered following cataract surgery	Not covered
Hearing Aids	Covered for authorized conventional hearing aids	Covered (one hearing aid every 36 months)	\$500 allowance per hearing aid every 36 months	\$500 allowance per hearing aid every 36 months	Not covered	Covered (one hearing aid every 36 months)	Not covered
Skilled Nursing Care Facility (excluding custodial care)	Covered in full (730 days, renewable after 60 days of nonconfinement)	Covered in full (730 days in a lifetime)	Covered in full (45 days covered per member each contract year)	20% coinsurance after deductible (45 days covered per member each contract year)	Not covered	Covered in full (120 days per calendar year)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations							
Annual Deductible	No deductible	No deductible	No deductible	\$2,000 per individual \$4,000 per family Deductible costs don't apply towards your coinsurance maximum.	\$100 per individual \$200 maximum per family	No deductible	\$250 per individual \$500 per family
Annual Coinsurance Maximum	N/A	N/A	N/A	20% coinsurance for services after deductible is met, except where noted.	\$500 per individual \$1,000 per family	N/A	\$2,000 per individual \$4,000 per family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family	N/A	\$6,350 per individual \$12,700 per family	\$600 per individual \$1,200 per family	\$600 per individual \$1,200 per family	\$2,250 per individual \$4,500 per family
Hospital Precertification	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours	Required at least 5 working days in advance	Required at least 5 working days in advance	Required — provider responsibility	Required — provider responsibility	Required — provider responsibility

Benefit Plan Comparison - Plan 2	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Inpatient Hospital							
Hospital Services	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible (non-emergency services must be rendered in a participating hospital)	Covered in full after deductible (non-emergency services must be rendered in a participating hospital)	80% after out-of-network deductible (non-emergency services must be rendered in a participating hospital)
Medical Care							
Office Visits: In Person	\$20 PCP copay; \$30 specialist copay	\$20 PCP copay; \$30 specialist copay	\$20 PCP copay; \$30 specialist copay	\$40 PCP copay; \$60 specialist copay	\$20 PCP copay; \$30 specialist copay	\$20 PCP copay; \$30 specialist copay	80% after out-of-network deductible
Telemedicine/Virtual Visits	\$20 copay	\$20 copay	Covered in full	Covered in full	\$20 PCP copay; \$30 specialist copay	\$20 PCP copay; \$30 specialist copay	80% after out-of-network deductible
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Not covered
Vision and Hearing Examinations	Covered in full	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Not covered	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered at participating providers every 36 months
Urgent Care	\$30 copay	\$30 copay	\$30 copay	\$60 copay	Plan pays 90% after deductible	\$30 copay	80% after out-of-network deductible
Emergency Room Services	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	\$100 copay (waived if admitted). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	\$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.
Laboratory, Pathology and Radiology (X-Ray) Services	Covered in full after deductible	Lab & pathology covered in full; Diagnostic tests & X-rays covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Allergy Testing and Injections	Covered in full after deductible	Covered in full after deductible	Covered in full	Covered in full	\$20 PCP copay; \$30 specialist copay	Covered in full after deductible	80% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy	Covered in full after deductible	\$30 copay; 60 visits per medical episode per plan year	\$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	\$40 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible	Covered in full after deductible (up to 60 visits per year combined with out-of network)	80% after out-of-network deductible at participating providers
Durable Medical Equipment	Covered in full after deductible for approved equipment	Covered in full	Covered in full after deductible	50% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	Covered in full after out-of-network deductible
Chiropractic Services/ Spinal Manipulation	Not covered	\$30 copay	\$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	\$40 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible (up to 38 visits per year)	Covered in full after deductible (up to 24 visits per year combined with out-of network)	80% after out-of-network deductible (up to 24 visits per year)
Reproductive Care							
Pre-Natal Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	80% after out-of-network deductible
Delivery and Routine Nursery Care	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Infertility Services	Coverage is limited to services for diagnosis, counseling, and treatment of bodily disorders causing infertility	Coverage is limited to diagnosis, counseling and treatment of infertility. Coverage includes artificial insemination for the treatment of infertility	Coverage is limited to diagnostic, counseling, and planning services for treatment of the underlying cause of infertility		Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility
Voluntary Sterilization	Covered in full - female Covered in full after deductible - male	Covered in full - female Covered in full after deductible - male	Covered in full - male & female	Covered in full - male & female	Covered in full (female only)	Covered in full - female Covered in full after deductible - male	80% after out-of-network deductible

Benefit Plan Comparison - Plan 2	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Mental Health and Substance Abuse							
Outpatient Care: In Person	\$20 copay	\$20 copay	\$20 copay	\$40 copay	Plan pays 90% after deductible	Covered in full after deductible (approved facilities)	80% after out-of-network deductible
Telemedicine/Virtual Visits	Not covered	\$20 copay	Covered in full	Covered in full	\$20 copay	\$20 copay	Not covered
Inpatient Care	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Prescription Drugs							
Prescription Drugs	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for same cost as above.</p>	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for same cost as above.</p>	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for 2 times the above cost.</p>	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for same cost as above.</p>	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for same cost as above.</p>	<p>\$10 generic drugs \$25 preferred brand drugs \$55 non-preferred brand drugs (copay waived for generic oral contraceptives)</p> <p>Limited to one month supply. Includes contraceptive medications.</p> <p>Mail-order prescriptions (90-day supply) are available for same cost as above.</p>	75% of approved amount less plan copay. Limited to one month supply. Includes contraceptive medications.
Other Services							
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-ocular surgery	Covered following cataract or intra-ocular surgery	Not covered	Not covered	Covered following cataract or intra-ocular surgery, accidental injury, or certain non-routine diagnoses. Plan pays 90% after deductible.	Covered following cataract or intra-ocular surgery	Not covered
Hearing Aids	Covered for authorized conventional hearing aids; deductible does not apply	Covered (one hearing aid every 36 months)	\$500 allowance per hearing aid every 36 months	\$500 allowance per hearing aid every 36 months	Not covered	Covered (one hearing aid every 36 months)	Not covered
Skilled Nursing Care Facility (excluding custodial care)	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible (45 days covered per member each year)	20% coinsurance after deductible (45 days covered per member each year)	Not covered	Covered in full after deductible (120 days per calendar year)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations							
Annual Deductible	\$100 per individual \$200 per family	\$100 per individual \$200 per family	\$100 per individual \$200 per family	\$2,000 per individual \$4,000 per family	\$100 per individual \$200 maximum per family	\$100 per individual \$200 maximum per family	\$250 per individual \$500 per family
Annual Coinsurance Maximum	N/A	N/A	N/A	N/A	\$500 per individual \$1,000 per family	N/A	\$2,000 per individual \$4,000 per family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family	\$600 per individual \$1,200 per family	\$600 per individual \$1,200 per family	\$2,250 per individual \$4,500 per family
Hospital Precertification	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours	Required at least 5 working days in advance	Required at least 5 working days in advance	Required — provider responsibility	Required — provider responsibility	Required — provider responsibility

Dental Insurance - New Enhanced Option for 2024

Dental insurance benefits are provided by Delta Dental, which is a Preferred Provider Organization (PPO). The plan covers a wide range of medically necessary dental services. The following chart outlines a summary of coverages for each type of plan (basic or enhanced) and by provider type.

You have two dental plan options: **Basic** or **Enhanced**

Summary of Dental Plan Benefits For Group# 7544

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

	Both Basic and Enhanced Plans Pay:	
	Delta Dental PPO Dentist	Delta Dental Premier Dentist/ Non-participating Dentist*
Diagnostic & Preventative		
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%
Basic Services		
Radiographs – X-rays	100%	80%
Sealants – to prevent decay of permanent teeth	90%	80%
Minor Restorative Services – fillings and crown repair	90%	80%
Endodontic Services – root canals	90%	80%
Periodontic Services – to treat gum disease	90%	80%
Oral Surgery Services – extractions and dental surgery	90%	80%
Major Restorative Services – crowns	90%	80%
Other Basic Services – misc. services	90%	80%
Relines and Repairs – to bridges, implants, and dentures	90%	80%
Major Services		
Prosthodontic Services – bridges, implants, and dentures	50%	50%
Orthodontic Services		
Orthodontic Services – braces	50%	50%
Orthodontic Age Limit	Up to age 19	Up to age 19

	Basic:	Enhanced:
New Enhanced Option for 2024!		
Calendar Year Max	\$1,500	\$2,000
Deductible	\$50/person; \$150/family	\$25/person; \$75/family
Occlusal (bite) Guard	One per lifetime	One per 5 years
Orthodontia Lifetime Max	\$1,000	\$1,500
Special Healthcare Needs	Not covered	Covered
Porcelain (white) Crowns & Bridges – posterior (back) teeth	Not covered	Crowns 90%; Bridges 50%
White resin fillings – posterior (back) teeth	Not covered	Covered

It is your responsibility to ensure that you use Delta Dental in-network providers if you want to receive the benefit of lower, contracted rates. Because in-network providers may change over time, it is recommended that you confirm that your provider is still in the Delta Dental network each time an appointment is made.

Additional Information - Basic

- **Maximum Payment** – \$1,500 per person total per Benefit Year on all services except orthodontic services. \$1,000 per person total per lifetime on orthodontic services.
- **Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, and orthodontic services.
- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 14.
- Bitewing X-rays are payable once in any calendar year for people under age 15 and once every two calendar years for people age 15 and older. Once dependents reach age 15, Delta Dental will look at all prior dates of service and pay only after two calendar years from the last date of service. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant-related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.



Additional Information - Enhanced

- **Maximum Payment** – \$2,000 per person total per Benefit Year on all services except orthodontic services. \$1,500 per person total per lifetime on orthodontic services.
- **Deductible** – \$25 Deductible per person total per Benefit Year limited to a maximum Deductible of \$75 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, and orthodontic services.
- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 14.
- Bitewing X-rays are payable once in any calendar year for people under age 15 and once every two calendar years for people age 15 and older. Once dependents reach age 15, Delta Dental will look at all prior dates of service and pay only after two calendar years from the last date of service. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are covered services on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant-related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.



Vision Insurance

Wayne State University has selected EyeMed as your vision insurance plan. This plan allows you to improve your eye health, while saving you money on your eye care purchases. Services are available through thousands of provider locations participating in the EyeMed “Select” network.

You have two vision plan options:

- Basic Vision Plan, or
- Enhanced Buy-Up Plan.

You have a **choice** when selecting your vision care provider. You can go to:

- Any in-network optometrist or ophthalmologist who has agreed to:
 - Charge participants a contracted fee, which is usually lower than those charged by out-of-network providers and is not subject to reasonable and customary provisions, and
 - File the vision claims for you.
- An out-of-network provider. Services received from out-of-network providers **are** subject to reasonable and customary provisions.

It is your responsibility to ensure that you use EyeMed in-network (the “Select” network) providers if you want to receive the benefit of lower, contracted and discounted rates. Keep in mind that in-network providers occasionally change and that some areas don’t have in-network providers. You’ll want to make sure the provider you choose is still in the EyeMed “Select” network before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider directly.

The chart on page 25 outlines a summary of benefits provided by each of the two vision plan options.

Please note: Members will receive an additional \$20 towards a contact lens purchase when purchased through contactsdirect.com.



Summary of Vision Plan Benefits For Group# 9730953

	Basic Plan	Enhanced Buy-Up Plan	Basic/Enhanced
	In-Network	In-Network	Out-of-Network Reimbursement
Exam with dilation as necessary	\$10 copay	\$10 copay	Up to \$35
Retinal Imaging Benefits	Up to \$39	Up to \$39	N/A
Contact Lens Fit and Follow-Up:			
Standard	Up to \$40	\$0 copay, paid-in-full fit and two follow-up visits	N/A / \$40
Premium	10% off retail price	\$0 copay, 10% off retail price, then apply \$40 allowance	N/A / \$40
Frames	\$0 copay, \$115 allowance; 20% off balance over \$115	\$0 copay, \$150 allowance; 20% off balance over \$150	Up to \$45
Standard Plastic Lenses:			
Single Vision	\$10 copay	\$10 copay	Up to \$25
Bifocal	\$10 copay	\$10 copay	Up to \$40
Trifocal	\$10 copay	\$10 copay	Up to \$55
Lenticular	\$10 copay	\$10 copay	Up to \$55
Standard Progressive	\$55 copay	\$10 copay	Up to \$55
Premium Progressive	\$55 copay, 80% of charge less \$120 allowance	\$10 copay, 80% of charge less \$120 allowance	Up to \$55
Lens Options: (paid by the member and added to the base price of the lens):			
UV Treatment	\$15 copay	\$0 copay	N/A / \$5
Tint (Solid and Gradient)	\$15 copay	\$0 copay	N/A / \$5
Standard Plastic Scratch Coating	\$0 copay	\$0 copay	Up to \$5
Standard Polycarbonate - Adults	\$35 copay	\$0 copay	Up to \$5
Standard Polycarbonate - Kids under 19	\$35 copay	\$0 copay	Up to \$5
Standard Anti-Reflective Coating	\$45 copay	\$0 copay	N/A / \$5
Polarized	20% off retail price	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	20% off retail price	N/A
Contact Lenses (allowance covers materials only):			
Conventional	\$0 copay, \$115 allowance; 15% off balance over \$115	\$0 copay, \$150 allowance; 15% off balance over \$150	Up to \$100
Disposables	\$0 copay, \$115 allowance plus balance over \$115	\$0 copay, \$150 allowance plus balance over \$150	Up to \$100
Medically Necessary	\$0 copay, paid in full	\$0 copay, paid in full	Up to \$200
LASIK and PRK Vision Correction Procedures	15% off retail price or 5% off promotional pricing	15% off retail price or 5% off promotional pricing	N/A
Amplifon Hearing Health Care	40% discount off hearing exams and a low-price guarantee on discounted hearing aids	40% discount off hearing exams and a low-price guarantee on discounted hearing aids	N/A
Additional Pairs Benefit	40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used		N/A
Frequency:			
Exam	Once every calendar year		
Frames	Once every calendar year		
Standard Plastic Lenses or Contact Lenses	Once every calendar year		

Life Insurance

Our Group Life Insurance Plan (the Plan), administered by Sun Life Financial, provides your family with valuable financial protection in the event of your death or the death of a covered dependent.

The Plan includes a university-provided basic life insurance benefit that helps protect your family in the event of your death. If you are eligible for basic life insurance, you will also have travel assistance coverage. In addition, a university-provided accidental death and dismemberment (AD&D) benefit is payable if you die as a result of a covered accident while you're on the job.

For added protection, you can purchase additional supplemental life insurance coverage for yourself, and dependent life insurance coverage for your eligible dependents:

- Spouse (excluding a spouse after a divorce); or your other eligible person (excluding terminated arrangements); and
- Child, defined as follows:
 - Your biological, legally adopted or placed for adoption child;
 - Your other eligible person's biological or legally adopted child (includes foreign adoptions); or
 - Your stepchild.

A dependent is not eligible for coverage if he or she:

- Is on active duty in the military service of any country (excluding weekend duty or summer encampment).

For additional information regarding life insurance, please visit hr.wayne.edu/tcw/health-welfare/life-insurance.

Coverage Type	Benefit Amount
Basic Life Insurance (Provided by WSU)	For most employees, basic life insurance will equal one times annual salary , rounded to the next higher \$1,000. United Here! Local #24 Housekeepers receive \$25,000 , not one times salary. The maximum death benefit varies by employee group.
Supplemental Life Insurance (Optional, employee-paid coverage, may be subject to approval)	Employees can elect Supplemental Life Insurance equaling one, two, three, or four times their base salary, rounded to the next higher \$1,000. The maximum death benefit (including basic life insurance) varies by employee group.
Dependent Life Insurance (Optional, employee-paid coverage, may be subject to approval)	\$20,000 coverage for your spouse and \$10,000 coverage for each of your eligible dependent children

Imputed Income

By law, the value of university-paid life insurance in excess of \$50,000 is included in your taxable income for the year. This value, known as “imputed income”, is calculated according to IRS tables and is reported as income on your annual W-2 form and on your paychecks throughout the year.

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel your life insurance coverage at any time, but evidence of insurability (EOI) may be required for enrollments and changes elected after more than 45 days from the date of hire.

If You Enroll/Change/Cancel Coverage...	You Can Enroll In...	Evidence of Insurability (EOI) Is Required...	Your Coverage Is Effective...
Within 45 calendar days of your eligibility date (e.g., your hire date or the date you first become eligible to participate)	<p>Basic Life Insurance (employer paid, eligible E-classes only)</p> <p>Supplemental Life Insurance (employee paid)</p> <p>Dependent Life Insurance (employee paid)</p>	<p>No</p> <p>No</p> <p>No</p>	On your eligibility date
More than 45 calendar days after your eligibility date or any other time during the year	<p>Basic Life Insurance (employer paid, eligible E-classes only)</p> <p>Supplemental Life Insurance (employee paid)</p> <p>Dependent Life Insurance (employee paid)</p>	<p>No</p> <p>Yes</p> <p>Yes (spouse/OEP only)</p>	<p>Effective date of Supplemental Life Insurance and Dependent Life Insurance for Spouse/OEP to be determined by Sun Life Financial; EOI subject to approval.</p> <p>Effective date of Dependent Life Insurance for children is first of the month following receipt of the enrollment form to the HR Service Center.</p>

Please note: If you leave the university, conversion and portability options are available.

Supplemental Life Insurance

You may elect to have supplemental life insurance coverage equivalent up to four times your annual salary. You pay the cost of your supplemental life insurance coverage with after-tax dollars deducted from your pay each month.

The cost of supplemental life insurance coverage is based on your age and coverage amount. If a birthday moves you to a different coverage age-group rate, the new rate is effective the first of the month coincident with or following your birthday. If your salary increases or decreases during the year, your coverage amount will change on the first of the month coincident with or following your salary increase/decrease. The cost of supplemental life insurance coverage may change from year to year.

Dependent Life Insurance

Dependent life insurance is offered to protect you from financial hardship if a covered eligible dependent dies. When you enroll in dependent life insurance coverage, all of your eligible dependents are covered automatically as long as you pay the costs. You pay the cost of your dependent life insurance coverage with after-tax dollars deducted from your pay each month.

For supplemental and dependent life insurance costs, please visit: hr.wayne.edu/tcw/health-welfare/life-rates.



No person may be insured by the Plan as a dependent of more than one WSU employee. If you gain or lose an eligible dependent, you should contact the HR Service Center to update your life insurance information.

Beneficiary Designation

You must name a beneficiary (the person or persons designated to receive Plan benefits in the event of your death). You may name as many beneficiaries as you wish — including individual persons, your estate, a trust, church or charitable organizations.

You are the designated beneficiary of your dependent life insurance benefits. You cannot name someone else as beneficiary, and you cannot name a contingent beneficiary.

If your marriage status changes (divorce, remarriage, etc.), you may wish to make a new valid beneficiary designation. Advising the university of your status change does **not** change your beneficiary designation. You must make a new beneficiary designation if you want to make changes to your existing designation. **If you named your spouse as your beneficiary prior to your divorce, your divorce does not automatically revoke your election and your ex-spouse will remain your beneficiary until you change your beneficiary designation.**

Age 70 Restrictions

Beginning at age 70, basic and supplemental life insurance coverage amounts start to reduce to the following percentages:

- Age 70 through 74 reduces to 67% of the benefit amount
- Age 75 through 79 reduces to 45% of the benefit amount
- Age 80 through 84 reduces to 30% of the benefit amount
- Age 85 or over reduces to 20% of the benefit amount

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 is a federal law which helps employees balance their work responsibilities with their family and medical needs. Whether you are unable to work because of your own serious health condition, or because you need to care for your parent, spouse, or child with a serious health condition, FMLA provides unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if you had not taken leave. FMLA leave may be taken all at once, or may be taken intermittently as the medical condition requires. WSU's third-party administrator for FMLA leaves is FMLASource.

Eligibility

To be eligible for FMLA leave, you must have worked for Wayne State University for 12 months and have worked at least 1,250 hours in the 12 months before you take leave.

Eligible employees are entitled to:

Twelve workweeks of leave during a 12-month period for:

- A serious health condition that makes you unable to perform the essential functions of your job;
- Incapacity due to pregnancy, prenatal medical care, or post-partum recovery;
- The birth of a child and to care for the newborn child within one year of birth;
- The placement with you of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- Care for your spouse, son, daughter, or parent who has a serious health condition; or
- Any qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is a covered military member on "covered active duty."

Twenty-six workweeks of leave during a 12-month period for:

- Care for a covered service member with a serious injury or illness if you are the service member's spouse, son, daughter, parent or next of kin (military caregiver leave).

You are responsible for:

- Notifying management 30 days in advance, or as soon as practical and possible, of the need for time off that might qualify for FMLA;
- Ensuring that your health care provider returns the completed FMLA medical certification form directly to FMLASource within 15 days of requesting FMLA leave;
- Following all departmental call-in procedures for absences; and
- Scheduling appointments to avoid disrupting the workflow in the work area, whenever possible.

Any time you are absent from work for an FMLA qualifying event:

- Contact your Supervisor, Business Manager, or Designated Representative.
- Call 877-GO2-FMLA (877-462-3652) or log onto **fmlasource.com** to start your leave process.
- You will need your Access ID (e.g. zz1222).

To learn more about the Family Medical Leave Act, visit: hr.wayne.edu/tcw/loa-fmla/fmla.

To contact FMLASource, visit: fmlasource.com/FMLAWeb/login/login.xhtml or call 877-GO2-FMLA (877-462-3652).

Michigan Paid Medical Leave Act (PMLA)

A new law, the Michigan Paid Medical Leave Act (PMLA), signed by Michigan Governor Rick Snyder on December 13, 2018 went into effect on **March 29, 2019**. The new law requires employers with 50 or more employees to provide eligible employees with paid medical leave to use for their own or their family members' medical needs and for purposes related to domestic violence, sexual assault and public health emergencies.

Since Wayne State University provides at least 40 hours of paid leave to benefit-eligible employees, the vast majority of employees **will not** be eligible for additional paid time under the law. However, employees who are non-exempt from the FLSA (Fair Labor Standards Act) are eligible for PMLA time.

You may take paid medical leave for the following:

- Physical or mental illness, injury, or health condition for you or your family member;
- Medical diagnosis, care, or treatment for you or your family member;
- Preventive care for you or your family member;
- Closure of your primary workplace by order of a public official due to a public health emergency;
- The care of your child whose school or place of care has been closed by order of a public official due to a public health emergency; or
- Your or your family member's exposure to a communicable disease that would jeopardize the health of others as determined by health authorities or a health care provider.

For domestic violence and sexual assault situations, you may use paid medical leave for the following:

- Medical care or psychological or other counseling;
- Receiving services from a victim services organization;
- Relocation;
- Obtaining legal services; or
- Participation in any civil or criminal proceedings related to or resulting from domestic violence or sexual assault.

Eligible family members include:

- Child: biological, adopted, foster or stepchild
- Legal ward
- Child to whom you stand in *loco parentis*
- Grandchild
- Grandparent
- Biological, adopted, foster or stepparent of yours or your spouse
- Legal guardian of yours or your spouse
- Person who stood in *loco parentis* when you were a minor child
- Sibling: biological, foster or adopted
- Spouse: a person to whom you are legally married under the laws of any state

Please note: The above eligibility definition only applies to the Michigan Paid Medical Leave Act.

To learn more about the Michigan Paid Medical Leave Act, visit: hr.wayne.edu/tcw/loa-fmla/pmla or contact your HR Consultant.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The ADA recognizes and protects the civil rights of people with disabilities. The ADA Amendment Act of 2008 (ADAAA) was passed on September 17, 2008. The ADAAA provides additional clarification and broadens the definition of the term “disability.”

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability and requires employers to provide reasonable accommodations to qualified individuals with disabilities who are employed or applicants for employment.

Wayne State University supports the rights of all persons, including those with disabilities. Wayne State complies with federal and state disability laws and makes reasonable accommodations for employees with disabilities. If you believe you have a disability that requires an accommodation to perform the essential functions of your job, wish to request an ADA accommodation for additional time off, and/or wish to determine whether there might be an alternative to additional time off, please contact the Wayne State University Office of Equal Opportunity (OEO) at 313-577-2280. You may also find information regarding reasonable accommodations at oeo.wayne.edu.



Long-Term Disability (LTD) Insurance

Wayne State University provides long-term disability (LTD) insurance coverage to eligible employees at no cost. Long-term disability insurance through New York Life Group Benefit Solutions provides a monthly income benefit up to 66-2/3% of your base salary, up to a maximum benefit as outlined in the Group Long Term Disability Insurance Certificate. If approved, LTD benefits would begin the later of 180 days of being disabled from your occupation or the exhaustion of your illness bank. LTD benefits are offset by other income benefits associated with your disability including, but not limited to, Social Security benefits and Worker's Compensation. To submit a long-term disability claim or if you have questions regarding this benefit, contact the HR Service Center at 313-577-3000.

Eligibility & Waiver of Waiting Period

The waiting period for enrollment in the long-term disability insurance varies based upon your classification. For AAUP members and Non-academic employees that are not represented, eligibility for long-term disability insurance goes into effect on the first of the month of which your status is 50% time or greater service in an eligible e-class. For Non-academic represented employees, eligibility for long-term disability insurance goes into effect on the first of the month following one year of 50% time or greater service in an eligible e-class. However, a provision in our disability insurance contract allows us to waive the one-year waiting period if you were covered under your former employer's group total disability insurance plan within three months of your WSU date of hire. Please provide verification (via an email from your former employer or a letter on your former employer's letterhead) and mail to: WSU HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI, 48202. The verification should provide: your name, your Social Security Number, name of former insurance carrier, termination date of former insurance plan and affirmation that the plan would have paid benefits for at least 5 years in the event of total disability. A copy of the plan document or brochure from your former employer explaining the plan should be attached to the email or enclosed with the letter. Verification from your former employer must be received by the HR Service Center within 90 days of your Wayne State University hire date for consideration.

Approved LTD Recipients

WSU subsidizes medical insurance rates for eligible LTD recipients. The university covers the cost of any existing life insurance coverage. If you were participating in the WSU 403(b) retirement savings plan at the start of your disability, New York Life Group Benefit Solutions will continue to contribute up to 15% of your last day of work salary to your retirement savings account(s).

If approved for LTD, your employment at WSU ends. You are then considered a LTD recipient and no longer an employee of the university. Your department has the right to post and fill your position, based upon the needs of the department. If you hold tenure or employment security status (ESS), such status will terminate concurrently with your employment.

In the event you recover from your illness/injury and you are interested in obtaining employment with WSU, you may apply for any vacancies in which you may be qualified for. This does not represent a guarantee of re-employment or establish any placement rights. Prior to re-employment you will be required to undergo a medical evaluation. If you stop receiving the LTD insurance benefit for whatever reason, you may qualify to transition to retiree status if you met the criteria to retire as of your last day worked at WSU.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts are employer-sponsored plans authorized by the federal government that allow you to set aside money from your paycheck on a “pre-tax” basis to pay for health care and dependent care expenses incurred for you, your spouse and/or children, and any other eligible dependent. Setting aside pre-tax dollars lowers your taxable income. Benefit-eligible employees are offered this opportunity to set aside pre-tax dollars, however, you may only enroll in a Flexible Spending Account within 30 days of your WSU hire date, during a Life Event or during the annual Open Enrollment period each fall (for the following year’s expenses).

Health Care & Dependent Care Reimbursement Accounts

You may elect to participate in either, or both, the health care reimbursement account or the dependent care reimbursement account; however, money cannot be transferred between the two accounts. For example, money in your health care reimbursement account may not be used to pay for dependent day care expenses.

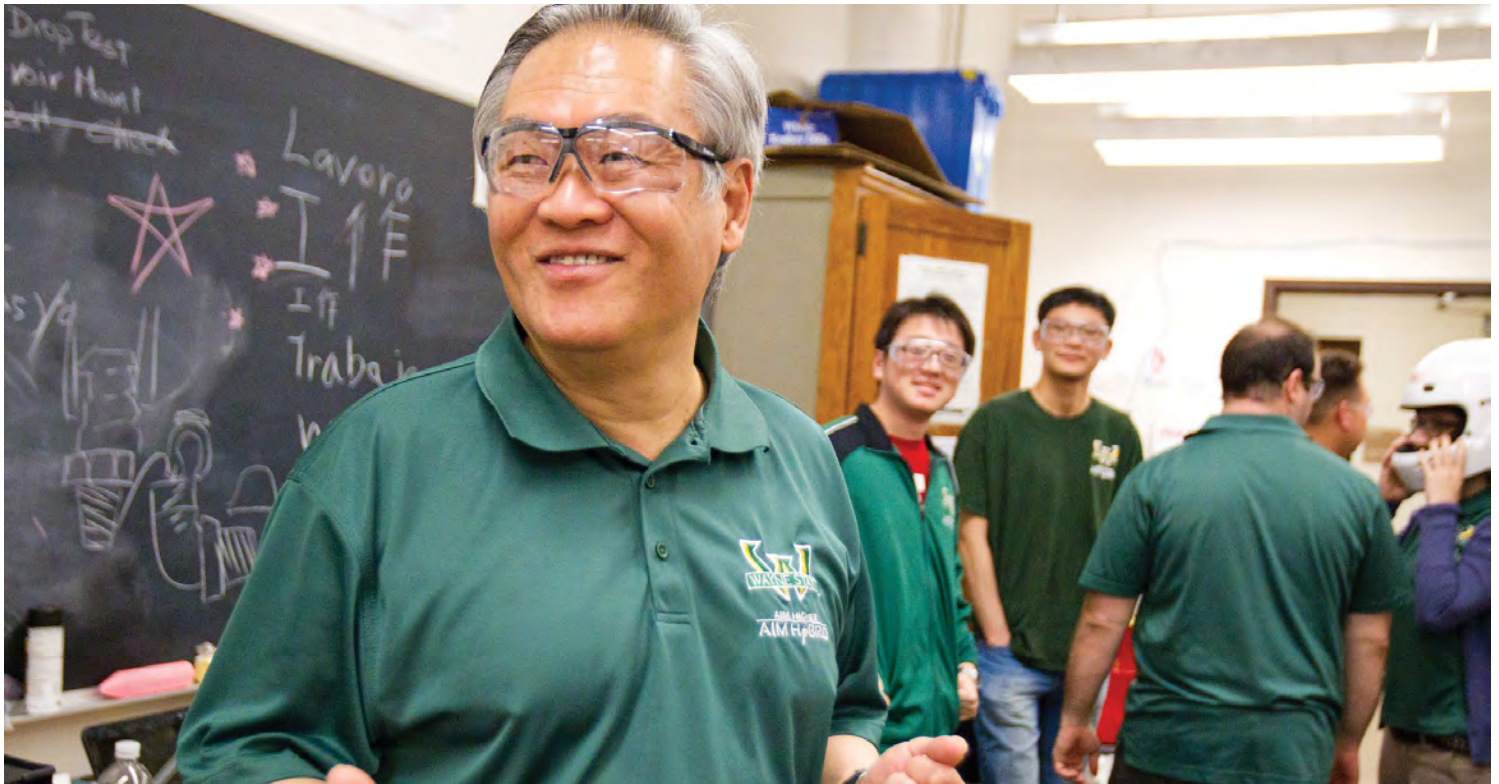
	Health Care Reimbursement Account	Dependent Care Reimbursement Account
Advantages of Both	<ul style="list-style-type: none"> • Pay for eligible, out-of-pocket expenses with pre-tax dollars • Reduce your taxable income • Increase your take home pay 	
What’s Covered	In general, eligible health-related expenses not covered by a health plan incurred by you, your spouse and/or children	In general, eligible day care expenses that allow you (and your spouse if you are married) to work or attend school full time
Eligible Expenses	<p>Examples include:</p> <ul style="list-style-type: none"> • Out-of-pocket costs • Deductibles and copays • Health care expenses not covered by your plan and approved by the IRS • Eyeglasses, contact lenses, braces for children, and hearing aids • Over the counter drugs • Menstrual products 	<p>Examples include care you must pay for:</p> <ul style="list-style-type: none"> • Child day care for children under age 13 • Adult dependent day care • Dependent day care centers <p>Please visit irs.gov/publications/p503 for qualified child and dependent care expenses.</p>
Restrictions	Medical expenses that are not deductible under Internal Revenue Code Section 213(d) may not be reimbursed	Expenses reimbursed for dependents under this plan may not be claimed as a federal tax credit on your tax return
Annual Election Limits	<p>Please note: Minimum and maximum annual election limits apply to both Health Care and Dependent Care Reimbursement Accounts. Limits may change annually. For limits, please visit: hr.wayne.edu/tcw/health-welfare/flexible-spending.</p>	
Access to Funds	Immediate access to annual election	You may access funds only up to the current account balance

Debit Card

FSA participants receive a debit-style Mastercard that allows direct access to FSA funds for eligible health and dependent care expenses. Your debit card will only work at provider locations that have the information inventory approval systems (IISA) installed. It is important to note that purchases made with your card on or after January 1 of the plan year will access funds from that plan year's FSA accounts. Because the card deducts funds directly from your FSA account to pay for services and supplies at the point of sale, it eliminates the need to file claims and wait for reimbursements. **You must, upon request, submit receipts to Wex within 14 days of making your purchases.**

Use It or Lose It!

FSAs are permitted under Sections 125 and 129 of the Internal Revenue Code. IRS regulations require that any balance remaining at the end of the plan year be forfeited. However, the IRS allows a grace period – through March 15 of the following year – during which you may continue to incur expenses and obtain reimbursement from your previous year's FSA balance. You may file claims for expenses incurred during a plan year – and the grace period – through April 30 of the following year. It is important that you make your FSA elections carefully to avoid forfeiture.



Please note: WEX – the company that administers our flexible spending accounts – uses different terminology to refer to these accounts:

Health Care Reimbursement Account = Medical FSA
Dependent Care Reimbursement Account = Dependent Care FSA

Retirement Savings Plans

WSU offers two retirement savings plans: a 403(b) and a 457(b). These retirement plans allow you to contribute to your account(s) every pay period. You may invest your contributions among a variety of funds offered by Fidelity Investments and/or TIAA. Enrollment in the retirement savings plans is not automatic.

Who Is Eligible?

You must be in an eligible employee classification (benefit-eligible employees who normally work 20+ hours per week or at least 50% appointment, or union employees whose bargaining contract permits participation). Student assistants, Technicians, Graduate assistants, and temporary employees are NOT eligible to participate.

403(b) Retirement Savings Plan Overview

Employee Contributions:

- Start any time after date of hire
- 1% of salary minimum, in increments of 1%
- Immediately vested (Employee Contributions only)

University Contributions:

- Begin when employee contributions begin
- 2% match for every 1% of employee contributions, to a maximum of 10%
- Must be age 26 (to receive University Contributions only)
- Vested after 2 years of service

To Waive Vesting Requirement

To waive the vesting requirement of 2 years of service for university contributions, we will count past service (within 3 years prior to your WSU hire date) at a previous employer, given the previous employer is:

- An institution of higher learning (e.g. college or university), or
- A nonprofit educational institution (e.g. K-12 school district), or
- A tax-exempt organization which is affiliated with higher education (e.g. a nonprofit teaching hospital), and
- You worked 50% or more time.

You must submit a Predecessor Employer Service Letter from the previous employer to the HR Service Center on company letterhead and signed by a representative, listing the following:

- Your job title
- Dates of employment (beginning & ending)
- Appointment percentage (must be at least 50%)
- Description of institution

All Predecessor Employer Service Letters must be submitted to the HR Service Center within 90 days of your Wayne State University hire date for consideration.

457(b) Retirement Savings Plan Overview

- Double your retirement savings! The employee contribution limit for the 457(b) plan is separate from the 403(b) plan, so you can make additional contributions up to the annual limits!
- The 457(b) plan offers the same TIAA and Fidelity Investments options as the 403(b) plan. Start saving any time after your hire date!
- The 457(b) plan does NOT have university contributions.
- No early withdrawal penalty! The IRS does not impose the 10% penalty if you withdraw your funds before you are age 59 ½; however, you may only make withdrawals from the 457(b) plan after you terminate your employment with WSU.

Please note: New 457(b) contributions will begin the first pay period of the following month after receipt of your 457(b) Salary Deferral Agreement to the HR Service Center.

Maximum Contributions

403(b): Maximum annual contribution limits apply to both employee contributions and university contributions. Employee contribution maximum limits include any employee contributions made to 403(b) plans sponsored by other employers, but do not include university contributions.

457(b): Maximum annual contribution limits apply to employee contributions, but are separate from the 403(b) employee contribution limits, so you can save more. Maximum limits include any employee contributions made to 457(b) plans sponsored by other employers.

For limits, please visit hr.wayne.edu/tcw/retirement-savings.

TIAA

Website:

tiaa.org/wayne

Telephone: **800-842-2252**

403(b) Plan No. 103167

457(b) Plan No. 403609

Access code: "wsubase"

Fidelity

Website:

netbenefits.com/waynestateuniversity

Telephone: **800-343-0860**

403(b) Plan No. 52864

457(b) Plan No. 84976

Tuition Assistance Programs

Employee Tuition Assistance

The Employee Tuition Assistance Program pays 100% of the cost of tuition (up to allowed course limits), and fees (registration fee, student service fee, omnibus fee, honor, or science fees only) for full-time employees (an appointment of 100%) or fractional-time employees (an appointment 50% to 99%).

To be eligible, you must be on the WSU payroll as of the last day of the Open Registration Period for the term for which benefits are requested.

Course Limits

For Full-Time Employees:

- Per year beginning the fall term – the greater of 2 courses or 6 credits per term, **and**
- Per year, spring/summer term (treated as 1 term) – the greater of 1 course or 4 credits for 1 term.

For Fractional-Time Employees:

- Per year, beginning the fall term – the greater of 1 course or 4 credits per term, for 3 terms.

Note: Members of certain bargaining units are subject to different limits.

Benefit Forfeiture

- The Employee must earn passing grades or the benefit is forfeited – Undergraduate courses “D” or better and Graduate courses “C” or better.
- The Employee **must** remain on the WSU payroll until the date the term ends for which benefits are requested or the benefit is forfeited.
- Forfeited Tuition benefit will be collected via payroll deduction or billed by student accounts receivable.

Reduced Tuition for Spouse/Child

The Reduced Tuition for Spouse/Child Program pays 50% of the cost of tuition for an eligible spouse or child(ren). This benefit does not cover any fees. “Spouse” means the legal Spouse or Other Eligible Person of an eligible employee as of the first day of classes for the term for which Reduced Tuition is requested. “Child” means a child or stepchild of an eligible employee and/or his/her spouse or Other Eligible Person AND who is less than 26 years old as of the first day of classes for the term for which Reduced Tuition is requested.

Course Limits

There are **NO course or credit limits** except that Reduced Tuition for Spouse/Child does not cover coursework for the MD, JD or PharmD degrees.

Benefit Forfeiture

- The Spouse/Child must earn passing grades – Undergraduate courses “D” or better and Graduate courses “C” or better (for certain bargaining units).
- If the employee terminates, the Reduced Tuition for Spouse/Child benefit continues for that term only.

Online Tuition Benefit Application

All applications must be submitted using the Tuition Benefit Application online. To learn more, please visit hr.wayne.edu/tcw/tuition-assistance. If you still have questions after reviewing the webpage(s), please email TuitionBenefit@wayne.edu.

Wellness Warriors Program

Make yourself a priority! Being a Wellness Warrior can put you on a path to health and wellness to become **Warrior Strong**.

The Wellness Warriors program serves to empower benefit-eligible employees to improve their own health by providing benefits and resources that build awareness, educate, and support good health decisions and behavior.

We've eliminated the enrollment process and have granted eligible employees access to all of WSU's employee wellness programming. All active medical-benefit-eligible employees are now able to participate in the Wellness Warriors program and potentially earn up to \$225 in Amazon e-gift cards!

Wellness is multifaceted, and to be a successful campus wellness program we should address every aspect of wellness for our most important asset - **YOU!** The program provides tools, resources and ongoing support for you to create a personalized wellness plan to adopt and maintain healthy habits. We utilize best practices to engage employees in 5 areas of wellness:



Emotional Physical Financial Career Community

Program Services

- Walking Club
- Personalized Wellness Portal
- Wellness Coaching & Nutrition Consultations
- Fitness Assessment & Personal Training
- Condition Management
- Weekly Meditation Group
- Workshops & Webinars
- Financial Consultations
- Employee Assistance Program
- Rewards and Prizes

Portal Log-in: <http://wsu.lifeadvisorwellness.com/>

Email us to join the walking club or weekly meditation! Email: wellness@wayne.edu

Other Wellness Programs

Flu Shot Clinics: Each fall, Campus Health Center provides flu shot clinics across campus. For more information, please visit wellness.wayne.edu/flu-shots.

Mother's Rooms: Rooms are provided across campus for breastfeeding mothers to utilize during the workday. For more information, please visit wellness.wayne.edu/mothers-rooms.

Life Advisor Employee Assistance Program (EAP)

We are pleased to offer a free and confidential employee assistance program with Ulliance. Ulliance Life Advisors can help you explore your unique work-life balance needs and identify the right services to support you. Immediate telephonic support is available, or you can schedule to see a local Ulliance EAP therapist at no charge to you, your spouse or your dependent children.

Counseling and Coaching Services

- Face-to-face or phone sessions with a licensed counselor close to work or home.
- Short-term, solution-focused support for work-life issues such as stress, substance use, grief/loss and overwhelming emotions.
- Support and motivation to achieve a work-life goal such as education, career advancement, financial or savings goals, or self-improvement goals, such as weight loss.

Support for Your Family

- Couples and family counseling services.
- Counseling and crisis support for your spouse and dependent children.

Work-Life Materials and Referrals

- Books and CDs on a wide variety of work-life topics mailed directly to your home at no cost to you.
- Referrals to free and low-cost resources related to financial concerns, legal issues, day care, elder care, and pet care.

Life Enhancement Resource Center

- Anytime access to articles, resources, healthy-living tips, as well as our orientation videos.
- Log in at lifeadvisorereap.com.

We Are Social!

Follow Ulliance on social media for real-time information, articles, tips, and inspiration for living a healthy and balanced life.

Confidential assistance with any type of personal concern or work-life challenge.

Ulliance is available 24/7

800-448-8326



Ulliance Life Advisor Consultants are available 24/7!

Voluntary Benefits

Home and Auto Insurance

Wayne State University offers a voluntary employee benefit program for auto and home insurance that could save you time and money. As an employee of WSU, you could receive exclusive savings on your auto and home insurance through Liberty Mutual:

- You are eligible to receive exclusive group savings on their already competitive rates.
- You could save even more on your home insurance when you insure both your car and home with Liberty Mutual.
- You could get additional discounts based on your driving experience, car, and home safety features and more.
- You have a choice of payment options including payroll deduction, electronic checking account withdrawals, recurring credit card or direct billing at home.

With Liberty Mutual, you'll also enjoy:

- 12-month policies vs. six-month policies.
- Access to Liberty Mutual's additional products such as motorcycle, condo, renters, and personal liability insurance.
- 24/7 claims assistance, fast appraisals and after-hours policy services.
- Convenient support by phone, online, or one-on-one with a local sales representative.
- As an Educator, additional endorsement coverages include:
 - Waived deductible if your vehicle is vandalized on WSU property or while using it for WSU-related events.
 - Waived deductible if your vehicle is damaged from a collision while driving it for WSU business.
 - Up to \$2,500 coverage for personal education materials or WSU property that is stolen or damaged while in your vehicle.



For more information and to obtain a free, no-obligation quote, please contact Liberty Mutual:

800-699-5298

libertymutual.com/wsu

Universal Life Insurance with Long-Term Care (LTC)

WSU is pleased to offer you the opportunity to purchase Universal Life Insurance with Long-Term Care through Trustmark. This program combines life insurance, cash value and LTC all in one policy, on an employee-paid basis. It is available to benefits-eligible employees and their family members.

This program has the flexibility of providing an affordable long-term care benefit in combination with a death benefit. You have two types of policies to choose from:

Universal LifeEvents® Insurance – This policy pays a higher death benefit during your working years when expenses are high and you need maximum protection. In your retirement years, when your financial needs are lower, your death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 18-64 for you and your spouse.

Standard Universal Life Insurance – This policy has all the same features as LifeEvents, except the death benefit does not reduce due to age. Issue age is up to age 75.

Enrollment occurs annually during a specified enrollment period. To learn more, visit hr.wayne.edu/tcw/

To review the Trustmark Universal Life Insurance with LTC Program in more detail, call the HR Service Center at **313-577-3000**

COBRA

Initial Election of COBRA Continuation Coverage by a Qualified Beneficiary

You can elect COBRA continuation coverage only for the options in which you were enrolled on the date your coverage ended, not the date of COBRA notification or enrollment. You can add or cancel any dependents on your initial election (new dependents will be considered non-qualified beneficiaries).

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to continue group medical, dental and vision benefits when you or your dependents become ineligible for university benefits. Medical, dental and vision coverage may be extended up to 18 months due to your termination of employment or reduction in work hours. Dependents who lose coverage as a result of eligibility status may continue coverage for 36 months.

When you lose eligibility based on your termination of employment, the department of Total Rewards and the HR Service Center will be aware of these changes. You will be mailed an application for COBRA coverage within 44 days from the external COBRA Third-Party Administrator.

Remember, you have 60 days from the latter of the date of the notice, or loss of coverage, to apply for COBRA coverage. If you do not receive your COBRA information within 30 days, contact the HR Service Center immediately at 313-577-3000.

If you lose eligibility due to a reduction of your full-time work status (less than 50%), or if your dependents lose coverage due to divorce or ineligibility, COBRA information will not be automatically mailed to you. You must notify the HR Service Center of the Life Event within 30 days of the event so that you and your dependents do not lose your eligibility for COBRA continuation coverage.

It is important to check with the HR Service Center prior to your employment status change event

(i.e., leaves of absence or reduction of full-time status to less than 50%) or if your COBRA notice was not received within 44 days of your last day worked or employment status change, to arrange for the continuation of your benefits. Timely submission of COBRA elections and payments are important – you will not be allowed to elect COBRA if you miss the election deadline. Your benefits will be automatically canceled unless the required premiums are paid on or before the due date. Once COBRA benefits are canceled because of nonpayment, they will not be reinstated.

You and/or your covered dependents are responsible for notifying the COBRA Administrator of a divorce, legal separation or a child losing dependent status while covered under the Plan so COBRA enrollment can be initiated. More information regarding your COBRA continuation rights is available from the COBRA Plan Administrator. Visit our website for more information.

Paying for COBRA Continuation Coverage

The cost of COBRA continuation coverage is the full cost (including both employee and employer costs) to provide the benefit plus a 2% administrative fee, for a total cost of 102%. The amount due each month for each qualified beneficiary will be disclosed in the COBRA election notice provided to you at the time of your qualifying event. The cost for COBRA continuation coverage may change from time to time during your period of COBRA continuation coverage and may increase over time.

If coverage is being continued due to disability, the cost during months 19 through 29 is 150% of the full cost of coverage.

Your payments must be sent to the COBRA administrator, Navia Benefit Solutions.

First payment — You must make your first payment within 45 days following your COBRA election. This payment must cover your costs from the date you lost coverage up to the time you make your payment. You may elect to make monthly payments either by check or automatic deductions from your bank account.

Remaining monthly payments — The payment for each month's coverage is due on the first day of the month. You'll be given a grace period of 30 days to make monthly payments. If you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the monthly payment is received within the 30-day grace period.

Checks that are returned unpaid from a bank for any reason are considered an untimely payment and result in cancellation of coverage. Partial payments will not be accepted and will be treated as non-payment, which will result in cancellation of coverage.

Qualifying Events & Maximum Duration of COBRA Continuation Coverage

For the Health Care Reimbursement Account (Medical FSA), a qualified beneficiary's coverage can be continued under COBRA until the last day of the **calendar year** in which the qualifying event occurred.

For medical, dental, vision and EAP coverage, the chart on the following page shows how long a qualified beneficiary's coverage can be continued under COBRA based on each qualifying event.

Qualifying Event	Qualified Beneficiaries	Maximum COBRA Period
Your death	Your covered dependents	36 months after loss of coverage
Termination of your employment for reasons other than gross misconduct	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after loss of coverage
Reduction in the number of hours you are employed, if there is a loss of coverage under the plan	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after loss of coverage
Your failure to return to active employment from a Family Medical Leave (FMLA)	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	18 months after the last day of leave of absence regardless of whether or not you continued coverage during FMLA leave
You or an eligible dependent becomes disabled during the first 60 days of COBRA continuation coverage and disability continues at least until the end of the original continuation period	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	Coverage can be extended for all qualified beneficiaries from the original 18-month period to 29 months, provided you notify the COBRA administrator within 65 days after the latest of: 1) date of the Determination of Disability by the Social Security Administration (SSA) or 2) qualifying event date, or 3) date qualified beneficiary actually loses coverage and before the end of the 18-month COBRA continuation period. If the notification does not occur in a timely manner, there will be no disability extension of COBRA continuation coverage.
Your divorce or legal separation	Your spouse and other affected covered dependents	36 months after loss of coverage
You become enrolled in Medicare coverage less than 18 months before your initial qualifying event (termination of employment or reduction in hours) and you lose coverage under the plan due to the initial qualifying event	Your covered dependents	36 months after your enrollment in Medicare
Your dependent child no longer meets eligibility requirements	The affected covered dependent	36 months after loss of coverage

Glossary

403(b) – A retirement investment plan for employees in which a contributor defers taxation on contributions until after withdrawal. Under a traditional 403(b), an employee places a portion of his/her pre-tax income into a 403(b) account and allows it to be invested. Taxation is deferred until withdrawal from the account, generally after retirement. Enrollment in the 403(b) is not automatic, you must elect to enroll.

Accidental Death and Dismemberment (AD&D) Insurance – Insurance coverage added to your existing life insurance as a paid benefit to either you or your beneficiaries if your death or dismemberment is a direct result of an accident (subject to the terms of the plan).

Annual Out-of-Pocket Maximum – The maximum amount you pay each calendar year for covered services, as defined by the medical plan, that generally includes the annual deductible, coinsurance and copays. Once you reach your out-of-pocket maximum, the medical plan pays 100% for most covered services for the remainder of the year.

Basic Life Insurance – Insurance coverage that provides a specified amount of money to be paid to the insured's designated beneficiaries upon death of the insured. Basic coverage is provided by the university at no cost to eligible employees.

Beneficiary – The person (or entity) you designate to receive any life insurance (or retirement) benefits for which you would be eligible in the event of your death.

Biweekly Premium Rate – The pre-tax (in most cases) employee portion of the cost for benefits elected by you for medical, dental, vision, and supplemental life insurance deducted from your paycheck each pay.

COBRA – Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers of 20 or more employees are required to include a coverage continuation provision in their group medical benefit plans. This provision gives an employee whose employment is terminated for any reason other than gross misconduct the right to continue coverage for up to 18 months. The continued coverage must be elected within the COBRA election period and is paid for by the employee, who may be charged no more than 102 percent of the group premium rate.

Coinsurance – A type of insurance in which the insured pays a share of the payment made against a claim (for example: "10% coinsurance" means the insured pays 10% of the cost).

Copayment (Copay) – A flat fee that you pay for some services, at the time you receive the treatment or service, such as a one-time per visit charge at the doctor's office or the one-time cost when picking up your prescription drugs.

Deductible – Depending on your plan, you may be required to pay all health care plan costs until you meet a certain payment amount known as the "deductible." Once you have paid those costs, or "once you have met the deductible," the plan will begin paying benefits according to the plan provisions.

Durable Medical Equipment (DME) – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen, equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Evidence of Insurability (EOI) – Also known as proof of good health, this document is required to be completed to enroll yourself or an eligible dependent in order to be considered for supplemental life insurance coverage after the initial 30-day enrollment eligibility period has expired.

Family and Medical Leave Act (FMLA) – A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member (see WSU-specific policy). When on leave under FMLA, you can continue health coverage under your group health plan.

Flexible Spending Accounts (FSA) – Accounts regulated by IRS Section 125 that allow you to reduce your salary and pay on a pre-tax basis for unreimbursed health care expenses for you and your dependent(s) (i.e. deductibles, copays, dental, vision expenses and other qualifying medically necessary services) and/or qualifying dependent day care expenses (i.e. care for a child, elderly parent or disabled spouse).

Formulary – A plan-approved list of prescription drugs and their appropriate dosages believed to be the most useful and cost effective for patient care.

Generic Drug – A drug with the same active ingredients and equivalent composition as its brand-name counterpart. Generally, it is exactly the same as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. The lower copay amount is charged when generic drugs are elected.

HMO (Health Maintenance Organization) – A legal entity, consisting of participating medical providers, that provides or arranges for care to be furnished to a given population group for a fixed fee per person. HMOs are used as alternatives to traditional indemnity plans.

Home Delivery Pharmacy Service – A mail order pharmacy service contracted by your health plan. There are some advantages to this service which may include price and convenience. You may request delivery of specified prescription drugs directly to your home. Home delivery pharmacy service is generally used for drugs that you do not need immediately.

Inpatient – Person who receives medical, dental, or other health-related services while residing in a hospital or other health care facility for at least one night.

Life Insurance – Insurance coverage that provides a specified amount of money to be paid to the insured's designated beneficiaries upon death of the insured.

Life Insurance Conversion or Portability – An option if your employee life insurance protection ends. You may have the option to continue the coverage by either "converting" it to an individual whole life insurance policy or "porting" (taking it with you as a term life insurance policy to a different employer).

Long-Term Disability (LTD) – Provides partial income protection against income loss due to serious long-term illness or injury.

Non-Preferred Brand-Name Drugs – This prescription drug formulary tier includes brand-name drugs for which there is either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay the highest prescription drug copay for these drugs.

Outpatient – Person who receives medical, dental, or other health-related services in a hospital or other health care facility but who is not residing there.

Preferred Brand-Name Drugs – This prescription drug formulary tier includes preferred brand-name drugs that do not have a generic equivalent. These drugs are more expensive than generics and members pay a higher prescription drug copay for them.

Preventive Care – Health care services intended to prevent a medical condition from occurring, or to detect the onset of a condition early so that it can be more effectively treated. Preventive care includes regular medical check-ups, screening tests, vaccinations, and the encouragement of a healthy lifestyle. It emphasizes prevention, early detection, and early treatment, thereby reducing the costs of health care in the long run.

Primary Care Physician (PCP) – An affiliated physician who has agreed to coordinate the medical care of members. A primary care physician may practice in the area of family practice, internal medicine, or pediatrics. This physician provides or coordinates a range of health care services on your behalf.

Provider – A physician, health care professional or health care facility licensed, certified or accredited as required by state law.

Substantiation (Required Documentation) – Documents required for proof of eligible health-related expenses when using your flexible spending account debit card.

Summary of Benefits and Coverage (SBC) – A required, standardized summary document of health plan benefits and coverage that includes a listing of covered benefits, cost sharing examples, coverage limitations and exceptions. (See Benefits and Wellness website for more details.)

Supplemental Life Insurance – Life insurance coverage that provides a specified amount over and above the amount provided by the university to be paid to the insured's designated beneficiaries upon death of the insured. Supplemental coverage is paid by the employee and is based on age and coverage amount.

Universal Life Insurance with Long-Term Care – A voluntary individual benefit option, 100% paid by the employee that provides a death benefit and long-term care benefits. Long-term care is a service provided when you can't perform at least two of the activities of daily living – bathing, dressing, using the toilet, getting out of bed, caring for incontinence and eating.

Urgent Care Center – Facility that provides care and treatment for urgent medical problems that are not life-threatening but require prompt attention. Sprained ankles, most burns, and minor wounds requiring stitches are typical examples of urgent conditions that could be handled by an urgent care center.

Frequently Asked Questions

Medical, Dental, Vision and Life Insurance

Is enrollment in benefits automatic?

No. Employees in benefit-eligible positions must enroll in medical, dental, vision and flexible spending account benefits within 45 days from their date of hire. If employees miss the 45-day enrollment period, and do not actively select and enroll in benefits, their coverage will default to **only** basic life insurance/AD&D and Long-Term Disability. Changes to coverage can be made during a Life Event or during the annual Open Enrollment period (held during October/November). Any changes made during Open Enrollment will go into effect January 1st of the following year.

How long can I keep my children as dependents on my insurance?

Children may remain on the insurance plans without having to provide proof of dependency or student status until age 26. The child may stay on the insurance coverage through the end of the month of their 26th birthday. Supporting documentation is required for all dependent coverage.

After enrollment, will I receive ID cards for my medical, dental and vision plan enrollments?

The medical plans mail ID cards after the effective date of coverage to the employee's home address as it appears in Academica's Employee Self-Service section. Delta Dental does not issue ID cards (the dentist may submit your Social Security number to verify your coverage). EyeMed will issue an ID card (the vision provider may use your Banner ID for identification purposes).

If I did not receive or lost my insurance card(s), what do I do?

Contact the medical carrier to request a new card and verify your mailing address on file with the medical carrier. For a list of carrier contact numbers and websites, see the Benefits Resource Directory on page 2.

How can I review my coverage and covered dependents online?

To view your benefits statement either use the following link: <https://academica.aws.wayne.edu/link/6ud> or log into Academica, click 'Employee Resources', click 'Employee Self-Service', click 'Benefit Plan Enrollment & Changes'. Once in the benefits portal, click "Wayne State University Benefits Summary".

When should I add my newborn baby to my benefits?

Employees celebrating the birth of a child must complete the online enrollment within 30 days after the birth of the child. The effective date of coverage will be retroactive to the date of birth and premiums will be due accordingly. Failure to complete the online enrollment and submit required dependent documentation within the 30 days will result in the dependent not being added to the benefit plans. To access the online enrollment portal either use the following link: <https://academica.aws.wayne.edu/link/6ud> or log into Academica, click 'Employee Resources', click 'Employee Self-Service', click 'Benefit Plan Enrollment & Changes'.

Can I keep my health insurance coverage after I terminate from the university?

Yes. COBRA federal law allows you to continue medical, dental and vision coverage for up to 18 months following termination. COBRA election forms will be mailed to your mailing address on file, by Benefitsolver. COBRA elections must be submitted within 60 days of receipt of the election form with no gap in coverage.

How do I see my Primary Care Physician (PCP) or have prescriptions filled before I get my ID card?

Contact the medical carrier for your group number and identification number. For a list of contact numbers, see the Benefits Resource Directory on page 2.

I called my medical/dental/vision carrier and they are stating that I do not have coverage. What do I need to do?

Review your paycheck to ensure premiums have been deducted for the coverage and review your Benefits Summary in the benefits portal. Please contact the HR Service Center for assistance at 313-577-3000. Have your nine-digit Banner ID (see your OneCard) available when you call.

Benefits & Laws

What happens to my health benefits during FMLA Leave?

WSU will continue to provide subsidized health benefits while employees are on an approved FMLA leave. Employees are still required to pay their share of the health benefit premiums. If the employee has sufficient illness/vacation bank(s) available, premiums will continue to be withheld from their bi-weekly pay. In the event an employee has exhausted all illness/vacation bank(s), please reach out to the HR Service Center to arrange for the direct pay option. This would allow employees to make benefit premium payments through a WSU billing agent.

*Please note that in the event an employee needs to remain on leave beyond their FMLA entitlement, they will no longer be eligible for the employer subsidy and would be responsible for 100% of the benefit premiums. Please reach out to the HR Service Center to arrange for direct billing.

Will being off work on FMLA impact my pay?

FMLA provides eligible employees with up to 12 weeks of **job protection**. The pay component of the FMLA leave would require employees to utilize available hours in their illness and/or vacation bank(s), which is dependent upon whether the FMLA request is for the employee or to care for a family member.

In the event the employee has exhausted their illness and/or vacation bank(s) and still requires FMLA, the time will be granted as FMLA without pay.

What is the Michigan Paid Medical Leave Act (PMLA)?

The Michigan Paid Medical Leave Act (PMLA) is a new law that requires employers with 50 or more employees to provide eligible employees with paid medical leave.

What is a public health emergency?

A public health emergency is an event of disease or contamination that affects, or has the potential to affect, a large number of people. The PMLA inclusion requires that it be declared by a public health official. PMLA **does not** apply to weather-related closures.

May an employee carry over unused paid medical leave from one benefit year to the next?

WSU will be using the rolling 12-month period for Michigan Paid Medical Leave Act tracking purposes. Employees can carry over up to 40 hours of unused accrued paid medical leave during the rolling 12-month period; however, employers are not required to allow employees to use more than 40 hours within a rolling 12-month period.

What is the Americans with Disabilities Act (ADA)?

The Americans with Disabilities Act (ADA) gives civil rights protection to individuals with disabilities. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation and government services.

Long-Term Disability (LTD)

If approved for Long-Term Disability (LTD), will I receive the disability benefit bi-weekly?

No, LTD disability benefits are paid on a monthly basis to eligible recipients. Monthly benefits are based on a 30-day month. The disability benefit will be prorated if payable for any period less than a month.

Do I have the option of electing health care benefits if approved for LTD?

Yes, you would be eligible to enroll in health care benefits as an LTD recipient. WSU subsidizes medical insurance for employees on Long-Term Disability. If you were actively enrolled in health care benefits prior to being approved for LTD benefits, there is no waiting period to enroll in health care benefits as an LTD recipient. If you were not actively enrolled in health care benefits prior to being approved for LTD benefits, you would have the option of enrolling in health care benefits as an LTD recipient during the annual Open Enrollment period.

Flexible Spending Accounts (FSAs)

What are Flexible Spending Accounts?

Flexible Spending Accounts (FSAs) are employer-sponsored plans authorized by the federal government that allow you to set aside money from your paycheck on a “pre-tax” basis to pay for health care and dependent care expenses for you, your spouse, and/or children and any other IRS-eligible dependent.

Can I change my election during the plan year?

Generally, you may not change or vary your elections during the plan year. The plan year is January 1 through December 31 of each year. There are exceptions to this general rule: you may change or revoke your election at any time during the plan year within 30 days of a family status change event such as divorce, marriage or birth, etc. as defined by Section 125 of the IRC and permitted by the plan.

What happens if I terminate my employment?

If you terminate your employment, you have 120 days after your termination date to submit claims receipts. Since this is a “use it or lose it” program, any unused funds will be forfeited unless you are able to retain the benefits via COBRA.

Retirement Savings Plans

How do I move my funds to another carrier?

You will have to contact the retirement plan carrier/s you selected and they will walk you through the process, as well as provide you with information about the available options.

Employee Wellness

How do I join the Wellness Warriors program? Is it free?

We've eliminated the enrollment process and have granted eligible employees access to all of WSU's employee wellness programming. All active medical-benefit-eligible employees are now able to participate in Wellness Warriors! The program has no cost. The following employee groups are not eligible: stipend recipients, student assistants, temporary employees, hourly employees, employees with less than 50% full-time status, part-time faculty, skilled trades, retirees, and terminated employees.

What are the benefits of participating in Wellness Warriors?

- Walking Club
- Weekly Meditation Group
- Personalized Wellness Portal
- Health Assessment
- Financial Wellness Consultations
- Nutrition Consultations
- Wellness Coaching
- Employee Assistance Program
- Life Advisor Workshops & Webinars
- Fitness Assessment
- Personal Training
- Condition Management
- Smoking Cessation
- Immunizations

To learn more, please visit wellness.wayne.edu

What is an EAP?

The Life Advisor Employee Assistance Program (EAP) is a CONFIDENTIAL emotional wellness benefit provided by Wayne State University to you and eligible members of your family through Ulliance. You, your spouse or live-in partner, as well as dependents under the age of 26 can access a variety of work-life resources through the EAP. All services are completely free to you and strictly confidential. You can contact the Life Advisor EAP 24 hours a day, 365 days a year at **800-448-8326**.

Other General Human Resources Questions

How do I process an address change?

Log in to Academica: select Employee Resources, select Employee Self-Service, select View Personal Info, select Update Address and Phone.

How do I obtain proof of employment and salary information?

This service is available 24 hours a day, 7 days a week, if your employment is after 2003. Option a) visit the work number website theworknumber.com, or option b) call 800-367-2884 and use employer code 12436. If your employment is before 2003, call the HR Service Center at 313-577-3000 or send an e-mail request to askhr@wayne.edu.

How do I apply for other jobs at WSU?

All job applications are submitted online via jobs.wayne.edu. This is where you will also go to check the status of any job for which you may have applied.

How do I process a name change?

You must complete a signed affidavit and bring the document along with valid picture ID (OneCard or Driver's License/State ID) and a signed Social Security card containing your new name to the HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, Michigan 48202.



Legal Notices

Providing False Information

Employees who submit false information intended to provide health care coverage for alleged dependents not eligible for such coverage may be subject to discipline up to and including discharge. Such employee will also be held financially responsible for all claims filed, and will be required to reimburse the university for any payments made on behalf of or for the benefit of an ineligible person claimed as a dependent.

Disclaimer

This booklet is intended as a convenient summary of the benefits (the Plan) for active benefit-eligible employees. It does not cover all provisions, limitations and exclusions. It is not intended to and does not create an express implied contract of employment. It does not contain any promises by the university and the university is not legally or otherwise bound by it. Wayne State University reserves the right to amend, modify, or terminate these plans at any time and in any manner.

Women's Health and Cancer Rights Act

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

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

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

Creditable Coverage Notice (Medicare Part D)

If you are age 65 or older or Medicare eligible due to end-stage renal disease or due to other disability, please read this notice carefully. This notice has important information about your current prescription drug coverage with Wayne State University and prescription drug coverage available for people with Medicare.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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.
2. Wayne State University has determined that the prescription drug coverage included in the WSU medical insurance plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and, therefore, is considered creditable coverage.

Because you currently have creditable prescription drug coverage through a WSU medical insurance plan as a covered employee or spouse, you do not need to enroll in Medicare prescription drug coverage at this time.

Please be aware if you drop or lose your WSU medical insurance coverage and do not enroll in Medicare prescription drug coverage after your WSU coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage (e.g. considered creditable coverage), your monthly premium for a Medicare prescription drug plan will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19 percent higher than what most other people pay.

You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following October to enroll.

If you become a WSU retiree, what are your options under the WSU medical insurance plan?

1. You can elect WSU retiree medical insurance coverage and NOT enroll in Medicare Part D.

Since WSU medical insurance coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can elect to keep your WSU coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. Each year from October 15 through December 7, you will have the opportunity to enroll in a Medicare prescription drug plan. However, if you lose your current creditable prescription drug coverage, you will also be eligible for a two-month Special Enrollment Period to join a Medicare prescription drug plan. Please note you cannot have both WSU medical insurance and a Medicare prescription drug plan. The WSU medical insurance plans do not coordinate with the Medicare prescription drug plans.

2. You can choose not to elect WSU retiree coverage AND enroll in alternative medical and prescription coverage (e.g., a Medigap plan and a Medicare prescription drug plan, or a Medicare Advantage plan).

If you decide to enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible for WSU medical insurance coverage. You will want to consider a Medigap or Medicare Advantage plan to replace your WSU coverage. If your spouse is not enrolled in Medicare, you will need to purchase alternative coverage (e.g., individual coverage) for your spouse.

If you choose **not** to continue WSU retiree coverage and change your mind at any time in the future, you may re-enroll in WSU coverage during our annual retiree Open Enrollment in November/December with coverage effective the following January 1. However, you **MUST** disenroll from any Medicare prescription drug plan. WSU medical insurance plans do not coordinate with Medicare prescription drug plans.

For more information about this notice or your current coverage: Contact the HR Service Center at 313-577-3000. You may receive a creditable coverage notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may also request a copy from the department of Total Rewards.

For more information about your options under Medicare prescription drug coverage: More detailed information about Medicare plans that offer prescription drug coverage will be available in the “Medicare & You” handbook. You may receive a copy of the handbook in the mail from Medicare. If not, you can request a copy by calling Medicare at 800-633-4227. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from the following sources:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [socialsecurity.gov](https://www.socialsecurity.gov) or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

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. If you have any questions about this notice, please contact the HR Service Center at 313-577-3000.

Who Will Follow This Notice

This notice describes the medical information practices of Wayne State University group health plan (the “Plan”) and that of any third party that assists in the administration of Plan claims.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan

administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical 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 the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine 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 medical information with a utilization review or precertification service provider. Likewise, we may share medical 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 (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan.

For example, we may use medical information in connection with: underwriting, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; arranging for medical review, audit services, and fraud and abuse detection programs; business planning and development, such as cost management; and general Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you 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.

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Wayne State University for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Wayne State University personnel solely for purposes of administering benefits under the Plan.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities 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 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.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 release medical 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 person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at the hospital.
- 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.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the department of Total Rewards. If you request a copy of the information, we may charge a fee for the cost 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

medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to change the information. You have the right to request a change for as long as the information is kept by or for the Plan.

To request a change, your request must be made in writing and submitted to the department of Total Rewards. In addition, you must provide a reason that supports your request.

We may deny your request for a change 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 change 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 change.
- Is not part of the information which you would be permitted to inspect and copy.
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations. To request this list of accounting of disclosures, you must submit your request in writing to the department of Total Rewards. Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional requests, we may charge you for the costs of providing the accounting. 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 the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you

to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing. In your request, you must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- To whom you want the limits to apply (for example, disclosures 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 HR Service Center. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

We have the right to deny these requests.

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.

You may obtain a copy of this notice at our website, hr.wayne.edu.

To obtain a paper copy of this notice, contact the HR Service Center at 313-577-3000.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the HR Service Center at 313-577-3000. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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 your or your dependents' other coverage). However, you must request enrollment within 30 days after your 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 the department of Total Rewards.

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.
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify the department of Total Rewards 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 below.

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 states listed on pages **58-59**, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **January 31, 2023**. Contact your State for more information on eligibility.

Coverage Under Michigan's Abortion Insurance Opt-Out Act

Fully insured plans in Michigan can no longer cover elective abortion unless a group rider is purchased. In order to maintain our current coverage under the Blue Care Network and Priority Health HMOs, elective abortions will be included as a rider. This rider applies to all plan participants enrolled in the Blue Care Network and Priority Health HMOs and cannot be declined on an individual basis. Your covered dependents may use this coverage without notice to you.

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: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: <https://www.dhcs.ca.gov/hipp>

Phone: 1-916-445-8322

Fax: 1-916-440-5676

Email: hipp@dhcs.ca.gov

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://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/>

[flmedicaidtprecovery.com/hipp/index.html](https://www.flmedicaidtprecovery.com/hipp/index.html)

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 1-678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

Phone: 1-678-564-1162, Press 2

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 and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-768-9012

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

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.com

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)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/?language=en_US

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

Phone: 1-800-977-6740 TTY: Maine relay 711

Phone: 1-800-977-6740 TTY: Maine relay 711

Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840 TTY: 1-617-886-8102

Phone: 1-800-862-4840 TTY: 1-617-886-8102

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

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

Phone: 1-800-657-3739

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/programs-services/medicaid/health-insurance-premium-program>
Phone: 1-603-271-5218
Toll free number for the HIPPA 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/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 1-800-692-7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rlte 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

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
Medicaid Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: <https://dhhr.wv.gov/bms/http://mywvhipp.com/>
Medicaid Phone: 1-304-558-1700
CHIP 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 January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Dept. of Labor, Employee Benefits Security Administration: [dol.gov/agencies/ebsa](https://www.dol.gov/agencies/ebsa)

Phone: 866-444-EBSA (3272) or U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services:

[cms.hhs.gov](https://www.cms.hhs.gov) Phone: 877-267-2323, Menu Option 4, Extension 61565

Total Rewards • Human Resources

Address: 5700 Cass Ave., Suite 3638, Detroit, Michigan 48202

Telephone: 313-577-3000 • **Fax:** 313-577-0637 • **Email:** askhr@wayne.edu

Web: hr.wayne.edu/tcw

Published June 2024