MSU Support Staff
OPEN ENROLLMENT GUIDE

Time to Choose Your Benefits for 2021

HIGHLIGHTS:

Page 2
Determine if you need to participate this year.

Page 3
Find instructions to complete enrollment.

Page 5
See contact info for all benefits providers.

Page 21
Learn about vision, critical illness & legal insurance.
WELCOME TO THE 2021 OPEN ENROLLMENT PERIOD

It’s time to choose your benefit options for the 2021 plan year! MSU Open Enrollment will be held from October 1-31, 2020. During this time, you can re-evaluate your benefit needs and make changes to benefit selections.

This guide contains information about the benefits options available for eligible support staff employees.

Questions? We’re here to help.

✉️ SolutionsCenter@hr.msu.edu
📞 517-353-4434 OR call toll-free 800-353-4434
💻 hr.msu.edu/open-enrollment

Virtual Benefits Fair

In an effort to reduce the spread of COVID-19, we will not be having an in-person Benefits Fair this year. We’re pleased to offer a Virtual Benefits Fair in October, where you’ll find an online source for curated content from our benefits vendors. HR staff and benefits vendors will be available to answer questions via chat or audio/video call. Find dates and times for the upcoming virtual fair at: hr.msu.edu/open-enrollment/benefits-fair.html

Drive-Through Flu Shots

MSU Pharmacies is offering drive-through flu shots this fall. Learn more about the vaccine on their website: pharmacy.msu.edu/pharmacy-news/flu-vaccine-offered-by-the-msu-health-care-pharmacies
## Should You Participate?

Do you need to take any action during the Open Enrollment period? Answer the following question:

**As an MSU benefits-eligible employee, which of the following statements is true regarding your benefits?** Check all boxes that apply to you.

<table>
<thead>
<tr>
<th>YES!</th>
<th>NO!</th>
</tr>
</thead>
<tbody>
<tr>
<td>I currently cover a spouse/other eligible individual (OEI) under my health benefits (who is NOT an MSU benefits-eligible employee or retiree), and I want to continue their coverage in 2021. You must complete a Spouse/OEI Affidavit every plan year to continue coverage. See page 3 for instructions.</td>
<td>I do not cover a spouse/OEI under my health benefits.</td>
</tr>
<tr>
<td>I want to enroll in, change or cancel health or dental insurance coverage for myself and/or my eligible dependents(s).</td>
<td>I do not want to make any changes to my health or dental insurance and want to keep the exact same coverage in 2021.</td>
</tr>
<tr>
<td>I want to enroll in, change or cancel life or accidental death &amp; dismemberment insurance for myself and/or my eligible dependents(s).</td>
<td>I do not want to enroll in, change or cancel my life or accidental death &amp; dismemberment insurance.</td>
</tr>
<tr>
<td>I want to enroll in, change or cancel my voluntary benefits (e.g. vision) options for myself and/or my eligible dependents(s). See page 21 for more info.</td>
<td>I do not want to enroll in, change or cancel my voluntary vision, legal and/or critical illness insurance.</td>
</tr>
<tr>
<td>I want to enroll or re-enroll in a Flexible Spending Account (FSA). You must re-enroll in an FSA every plan year.</td>
<td>I do not want to enroll in a Flexible Spending Account (FSA) for 2021.</td>
</tr>
<tr>
<td>I elect to waive my health care coverage through MSU. See page 7 for how to enroll in the waiver.</td>
<td>I currently elect to waive my health care coverage through MSU, and I want to continue to waive my health care coverage through MSU. See page 7 for more details.</td>
</tr>
</tbody>
</table>

**YES!** If you selected any of the above options, you must participate in Open Enrollment between Oct. 1–31. See page 3 for enrollment instructions.

**NO!** If you only selected the above option(s), and did not select any options in the “Yes” column, you do not need to participate in Open Enrollment. However, we still encourage you to review your benefits options to make sure you’re getting the best coverage.

Questions? Visit hr.msu.edu/open-enrollment
Open Enrollment Instructions

Use the Enterprise Business System (EBS) to complete Open Enrollment for health, dental, life and flexible spending accounts. Follow these steps:

1. Visit ebs.msu.edu. Log in with your MSU NetID. No NetID? Visit netid.msu.edu or call MSU IT at 517-432-6200.

2. Click the My Benefits top navigation tab.

3. Click the Benefit/Retirement Enrollment and Changes tile. Select the Open Enrollment option from the dropdown menu, then click Next.

4. A CDHP/HSA plan disclaimer will appear (regardless of your eligibility for CDHP/HSA). Read and click OK.

5. If the Health Plan Affidavit for Spouse/OEI appears, answer Yes or No and click Next. The following statement will confirm your answer. If the info is correct, click Next.

6. On the Personal Profile screen, verify name and address info and click Next. To make corrections, find instructions at hr.msu.edu/ebshelp/personalprofile/addresses.html.

7. On the Dependents screen, verify all family members/dependents and click Next. If info is missing, exit Open Enrollment and submit the Add a Family Member or Dependent form. If it is inaccurate, contact MSU HR.

8. The Benefits Summary screen displays current coverage. When finished reviewing, click Next.

9. The next screens display the different plans available (health plans, flexible spending accounts, life/accident plans, etc.). You can Add, Edit or Delete enrollment in these plans. To exit, click Cancel – all changes will be lost.

10. When you reach the Review and Save screen you can Add, Change or Remove coverage by using the top navigation to navigate back to previous screens. Click Save.

11. On the final screen, review info on the Benefit Elections Summary. You have the option to click additional links such as MSU Benefits Plus or Retirement/Health Savings Accounts.

12. You have completed the enrollment steps for the MSU administered benefit programs. You should receive a confirmation email shortly.

How to Enroll in Your Benefits Through the EBS Portal

Enrollment Instructions Video

The visually inclined can watch a How-To Enroll Video on the HR website at hr.msu.edu/open-enrollment/instructions.html.

Other Enrollment Instructions

Page 21: Voluntary Benefits (vision, legal, critical illness insurance, among others)
Page 24: Retirement Programs
What’s New or Notable for 2021?

Read the following important changes, updates, and/or reminders regarding this year’s Open Enrollment and the 2021 plan year. Visit the HR website (hr.msu.edu) for the most up-to-date info.

NEW INFORMATION

Increase to Premium Threshold for Spousal Affidavit
If your spouse/other eligible individual (OEI) has access to health care coverage through their own current or former employer, they must purchase the coverage their own employer offers if the annual employee premium cost for single-person coverage is $1,500 or less. You may still cover your spouse/OEI on your MSU health coverage as a secondary plan.

Aetna DMO Co-Pay Changes
Aetna DMO co-pays for orthodontics have increased. Co-pays have not changed for the Aetna Premium DMO plan. Find co-pays by plan on page 16.

MSU’s Flexible Spending Account Plan Administrator Update
MSU’s flexible spending account (FSA) plan administrator, WageWorks, was recently acquired by HealthEquity. This means you will see new co-branding between WageWorks and HealthEquity as these two companies join to provide the best experience possible to their members. Your FSA plan will remain the same, they are simply changing their name and branding.

Increase to Benefit Level for Life and Accidental Death and Dismemberment (AD&D) Insurance
Employee-paid Life and AD&D insurance is now available at a benefit level 10 times your salary. Learn more on pages 17 and 18.

Best Doctors Now Called Teladoc Medical Experts + New Support Option
You will still have the same great benefit, just with a different name and branding effective January 1, 2021. Additionally, they have a new support option called Mental Health Navigator. Learn more on page 23.

NOTABLE INFORMATION

Federal Regulations Allowing Benefit Changes During Emergency Situation
During the COVID-19 emergency period only, which began March 1 and ends 60 days after the national emergency period officially ends, changes to health, dental and health care and dependent care flexible spending accounts are allowed even if unrelated to a qualified life event. This means you can make updates outside of Open Enrollment in October for health, dental and FSA plans. Learn more on page 5.

Flexible Spending Accounts (FSA): Difference Between Dependent Care and Health Care FSA
MSU’s FSA vendor offers eligible employees two different FSAs: Dependent Care FSA and/or Health Care FSA. Before you enroll, make sure you know the difference between the two options. Learn more on page 19.

Review Your Voluntary Benefit Options, Such as Vision, Legal and Critical Illness Insurance
Many voluntary benefits – like vision, legal, and critical illness insurance – require you to enroll, make changes or cancel during the Open Enrollment period. Learn more on page 21.
COVID-19 Impact to Benefits

Usually, during the Open Enrollment period (Oct. 1–31) you are free to add, change or cancel your benefits. However, effective March 1, 2020, the Department of Labor (DOL) and Internal Revenue Services (IRS) provided provisions to extend deadlines for birth, marriage and loss of coverage and relax rules for adding, canceling and changing health, dental and flexible spending account (FSA) plans. The changes are in effect until 60 days after the COVID-19 emergency period ends, as determined by the federal government.

These provisions are temporary and subject to change by the DOL and IRS at any time due to the changing nature of the pandemic. We strongly encourage you to carefully review and make any necessary changes to your benefits options for the 2021 plan year during the Open Enrollment period in October.

What Happens When the COVID-19 Emergency Period Ends?

60 days after the emergency period ends, the provisions provided by the DOL and IRS will no longer be in effect and you WILL NOT be able to reverse or change your benefits, which includes the following:

- Switch from one health or dental plan to another.
- Add yourself or additional dependents to health or dental coverage.
- Cancel or change health or dental coverage for you or your dependent(s).
- Cancel or change life or accidental death and dismemberment insurance.
- Enroll or re-enroll in a flexible spending account plan.
- Add, cancel or change voluntary vision insurance, group legal services and critical illness insurance.

Your choices are permanent until the next Open Enrollment period, with changes effective January 1. Carefully review Open Enrollment materials to help you select the plans that best meet your coverage and financial needs.

Note on Vision, Legal and Critical Illness Insurance:

This temporary change from the DOL and IRS does NOT extend to voluntary vision, legal, and critical illness insurance. If you need to cancel, add or change any of these voluntary benefits options you must do so during Open Enrollment in October.
Blue Care Network (BCN)

BCN is a Health Maintenance Organization (HMO), which means you select and work closely with a primary care physician to manage your care. Deductibles, co-insurance and prior authorization requirements apply in some circumstances.

The in-network deductible is $100 per individual and $200 per family. After meeting the deductible, a 20% co-insurance may apply, up to a maximum of $3,000/single or $6,000/family, per calendar year.

For questions about specific coverage details or to access a listing of BCN participating providers visit BCBSM.com or call 1-800-662-6667.

Highlights of the BCN Plan:
- Lower premium cost.
- Only eligible to employees who live in Michigan.
- Access coverage with BlueCard when traveling out-of-state and Blue Cross Blue Shield Global Core for traveling outside of the USA.
- Plan does not require a referral, but some services are subject to prior authorization.
- You must choose a primary care physician.

For more information, see the Health Plan Coverage Summary on page 10.

Community Blue PPO

Community Blue is a Preferred Provider Organization (PPO), which gives you the flexibility to manage your own care. Deductibles, co-insurance and prior authorization requirements apply in some circumstances. There is a worldwide network of participating PPO physicians and hospitals.

The deductible is $0 for in-network services and $250/single or $500/family for out-of-network services. After meeting the out-of-network deductible, a 20% co-insurance may apply, up to a maximum of $2,000/single or $4,000/family, per calendar year.

For questions about specific coverage details or to access a listing of PPO participating providers, visit BCBSM.com or call 888-288-1726.

Highlights of the Community Blue PPO Plan:
- Does not have an in-network deductible requirement.
- Higher premium cost.
- More flexibility in managing care.
- Does not require you to choose a primary care physician.

For more information, see the Health Plan Coverage Summary on page 10.

Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA)

This plan is only available to non-union support staff and their benefits-eligible dependents. Support staff represented by a union are not eligible. If you do not anticipate having high health care needs and are looking for a sound strategy to save for your retirement health care, this plan may be the most cost-effective option for you. To enroll in the plan, contact HR Solutions Center for an Offline Enrollment Form: SolutionsCenter@hr.msu.edu or 517-353-4434.

Consumer Driven Health Plan

While you pay a deductible ($2,000/single and $4,000/family) first before the plan pays medical and prescription benefits, preventive care and certain generic medications for chronic conditions (asthma, cholesterol, diabetes, and anti-hypertensives) are 100% covered with no deductible or co-pays when using an in-network provider. Review the Health Plan Coverage Summary on page 10 to anticipate your annual costs under this plan – you may find that most of your annual medical costs are 100% covered.

The provider network for this plan is the same as the Community Blue PPO plan, which means you can choose from a larger provider network.

This plan limits the maximum amount you pay for any covered services in a year to $3,000/single and $6,000/
family using in-network providers. After expenses reach this amount, you do not have to pay for any other health care costs, including prescription drugs.

**Health Savings Account**

Along with the CDHP, you should enroll for the HSA at the same time. MSU contributes up to $750 to the HSA each year and you may add funds to the HSA tax-free. If you do not enroll during Open Enrollment, you will lose MSU’s contribution. You can use these HSA funds to pay for any eligible medical expenses or doctor visits you do incur. Employer and employee combined annual HSA contributions are limited to the 2021 IRS limits of $3,600/single and $7,200/family. These contributions are triple tax-free! You make contributions pre-tax, your account balance earns interest tax-free, and your distributions are tax-free if they are used for eligible medical expenses.

**Please Note:** due to IRS regulations, Health Care FSAs are not compatible with Health Savings Accounts (HSA). You are unable to participate in a Health Care FSA if you enroll in the HSA offered with the CDHP.

Do you have an existing HSA from a previous employer? You can add those funds into your new HSA. The money in the HSA is yours to take with you – even if you leave MSU for a different employer or retire. In fact, investing in your HSA now to use in your retirement is a sound strategy to fund your medical expenses in retirement.

For questions about the CDHP, contact Blue Cross Blue Shield of Michigan at 877-354-2583. For questions about the HSA, contact Health Equity at 888-288-1726.

**Health Plan Waivers**

If you are covered by another health plan that adequately meets your health care needs you may want to consider waiving your MSU health coverage. Individuals who waive coverage will receive a payment of up to $600 per year. Payments occur in February for the previous plan year. This means if you enroll in the waiver for the 2021 plan year, you will receive your payment in February 2022.

Enrollment is not automatic, you must enroll online for the waiver during Open Enrollment.

**Note:** Employees and spouses who are both employed at MSU are not eligible for the waiver option. Find detailed waiver info at hr.msu.edu/benefits/healthcare/waiver.html.

**Summaries of Benefits and Coverage (SBC)**

The Affordable Care Act requires health plans and employers who provide self-insured plans to provide comparative information to consumers on health plan options. Find SBC documents for the health plan options at hr.msu.edu/benefits/summaries/.

**Legal Notices**

Our legal notice publication is attached to the end of this PDF. It includes important legal notices regarding health care privacy and other laws.
Contributions are made pre-tax through payroll deduction on a monthly basis.

### Dependent Age Criteria

Children (biological, step or adopted) are eligible through the end of the calendar year they turn age 26.

Non-adopted grandchildren, nieces, nephews or wards are eligible through legal guardianship through the end of the calendar year they turn age 23.

Dependents who become incapacitated before age 19 can continue coverage after age 23 or 26 by completing the [MSU Dependent Disability Certification Form](http://hr.msu.edu). You will receive an email from HR with options to continue coverage for children once they have aged out of coverage.

### Health Plan Premiums for Sponsored Dependents

This is the monthly premium rate to add a sponsored dependent to your health and prescription coverage. A sponsored dependent is someone who is related to you by blood, marriage or legal adoption, is a member of your household and is dependent on you for more than half of their support. The dependent must meet the IRS dependency test. Find details on the HR website: [hr.msu.edu](http://hr.msu.edu).

- **Blue Care Network (BCN) with CVS/Caremark**:
  - Single: $27.38
  - 2 person Family: $52.52
  - Family: $61.31
  - Paid by MSU: $95.02
  - Paid by MSU: $124.16
  - Paid by MSU: $130.61

- **CDHP with HSA with CVS/Caremark**:
  - Single: $284.64
  - 2 person Family: $597.75
  - Family: $711.60
  - Paid by MSU: $431.17
  - Paid by MSU: $905.48
  - Paid by MSU: $1077.95

- **Community Blue PPO with CVS/Caremark**:
  - Single: $307.73
  - 2 person Family: $616.35
  - Family: $732.69
  - Paid by MSU: $465.46
  - Paid by MSU: $1213.21

1. The lowest cost plan for most support staff for the 2021 plan year is Blue Care Network.
2. Support staff who select the Community Blue plan will pay the difference between the two plans on a pre-tax basis.
3. This plan is only available to non-union staff. You pay 7% of the plan premium on a pre-tax basis. Learn more about the CDHP with HSA plan on page 6.

### Health Plan Premiums for Family Continuation

This is the premium rate if you wish to add a non-adopted grandchild, niece, nephew or ward through legal guardianship (age 23 to 25) to your health and prescription coverage. More details can be found on the HR website: [hr.msu.edu](http://hr.msu.edu).

- **Blue Care Network (BCN) with CVS/Caremark**: $293.08
- **CDHP with HSA with CVS/Caremark**: $171.04
- **Community Blue PPO with CVS/Caremark**: $435.39

The family continuation premium is in addition to the staff monthly premium rates listed above.
Glossary of Terms

Allowed Amount
Maximum amount on which payment is based for covered health care services. If your provider charges more than the allowed amount, you may have to pay the difference.

Coordination of Benefits (COB)
A provision to help avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care/treatment. One plan becomes the “primary” plan and the other becomes the “secondary” plan. This establishes an order in which the plans pay their benefits.

Co-payment
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.

Deductible
A set dollar amount that you must pay out-of-pocket toward certain health care services before insurance starts to pay. Deductibles run on a calendar-year basis.

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

In-network
Refers to the use of health care professionals who participate in the health plan’s provider and hospital network.

Out-of-network
Refers to the use of health care professionals who are not contracted with the health insurance plan.

Out-of-pocket Maximum(s)
The highest amount you are required to pay for covered services. Once you reach the out-of-pocket maximum(s), the plan pays 100% of expenses for covered services.

Prior Authorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called preauthorization, prior approval or precertification. Your health insurance or plan may require prior authorization for certain services before you receive them, except in an emergency. Prior authorization isn’t a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Referral
Specific directions or instructions from your primary care physician that direct a member to a participating health care professional for medically necessary care. A referral may be written or electronic.
### Health Plan Coverage Summary

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Community Blue In-Network</th>
<th>Community Blue Out-of-Network</th>
<th>Blue Care Network In-Network</th>
<th>Blue Care Network Out-of-Network</th>
<th>CDHP w/HSA In-Network</th>
<th>CDHP w/HSA Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
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<tr>
<td>Health Maintenance Exam 1 per calendar year</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
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<tr>
<td>Annual Gynecological Exam 1 per calendar year</td>
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<td>Covered 100%</td>
<td>Not covered</td>
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<tr>
<td>Pap Smear Screening (lab services only) 1 per calendar year</td>
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<td>Not covered</td>
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<td>Not covered</td>
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<td>Not covered</td>
</tr>
<tr>
<td>Mammography Screening 1 per calendar year</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
<td>Covered 80% of eligible expenses after deductible Prior authorization may be required</td>
<td>Covered 100%</td>
<td>Covered 60% after deductible</td>
</tr>
<tr>
<td>Contraceptive Devices (IUD, Diaphragm, Norplant)</td>
<td>Covered 100%</td>
<td>Covered 100% after deductible</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
<td>Covered 60% after deductible</td>
</tr>
<tr>
<td>Contraceptive Injections</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
<td>Covered 60% after deductible</td>
</tr>
<tr>
<td>Well-Baby and Child Care Exams</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
<td>Not covered</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations (as recommended by the Advisory Committee on Immunization Practices or mandated by the Affordable Care Act)</td>
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<td>Not covered</td>
<td>Covered 100%</td>
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<tr>
<td>Flu Shots</td>
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<tr>
<td>Fecal Occult Blood Screening 1 per calendar year</td>
<td>Covered 100%</td>
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<tr>
<td>Preventive Colonoscopy 1 per calendar year</td>
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<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
<td>Covered 80% of eligible expenses after deductible Prior authorization may be required</td>
<td>Covered 100%</td>
<td>Covered 60% after deductible</td>
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<tr>
<td>Flexible Sigmoidoscopy Exam 1 per calendar year</td>
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<tr>
<td>Prostate Exam 1 per calendar year</td>
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<td>Not covered</td>
<td>Covered 100%</td>
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<tr>
<td>Prostate Specific Antigen Screen 1 per calendar year</td>
<td>Covered 100%</td>
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<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Not covered</td>
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<tr>
<td><strong>PHYSICIAN OFFICE SERVICES (MEDICALLY NECESSARY)</strong></td>
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<tr>
<td>Office Visits/Consultations</td>
<td>Co-pay: $20</td>
<td>Covered 80% after deductible</td>
<td>Co-pay: $20</td>
<td>Covered 80% after deductible</td>
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<td><strong>EMERGENCY MEDICAL CARE</strong></td>
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<tr>
<td>Hospital Emergency Room</td>
<td>Co-pay: $50 (if emergency services provided or if admitted) OR $250</td>
<td>Co-pay: $50 (if emergency services provided or if admitted) OR $250</td>
<td>Co-pay: $50 (if emergency services provided or if admitted) OR $250</td>
<td>Co-pay: $50 (if emergency services provided or if admitted) OR $250</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Emergency Room Physician's Services</td>
<td>Co-pay: $20 (when medical emergency criteria not met)</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Co-pay: $25</td>
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<td>Co-pay: $25</td>
<td>Covered 80% after deductible</td>
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<td>Not covered</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Covered 100% of the approved amount</td>
<td>Covered 100% of the approved amount</td>
<td>Covered 80% after deductible, ground and air</td>
<td>Covered 80% after deductible, ground and air</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
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<tr>
<td>Benefit</td>
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<td>Blue Care Network</td>
<td>CDHP w/HSA</td>
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<td></td>
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<td>Out-of-Network</td>
<td>In-Network</td>
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<tr>
<td></td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory and Pathology Tests</td>
<td></td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Tests and X-Rays</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered 100%</td>
<td>Covered 100% after deductible</td>
<td>Covered 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Natal and Post-Natal Care</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Pre-Natal: Covered 100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Post-Natal: Covered 80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered 100% (unlimited days) prior authorization may be required</td>
<td>Covered 100% after deductible (unlimited days) prior authorization may be required</td>
<td>Covered 80% after deductible (unlimited days) prior authorization may be required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery and Related Surgical Services</td>
<td>Covered 100% prior authorization may be required</td>
<td>Covered 100% after deductible prior authorization may be required</td>
<td>Covered 80% after deductible prior authorization may be required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Male Sterilization: Covered 100% under preventive benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMAN ORGAN TRANSPLANTS</td>
<td>Covered 100% prior authorization may be required</td>
<td>Covered 80% after deductible prior authorization may be required</td>
<td>Covered 80% after deductible prior authorization may be required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer and life-threatening conditions (all stages, including routine care)</td>
<td>Covered 100% prior authorization may be required</td>
<td>Covered 100% after deductible prior authorization may be required</td>
<td>Covered 80% after deductible prior authorization may be required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. In-Network: Covered 100% after deductible
2. Out-of-Network: Covered 80% after deductible
3. Prior authorization may be required
4. Female sterilization: Covered 60% after deductible
5. Male sterilization: Not covered
6. Transplant. Prior authorization may be required
7. Male Sterilization: Covered 50% after deductible
8. Female Sterilization: Covered 100% under preventive benefit
9. Covered 100% under preventive benefit
10. Male sterilization: Not covered
11. Cancer and life-threatening conditions (all stages, including routine care)
### ALTERNATIVES TO HOSPITAL CARE

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Community Blue</th>
<th>Blue Care Network</th>
<th>CDHP w/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care (must meet medical necessity guidelines for skilled care)</td>
<td>Covered 100% in approved facilities (up to 120 days per calendar year)</td>
<td>Covered 100% after deductible (combined in- and out-of-network benefits limited to 100 days per calendar year)</td>
<td>Covered 80% after deductible (combined in- and out-of-network benefits limited to 90 days per calendar year)</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered 100% with approved providers</td>
<td>Covered 100% after deductible</td>
<td>Covered 100% after deductible when authorized</td>
</tr>
<tr>
<td>Home Health Care (medically necessary)</td>
<td>Covered 100% with approved providers (unlimited visits)</td>
<td>Covered 100% after deductible (combined in- and out-of-network benefits limited to 60 days per calendar year)</td>
<td>Covered 80% after deductible (combined in- and out-of-network benefits limited to 60 days per calendar year)</td>
</tr>
</tbody>
</table>

### MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT (IN APPROVED FACILITIES)

<table>
<thead>
<tr>
<th>Inpatient Mental Health/Substance Abuse Care</th>
<th>Covered 100%</th>
<th>Covered 80% after deductible</th>
<th>Covered 100% after deductible</th>
<th>Covered 80% after deductible</th>
<th>Covered 60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health/Substance Abuse Care - Office Visits</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100% after deductible</td>
<td>Covered 80% after deductible</td>
<td>Covered 60% after deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health/Substance Abuse Care - Facility</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100% after deductible</td>
<td>Covered 80% after deductible</td>
<td>Covered 60% after deductible</td>
</tr>
</tbody>
</table>

### OTHER SERVICES

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Community Blue</th>
<th>Blue Care Network</th>
<th>CDHP w/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing and Therapy (includes allergy injections)</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Spinal Manipulation and Osteopathic Manipulation</td>
<td>Co-pay: $20 (In- and out-of-network services have an annual combined max. of 24 visits)</td>
<td>Covered 80% after deductible (In- and out-of-network services have an annual combined max. of 24 visits)</td>
<td>Co-pay: $20 (In-network only. Annual max. of 24 visits)</td>
</tr>
<tr>
<td>Outpatient Diabetes Management (certified providers)</td>
<td>Covered 100%</td>
<td>Covered 80% after deductible</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Outpatient Physical, Speech, and Occupational Therapy (subject to medical criteria)*</td>
<td>Covered 100% (In- and out-of-network services have an annual combined max. of 60 visits)</td>
<td>Covered 80% after deductible (In- and out-of-network services have an annual combined max. of 60 visits)</td>
<td>Co-pay: $20 (combined in- and out-of-network benefits limited to 60 visits per calendar year)</td>
</tr>
</tbody>
</table>

*Autism Spectrum Disorder services are not subject to Outpatient Physical, Speech, and Occupational Therapy visit limit.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Community Blue</th>
<th>Blue Care Network</th>
<th>CDHP w/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment and Medical Supplies (including breastfeeding supplies)</td>
<td>Covered 100% of the approved amount</td>
<td>Covered 80% Prior authorization may be required</td>
<td>Covered 80% Prior authorization may be required</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Covered 50%</td>
<td>Not covered</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Autism Spectrum Disorder (Applied behavioral analysis treatment - must be provided by an Approved Autism Evaluation Center (AAEC) - limited through age 19)</td>
<td>Covered 100% for applied behavioral analysis Prior authorization required</td>
<td>Co-pay: $20 per visit for applied behavioral analysis Prior authorization required</td>
<td>Covered 80% after deductible Prior authorization required</td>
</tr>
<tr>
<td>Foreign Travel</td>
<td>Covered for non-emergency and emergency care as well as accidental injuries</td>
<td>Covered for non-emergency and emergency care as well as accidental injuries</td>
<td>Covered for non-emergency and emergency care as well as accidental injuries</td>
</tr>
<tr>
<td>DEDUCTIBLES, CO-PAYS, AND DOLLAR MAXIMUMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>None</td>
<td>$100 per member/$1,000 per family per calendar year</td>
<td>$2,000 for single/$4,000 for family-level coverage per calendar year</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (amount includes deductible, co-insurance and co-pays, where applicable)</td>
<td>$2,000 per member/$4,000 per family per calendar year</td>
<td>$3,000 per member/$6,000 per family per calendar year for medical services only</td>
<td>$3,000 for single/$6,000 for family-level coverage per calendar year for both medical and prescription services</td>
</tr>
<tr>
<td>Prescription Drug Benefit</td>
<td>$1,000 per member/$2,000 per family out-of-pocket maximum (see page 14 for co-pays)</td>
<td>$1,000 per member/$2,000 per family out-of-pocket maximum (see page 14 for co-pays)</td>
<td>Subject to deductible, co-insurance and out-of-pocket max</td>
</tr>
</tbody>
</table>

1. Chemical profile, complete blood count, urinalysis, cholesterol testing, chest x-ray and EKG are payable as part of the Health Maintenance Exam.
2. You may be responsible for the difference between BCBSM’s or BCN’s approved amount and the provider’s charge when services are rendered by a non-participating provider, premiums and health care this plan doesn’t cover, where applicable.
3. Referrals to specialists are not required.
4. Age restrictions may apply.
Prescription Drug Information

The prescription drug plan is administered through CVS/Caremark. Employees continue to be automatically enrolled for prescription drug coverage in CVS/Caremark when they enroll in one of the health plans (Community Blue PPO, Blue Care Network (BCN) or the Consumer Driven Health Plan with Health Savings Account (CDHP with HSA)).

The table below shows co-pay rates for various types of prescription drugs for Community Blue and BCN enrollees effective January 1, 2021. Enrollees can use any in-network pharmacy for this benefit.

<table>
<thead>
<tr>
<th>CVS/Caremark Prescription Plan Co-Pays for BCN &amp; Community Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

**ANNUAL OUT-OF-POCKET CO-PAY MAXIMUM**

- Individual: $1000
- Family: $2000

*90-day supply (except Bio-Tech/Specialty Drugs) may only be filled at MSU Pharmacies or through CVS/Caremark mail order.

**Important Note for Non-Union Support Staff that Enroll in the CDHP with HSA Plan:**

If you are a CDHP with HSA enrollee, you have different prescription benefits. Prescription drug costs under this plan are subject to plan deductible and co-insurance, and then the total cost is covered after you reach the out-of-pocket maximum. This means that you pay 100% of prescription costs until you reach the deductible. Once the deductible is met, the plan covers 80% of the costs while you pay 20% co-insurance. Once the out-of-pocket maximum is reached, prescriptions are 100% covered.

Certain preventive generic prescription drugs for chronic conditions (asthma, cholesterol, diabetes and anti-hypertensives) are 100% covered without a deductible or co-insurance.

Be sure to enroll in the HSA when you enroll in the CDHP plan to receive MSU’s HSA contribution of $750. You can use this money to pay for eligible medical and prescription costs.
Dental Plan Information

MSU offers Delta Dental to all benefits-eligible support staff, and either Aetna DMO or Aetna Premium DMO, depending on your union affiliation (see below).

In a Dental Maintenance Organization (DMO) like Aetna DMO and Aetna Premium DMO, you select a participating primary care dentist. Your primary dental care is provided by that dentist and only at locations and by dentists that participate in the plan. Although choice of providers is more limited, a DMO tends to cover a greater range of services at lower co-pays than traditional dental plans.

If you plan to enroll in the Aetna DMO or Aetna Premium DMO, please verify that the dentist you want to use accepts “Aetna DMO” rather than just “Aetna” to avoid rejected claims.

The Delta Dental PPO plan typically allows more freedom in selecting service providers and services performed but tends to have higher out-of-pocket costs compared to a DMO plan. Delta offers hundreds of participating providers and allows you to seek care from both participating and non-participating providers. Note: You may incur additional costs if you use a non-participating provider. Contact Delta Dental for info on participating providers.

Dependent Age Criteria: Children (biological, step or adopted), non-adopted grandchildren, nieces, nephews or wards through legal guardianship are eligible through the end of the calendar year they turn age 23. Dependents who become incapacitated before age 19 can continue coverage after age 23 by completing the MSU Dependent Disability Certification Form.

Monthly Dental Plan Premiums

1. **Aetna DMO:** This plan is available to 274, AP and POAM employees.

2. **Aetna Premium DMO:** This plan is available to CT, APSA, 324, 1585, SSTU, nurses, resident advisors and MSU Extension employees.

3. **Delta Dental PPO:** This plan is available to all benefits-eligible support staff.

<table>
<thead>
<tr>
<th>PLAN</th>
<th>FULL-TIME (90%–100%)</th>
<th>3/4 TIME (65%–89.9%)</th>
<th>1/2 TIME (50%–64.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AETNA DMO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
</tr>
<tr>
<td>2 Person</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td>$10.44</td>
<td>$15.30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$19.49</td>
<td>$28.79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$33.64</td>
<td>$48.85</td>
</tr>
<tr>
<td><strong>AETNA PREMIUM DMO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$10.44</td>
<td>$15.30</td>
<td>$20.16</td>
</tr>
<tr>
<td>2 Person</td>
<td>$19.49</td>
<td>$28.79</td>
<td>$38.10</td>
</tr>
<tr>
<td>Family</td>
<td>$33.64</td>
<td>$48.85</td>
<td>$64.06</td>
</tr>
<tr>
<td><strong>DELTA DENTAL PPO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
</tr>
<tr>
<td>2 Person</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
</tr>
<tr>
<td>Family</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
<td>Paid by MSU</td>
</tr>
<tr>
<td></td>
<td>$10.44</td>
<td>$15.30</td>
<td>$6.79</td>
</tr>
<tr>
<td></td>
<td>$19.49</td>
<td>$28.79</td>
<td>$30.42</td>
</tr>
<tr>
<td></td>
<td>$33.64</td>
<td>$48.85</td>
<td>$64.06</td>
</tr>
</tbody>
</table>
### DENTAL PLAN SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>DENTAL SERVICE</th>
<th>AETNA DMO</th>
<th>AETNA PREMIUM DMO</th>
<th>DELTA DENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSTIC AND PREVENTIVE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>$20 co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Cleanings</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>X-rays</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Fluoride</td>
<td>No co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Sealants (to prevent decay of permanent molars for dependents)</td>
<td>$10 co-pay per tooth</td>
<td>$10 co-pay per tooth</td>
<td>Not covered</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>$100 co-pay</td>
<td>$80 co-pay (fixed and removable)</td>
<td>50% co-pay (less than age 19)</td>
</tr>
<tr>
<td><strong>MINOR RESTORATIVE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam (silver) fillings</td>
<td>$22 co-pay for one</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Composite (resin) fillings (anterior teeth)</td>
<td>$40 co-pay for one</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td><strong>PROSTHETICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns (semi-precious)</td>
<td>$488 co-pay</td>
<td>$315 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Bridges (per unit)</td>
<td>$488 co-pay</td>
<td>$315 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Denture (each)</td>
<td>$500 co-pay</td>
<td>$320 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Partial (each)</td>
<td>$513-613 co-pay</td>
<td>$320 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td><strong>ORAL SURGERY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple extraction</td>
<td>$12 co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Extraction - erupted tooth</td>
<td>$30 co-pay</td>
<td>No co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Extraction - soft tissue impaction</td>
<td>$80 co-pay</td>
<td>$60 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Extraction - partial bony impaction</td>
<td>$175 co-pay</td>
<td>$80 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Extraction - complete bony impaction</td>
<td>$225 co-pay</td>
<td>$120 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td><strong>ENDODONTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Root canal - anterior</td>
<td>$150 co-pay</td>
<td>$120 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Root canal - bicuspid</td>
<td>$195 co-pay</td>
<td>$180 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Root canal - molar</td>
<td>$435 co-pay</td>
<td>$300 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Apicoectomy</td>
<td>$156 co-pay</td>
<td>$170 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td><strong>PERIODONTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gingivectomy (per quadrant)</td>
<td>$160 co-pay</td>
<td>$125 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Osseous surgery (per quadrant)</td>
<td>$445 co-pay</td>
<td>$375 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Root scaling (per quadrant)</td>
<td>$65 co-pay</td>
<td>$60 co-pay</td>
<td>50% co-pay</td>
</tr>
<tr>
<td><strong>ORTHODONTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child (under age 19)</td>
<td>$3,000 co-pay(1)</td>
<td>$1,500 co-pay(1)</td>
<td>50% co-pay</td>
</tr>
<tr>
<td>Adult (age 19 or older)</td>
<td>$3,000 co-pay(1)</td>
<td>$1,500 co-pay(1)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>DENTAL PLAN MAXIMUMS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td>No maximum</td>
<td>No maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>Lifetime Orthodontics</td>
<td>No maximum</td>
<td>No maximum</td>
<td>$600 maximum</td>
</tr>
</tbody>
</table>

1. Includes screening exam, diagnostic records, orthodontic treatment and orthodontic retention.
Life Insurance Information

MSU offers optional employee-paid life insurance to all regular full- and part-time (50% or more) employees, as well as to your spouse/other eligible individual (OEI) and dependent children. You do not need to be enrolled to add your children or spouse/OEI.

Life insurance is offered at 1 to 10 times your annual salary. There are various levels of coverage for your spouse/OEI and children. You must provide evidence of insurability when enrolling or increasing your life insurance coverage for yourself or your spouse/OEI. Evidence of insurability is not required for children. Prudential will contact you via your MSU NetID email address with instructions on how to submit evidence of insurability. Please see Dependent Age Criteria at the bottom of page 18.

How Much Does Optional Life Insurance Cost?

Use the charts and formulas below to calculate the monthly cost for you, your spouse/OEI, and/or your children. Note: rates will change on the date you enter a new age bracket or if your salary changes.

**EMPLOYEE LIFE INSURANCE COST**

**STEP ONE** – determine the following:
1. Your salary.
2. Your rate (see Chart A.)
3. Your benefit level. Choose from 1 – 10 times your salary, up to a maximum of $2,000,000.

**STEP TWO** – use the following formula and your answers from step one to calculate monthly cost:

\[
\text{Salary} \times \text{Rate} \times \text{Benefit Level} \div 1,000 = \$\text{___}/month
\]

**EXAMPLE**
1. Salary = $50,000
2. Age = 25, so rate = $0.027 (according to Chart A.)
3. Benefit level chosen = 5 x salary

\[
\$50,000 \times 0.027 \times 5 = \$6.75/month
\]

**SPOUSE/OEI LIFE INSURANCE COST**

**STEP ONE** – determine the following:
1. Spouse/OEI coverage level. Choose from options in Chart B.
2. Spouse/OEI rate (use age of employee, NOT spouse/OEI) (see Chart C.)

**STEP TWO** – use the following formula and your answers from step one to calculate monthly cost:

\[
\text{Spouse/OEI Coverage Level} \times \text{Rate} \div 1,000 = \$\text{___}/month
\]

**EXAMPLE**
1. Coverage Level = $10,000
2. Age = 25, so rate = $0.04 (according to Chart C.)

\[
10,000 \times 0.04 \div 1,000 = \$0.40/month
\]

**CHILD LIFE INSURANCE COST**

**STEP ONE** – determine the following:
1. Child coverage level. Choose from options in Chart D.

**STEP TWO** – use the following formula and your answer from step one to determine monthly cost:

\[
\text{Child Coverage Level} \times \text{Rate} \div 1,000 = \$\text{___}/month
\]

**EXAMPLE**
1. Child coverage level = $10,000

\[
10,000 \times 0.083 \div 1,000 = \$0.83/month
\]
Accidental Death & Dismemberment Insurance

Optional employee-paid accidental death and dismemberment (AD&D) insurance provides various amounts of coverage for accidental death or dismemberment or loss of sight whether in the course of business or pleasure. Optional family coverage is also offered. Prudential is the plan administrator for AD&D insurance. This is available to all regular full- and part-time (50% or more) employees, as well as to your spouse/other eligible individual (OEI) and dependent children.

You can enroll in AD&D coverage at 1 to 10 times your annual salary. Benefit levels vary by type of insurance selected (employee-only or family) and the extent of the injury. Evidence of insurability is not required. Benefit amounts for spouse/OEI and/or child(ren) are based on a percentage of your benefit amount. Please refer to the Prudential brochure for more info (see side panel).

How Much Does Optional AD&D Insurance Cost?

Use the chart and formula below to find the cost of insurance for you, your spouse/OEI, and your children. Rates are subject to change.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only</td>
<td>$0.015</td>
</tr>
<tr>
<td>Family</td>
<td>$0.023</td>
</tr>
</tbody>
</table>

**Chart A. Rates Per $1,000 of Coverage**

**AD&D INSURANCE COST**

**STEP ONE** – determine the following:

1. Your salary.
2. Your rate (see Chart A.)
3. Your benefit level. Choose from 1 – 10 times your salary, up to a maximum of $1,000,000 for the employee, $600,000 for a spouse/OEI, or $100,000 per child.

**STEP TWO** – use the following formula and your answers from step one to calculate monthly cost:

\[
\text{Salary} \times \text{Rate} \times \text{Benefit Level} \div 1,000 = \$\text{___}/\text{month}
\]

**EXAMPLE**

1. Salary = $50,000
2. Employee rate = $0.015 (according to Chart A.)
3. Benefit level chosen = 5 x salary

\[
\$50,000 \times 0.015 \times 5 \div 1,000 = \$3.75/\text{month}
\]

**Dependent Age Criteria:** Effective January 1, 2021, AD&D and Life insurance dependent Child(ren) are eligible to the end of the calendar year during which the child turns age 23 with no restrictions such as student enrollment or IRS dependency. It is the enrollee’s responsibility to cancel coverage when dependent children no longer qualify in order to stop premium deductions. Children who become incapacitated before the age limit can continue coverage after the age limit if (1) the child is mentally and/or physically incapable of earning a living AND (2) Prudential has received proof of incapacity within 31 days. If the child becomes incapacitated after the age limit, they will not be able to continue coverage.
Flexible Spending Accounts (FSA)

What is an FSA?
Looking to save money? We all spend money on medical expenses such as prescription and office visit co-pays, dental work and over-the-counter items like bandages. And many parents spend thousands of dollars each year on child care. An FSA allows you to use pre-tax dollars to buy these common household items and services – saving you an average of 30%!

MSU’s FSA vendor is HealthEquity/WageWorks and they offer eligible employees two different kinds of FSAs. The Health Care FSA can be used for eligible medical expenses. The Dependent Care FSA can be used for eligible child and dependent care expenses. Learn more about these options below.

Due to IRS regulations, non-union support staff are unable to enroll in a Health Care FSA if they enroll in the Health Savings Account (HSA) offered with the Consumer Driven Health Plan (CDHP).

What’s the Difference?
You have the option to enroll in two different FSAs: Dependent Care and/or Health Care. Before you enroll, learn the differences between the two. Visit hr.msu.edu/benefits/flexible-spending-accounts to find info on all eligible expenses for both the health care and dependent care FSAs.

**Health Care FSA**

- **Overview**
  Use money from your Health Care FSA on eligible medical expenses for you and your dependents.

- **Examples of Eligible Expenses**
  - Medical/dental plan deductible/co-pays
  - Eyeglasses
  - Hearing aids
  - Pain relievers
  - And much more!

- **How Much Can I Contribute?**
  An individual may contribute up to $2,750. If both you and your spouse have a Health Care FSA, you each may contribute up to $2,750. Savings vary based on your income tax rate and the number of out-of-pocket health and child care costs you typically incur.

**Dependent Care FSA**

- **Overview**
  Use money from your Dependent Care FSA on eligible child and dependent care expenses. This plan is NOT for dependent health care expenses.

- **Examples of Eligible Expenses**
  - Child or elder daycare
  - Preschool
  - Summer day camp
  - Before/after school programs

- **How Much Can I Contribute?**
  A household may contribute up to $5,000. If you and your spouse both have a Dependent Care FSA, your combined household contributions cannot total more than $5,000 at MSU or through another employer.
How FSAs Work
You will confirm your contribution amount for the 2021 calendar year when you enroll. Your contributions will be deducted from your paycheck and will not be taxed. See maximum contribution amounts on page 19.

Carefully estimate the eligible expenses you are likely to incur in 2021. The IRS mandates any unused funds to be forfeited, so it’s important you plan ahead to match your FSA withholdings to the amount you are likely to spend on eligible health care and/or dependent care costs. Review important deadlines for using your funds and submitting claims in the right side panel.

When you pay for an eligible expense, you will fill out a reimbursement request. You’ll submit receipts for the expense with the request. You will then be reimbursed for those expenses with the tax-free dollars from your account(s). For some expenses, like prescriptions and office visit co-pays, you can pay directly with your Health Care FSA debit card.

Helpful Health Care FSA Information

• **Keep all of your receipts for eligible expenses.** IRS rules require FSA administrators to substantiate the eligibility of all items and services, including those transactions using Health Care FSA debit cards. Some types of expenses, like doctor visits or prescription drug co-pays, can be automatically substantiated because co-pays are predictable amounts from medical providers.

• **HealthEquity/WageWorks may ask you to send in supporting documentation for a card transaction.** Acceptable documentation contains the following five pieces of information:
  1. Date of Service
  2. Description of Service (such as co-pay)
  3. Patient Name
  4. Provider’s Name
  5. Amount of Transaction

• **An Explanation of Benefits (EOB)** from your insurance carrier contains all five pieces of information and is available from your insurance carrier if you used insurance for your card transaction.

• **Due to IRS regulations, Health Care FSAs are not compatible with Health Savings Accounts (HSA).** Non-union support staff are unable to participate in a Health Care FSA if they enroll in the HSA offered with the CDHP. Also, if your spouse’s health plan has an HSA and you enroll in a Health Care FSA, you may have IRS compatibility issues.

• **Visit the FSA Store at FSASTORE.COM to buy your eligible expenses online!**
Voluntary Benefits

You have access to optional, employee-paid benefits via the voluntary benefits portal at MSUBenefitsPlus.com.

Please note there is no university financial contribution toward these benefits. Enrollees pay the premiums for the benefits they select and those payments are most often collected via payroll deduction. Currently, the voluntary benefits available include:

- Vision Insurance
- Pet Insurance
- Legal Insurance
- Critical Illness Insurance
- Long-Term Care Insurance
- Auto and Home Insurance

Can I Enroll or Cancel at Any Time?

Vision, legal and critical illness insurance have an annual Open Enrollment period of October 1 through October 31, 2020, with coverage effective January 1. This means you can only enroll or cancel in October each year and once you enroll, you cannot change or cancel that enrollment until the next annual Open Enrollment period (unless you have a qualifying life event). Your enrollment in vision, legal and critical illness insurance will continue (no need to re-enroll during Open Enrollment) unless you cancel.

Other programs, like auto, home, long-term care and pet insurance, allow you to enroll at anytime throughout the year.

How Do I Enroll or Learn More?

Visit MSUBenefitsPlus.com to learn more about available programs and enroll online.

First Time Users

You need to sign up for an account. Signing up for an account does not obligate you to enroll in any benefits; it merely gives you access to learn about and enroll in the various programs. You will need your MSU ZPID number, which is located on your MSU Spartan Card ID badge or in the EBS Portal. Use a capital “Z” when putting in your ZPID number.

Existing Users

Click on the Log In link in the top right corner of the page.
Vision Insurance
Vision insurance can help with the cost of glasses and contact lenses for you and your family. VSP offers two plan options: the standard coverage plan, or a premium coverage plan with an additional enhanced eyewear option of your choice. You can view a plan summary sheet with basic information about the two plan coverage options and rates in the portal. Pay via payroll deductions.

Pet Insurance
Pet insurance can reimburse you for vet bills related to covered conditions. Nationwide offers several levels of coverage, and rates vary depending on the plan you select and the age of your pet. Visit the portal to enroll for pet insurance and pay via payroll deduction.

Long-Term Care Insurance
You can enroll in long-term care coverage with Transamerica. These policies are individual (as opposed to group) plans and evidence of insurability is required. You may apply anytime and your coverage start date will be determined by whether and when your application is approved through the underwriting process. You may choose from several premium payment frequencies; payment methods include direct bill and automatic electronic funds transfer (EFT) from your checking account.

MSU is currently offering the opportunity to consult with long-term care specialists from the Todd Benefits Group, a third party firm specializing in long-term care benefits, to help you select the Transamerica options that best meet your needs.

Legal Insurance
With pre-paid legal coverage, you can access legal assistance in a wide variety of situations when you need it without worrying about the costs. The legal plan offers expanded and/or enhanced benefits, such as insurance claims, divorce, home equity loans, refinancing and elder law. ARAG® Legal Insurance Plan excludes most pre-existing legal issues and business-related matters. A pre-existing condition, which ARAG has defined as any legal matter which is initiated prior to the effective date of coverage will be considered excluded and no benefits will apply. You can view a plan summary sheet with basic information about the two plan coverage options and rates in the portal. Pay via payroll deductions.

Critical Illness Insurance
Critical illness insurance gives you extra cash in the event you or covered family members experience a covered illness. This money can be used to offset unexpected medical expenses or for any other use you wish. Simplified plan options are offered through MetLife with no evidence of insurability requirement. You can view a plan summary sheet with basic information about the plan coverage and rates in the portal. Pay via payroll deductions.

Auto and Home Insurance
You can get bids from and enroll in auto and home insurance with either MetLife or Liberty Mutual and pay for those policies via payroll deduction. There is no formal enrollment period for auto and home insurance, you may enroll at anytime. The coverage period depends on when your policy is issued.

Dependent Age Criteria for Vision, Legal and Critical Illness Insurance:
Effective January 1, 2021, dependent child(ren) are eligible to the end of the calendar year during which the child turns age 23 with no restrictions such as student enrollment or IRS dependency.

Access the Voluntary Benefits Portal
VISIT MSUBenefitsPlus.com to access the portal and sign up/find info for the above benefits.

MSU Benefits Plus
☎️ 888-758-7575
Teladoc for Online Medical Care

Teladoc offers 24/7 access to a health care professional by phone, web, or mobile app. Talk to a doctor about your care needs as you stay safe in your home, avoiding exposure and the potential spread of COVID-19. This is available to MSU employees and their dependents who are enrolled in an MSU health plan.

How Does it Work?

When you need medical advice, you can receive convenient, quality care from a licensed health care professional in three easy steps:

1. **Request**: ask for a visit with a doctor 24 hours a day, 365 days a year by web, phone or mobile app.
2. **Visit**: talk to the doctor. Take as much time as you need to explain your medical situation – there’s no limit.
3. **Resolve**: if medically necessary, a prescription will be sent to the pharmacy of your choice.

There is no copay associated with accessing this service at this time except for those employees/dependents enrolled in the CDHP with HSA plan. Due to IRS regulations, if you are enrolled in the CDHP with HSA plan you pay the full charge until your annual deductible is met.

Teladoc Medical Experts (formerly called Best Doctors)

Effective January 1, 2021, your Best Doctors benefit will be changing their name and branding to Teladoc Medical Experts. You will see joint branding between Best Doctors and Teladoc Medical Experts throughout the rest of 2020. You can still expect to receive the same great service and benefit options from Teladoc Medical Experts that you’ve previously received from Best Doctors - they are simply changing their name and branding.

Teladoc Medical Experts gives expert second opinions and provides answers to your medical questions. If you’re facing a serious diagnosis or your medical care was delayed due to COVID-19 (such as surgery or chemotherapy) Teladoc Medical Experts can help you determine the best course of action.

Teladoc Medical Experts also offers Treatment Decision Support, Medical Records eSummary and the Mental Health Navigator. Learn more about these options at teladoc.com/medical-experts.
Livongo for Diabetes Management

Livongo helps you manage your diabetes by delivering tools and resources directly to your home – all free to you and/or your eligible dependents. Get unlimited supplies, smart meter and optional coaching while continuing to practice safe social distancing to avoid exposure to COVID-19.

Benefits of the program:
- **More than a standard meter**: The Livongo connected meter provides real-time tips and uploads readings.
- **Unlimited free strips and lancets**: You can get as many strips and lancets as you need with no hidden costs or copays. When your supplies are about to run out, Livongo ships you more.
- **Optional coaching anytime and anywhere**: Connect to a Livongo coach for one-on-one support by phone, email, text or mobile app to help with questions about nutrition or lifestyle changes and live interventions triggered by acute alerts.

It takes less than 10 minutes to sign up and start your profile. Use the contact information to the right. You may enroll in Livongo at anytime throughout the year.

Retirement Programs at MSU

MSU is dedicated to offering you the best possible retirement plans, and we encourage you to take advantage of the retirement savings options available to you. The university offers Fidelity and TIAA as providers of administration, recordkeeping and investment options for each of the MSU retirement plans. Both companies offer resources and tools to help participants plan their investment strategy.

The university’s 403(b) Retirement Plan includes the MSU 403(b) Base Retirement Program and the MSU 403(b) Supplemental Retirement Program. These programs, as well as the MSU 457(b) Deferred Compensation Plan, are designed to help you invest more money today to help you have the income you need during your retirement.

Retirement plans are offered year round, and coverage can be added and modified outside of the Open Enrollment period.

**Thinking About Retiring Soon?** We encourage you to visit the HR website to find resources to help you transition smoothly into retirement: [hr.msu.edu/benefits/retirement/prepare-to-retire.html](http://hr.msu.edu/benefits/retirement/prepare-to-retire.html)

Living with diabetes? Have supplies delivered to your home for free.

**Livongo**
☎️ 800-945-4355
 доп livongo.com
⬇️ Download the Livongo app

**VISIT**
[welcome.livongo.com/MSU](http://welcome.livongo.com/MSU) to learn more and sign up.

Need help choosing an investment mix?

Fidelity and TIAA can help you choose investments for your retirement portfolio and have more resources on their websites. Contact the vendor directly:

**Fidelity**
☎️ 800-343-0860
donetbenefits.com/msu
⬇️ Search “NetBenefits” to download app

**TIAA**
☎️ 800-842-2252
dottiaa.org/msu
⬇️ Download the TIAA app

**VISIT**
hr.msu.edu/benefits/retirement to access retirement resources and information.

Questions? Visit hr.msu.edu/open-enrollment
**Important Notices About Your Health Care Rights**

MSU HR is pleased to provide you with this resource to help you learn about or refamiliarize yourself with various regulations intended to safeguard your health care rights. Included in this publication you will find health care notices regarding:

- A notice of privacy practices. This describes how medical information about you can be used and disclosed and how you can access this information.
- Information about Medicaid and the Children’s Health Insurance Program.

**Women’s Health and Cancer Rights Act of 1998**

As required by the Women's Health and Cancer Rights Act of 1998 (effective October 21, 1998), MSU Health Plans provide the following coverage:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast for symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

If you have any additional questions, please contact your health plan administrator.

**Contact Information for MSU Health and Dental Plans**

Please keep the below contact information for MSU Health Plans in a safe place so you can call on our plans at any time with questions:

- Humana: 1-800-273-2509
- Delta Dental: 800-524-0149
- Aetna Dental Maintenance Organization (DMO): 877-238-6200
- Health Savings Account (administered by Health Equity): 877-219-4506

As always, please feel free to contact MSU Human Resources for assistance at: SolutionsCenter@hr.msu.edu, 517-353-4434 or 800-353-4434.

**HIPAA: Notice of Privacy Practices Michigan State University Health Plans**

**EFFECTIVE DATE**

This Notice is effective January 1, 2013.

**PURPOSE**

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

The Michigan State University Health Plans (collectively referenced in this notice as the “Plan”) are regulated by numerous federal and state laws.

The Health Insurance Portability and Accountability Act (HIPAA) identifies protected health information (PHI) and requires that the Plan, with Michigan State University and the Plan administrator(s) and insurer(s) maintain a privacy policy and that it provides you with this notice of the Plan’s legal duties and privacy practices. This notice provides information about the ways your medical information may be used and disclosed by the Plan and how you may access your health information.

PHI means individually identifiable health information that is created or received by the Plan that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you; and that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. If state law provides privacy protections that are more stringent than those provided by federal law, the Plan will maintain your PHI in accordance with the more stringent state law standard.

In general, the Plan receives and maintains health information only as needed for claims or Plan administration. The primary source of your health information continues to be the healthcare provider (for example, your doctor, dentist or hospital) that created the records. Most health plans are administered by a third party administrator (TPA) or insurer, and Michigan State University, the Plan sponsor, does not have access to the PHI.

The Plan is required to operate in accordance with the terms of this notice. The Plan reserves the right to change the terms of this notice. If there is any material change to the uses or disclosures, your rights, or the Plan’s legal duties or privacy practices, the notice will be revised and you’ll receive a copy. The new provisions will apply to all PHI maintained by the Plan, including information that existed prior to revision.

**Uses and Disclosures Permitted Without Your Authorization or Consent**

The Plan is permitted to use or disclose PHI without your consent or authorization in order to carry out treatment, payment or healthcare operations. Information about treatment involves the care and services you receive from a healthcare provider. For example, the Plan may use information about the treatment of a medical condition by a doctor or hospital to make sure the Plan is well run, administered properly and does not waste money. Information about payment may involve activities to verify coverage, eligibility, or claims management. Information concerning healthcare operations may be used to project future healthcare costs or audit the accuracy of claims processing functions.
The Plan may also use your PHI to undertake underwriting, premium rating and other insurance activities related to changing TPA contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information for underwriting purposes which include eligibility determination, calculating premiums, the application of pre-existing conditions, exclusions and any other activities related to the creation, renewal, or replacement of a TPA contract or health benefit.

The Plan may disclose health information to the University if the information is needed to carry out administrative functions of the Plan. In certain cases, the Plan or TPA may disclose your PHI to specific employees of the University who assist in the administration of the Plan. Before your PHI can be used by or disclosed to these employees, the University must take certain steps to separate the work of these employees from the rest of the workforce so that the University cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, a designated employee may have the need to contact a TPA to verify coverage status or to investigate a claim without your specific authorization.

The Plan may disclose information to the University that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get a new TPA contract, or to change the Plan. For example, if the University wants to consider adding or changing an organ transplant benefit, it may receive this summary health information to assess the cost of that benefit.

The Plan may also use or disclose your PHI for any purpose required by law, such as responding to a court order, subpoena, warrant, summons, or similar process authorized under state or federal law; to identify or locate a suspect, fugitive, material witness, or similar person; to provide information about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person’s agreement; to report a death we believe may be the result of criminal conduct; to report criminal conduct at the University; to coroners or medical examiners; 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; to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and, to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

The Plan may disclose medical information about you for public health activities. These activities generally include licensing and certification carried out by public health authorities; prevention or control of disease, injury, or disability; reports of births and deaths; reports of child abuse or neglect; notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; organ or tissue donation; and notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. The Plan will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and the disclosure is necessary to prevent serious harm.

Uses and disclosures other than those listed will be made only with your written authorization. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions to include certain treatment, payment or healthcare operations); use or disclosure for marketing purposes (with limited exceptions); and disclosure in exchange for remuneration on behalf of the recipient of your protected health information.

You should be aware that the Plan is not responsible for any further disclosures made by the party to whom you authorize the release of your PHI. If you provide the Plan with authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization.

Your Rights

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

**Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Michigan State University Human Resources. If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Michigan State University Human Resources.

**Right to Amend.** If you feel that the protected health information the Plan has about you is incorrect or incomplete, you may ask it to amend the information. You may request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Michigan State University Human Resources. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the plan may deny your request if you ask it to amend information that is not part of the medical information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy or is already accurate and complete.

If your request is denied, you have the right to file a statement of disagreement. Any future disclosures of the disputed information will include your statement.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Michigan State University Human Resources. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you for the costs of providing the list. You will be notified of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on your protected health information that is used or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, the Plan is not required to agree to your request. However, if it does agree to the request, it will...
If you or your dependents 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 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.

### Table: Premium Assistance Under Medicaid and CHIP

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: myalhipp.com/ Phone: 1-855-692-5447</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>Website: myakhipp.com/ Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</td>
<td></td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td>Website: myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA – Medicaid</td>
<td>Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-800-541-5555</td>
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<td></td>
</tr>
<tr>
<td>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health (CHIP+)</td>
<td>Medicaid Website: dhs.colorado.gov/health/medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLORIDA – Medicaid</td>
<td>Website: flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IOWA – Medicaid and CHIP (HawkI)</td>
<td>Medicaid Website: dhs.iowa.gov/ime/members Phone: 1-800-539-8366 HawkI Website: dhs.iowa.gov/Hawki HawkI Phone: 1-800-257-8563</td>
<td>Medicaid Website: dhs.iowa.gov/ime/members Phone: 1-800-539-8366 HawkI Website: dhs.iowa.gov/Hawki HawkI Phone: 1-800-257-8563</td>
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<tr>
<td>INDIANA – Medicaid</td>
<td>Website: myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<tr>
<td>KANSAS – Medicaid</td>
<td>Website: kansashealth.gov/medicaid</td>
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<tr>
<td>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health (CHIP+)</td>
<td>Medicaid Website: dhs.colorado.gov/health/medicaid</td>
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<tr>
<td>State</td>
<td>Program</td>
<td>Website</td>
<td>Phone</td>
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<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td>Website: healthfirstky.gov</td>
<td>Phone: 1-800-221-5943</td>
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<td></td>
<td>(CHIP)</td>
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<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td>Website: oklahoma.gov/hipp</td>
<td>Phone: 1-888-365-3742</td>
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<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td>Website: mywvhipp.com/</td>
<td>Phone: 1-855-699-9075</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td>Website: greenmountaincare.org</td>
<td>Phone: 1-800-250-8427</td>
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<tr>
<td>OREGON</td>
<td>Medicaid</td>
<td>Website: oregonhealthcare.gov/index-es.html</td>
<td>Phone: 1-800-699-9075</td>
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<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td>Website: medicaidla.org</td>
<td>Phone: 1-888-342-6207 (Medicaid) or 1-885-618-5488 (LaHIPP)</td>
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<tr>
<td>MAINE</td>
<td>Medicaid</td>
<td>Website: maine.gov/dhs/hipp/index.html</td>
<td>Phone: 1-800-442-6003</td>
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<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
<td>Website: southcarolina.gov/healthcare/index</td>
<td>Phone: 1-800-828-0059</td>
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<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td>Website: dss.mo.gov/hipp</td>
<td>Phone: 573-751-2005</td>
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<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td>Website: healthfirsttexas.com</td>
<td>Phone: 1-800-440-0493</td>
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<td>MONTANA</td>
<td>Medicaid</td>
<td>Website: gethipptexas.com/</td>
<td>Phone: 1-800-694-3084</td>
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<tr>
<td>SOUTH DAKOTA</td>
<td>Medicaid</td>
<td>Website: healthfirstsd.gov/aspx</td>
<td>Phone: 1-800-549-0820</td>
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<tr>
<td>NEBRASKA</td>
<td>Medicaid</td>
<td>Website: ACCESSNebraska.ne.gov</td>
<td>Phone: 1-855-632-7633</td>
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<tr>
<td>UTAH</td>
<td>Medicaid and CHIP</td>
<td>Website: health.utah.gov/hipp/index/html</td>
<td>Phone: 1-800-543-7669</td>
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<tr>
<td>NEVADA</td>
<td>Medicaid</td>
<td>Website: drcf.pr.gov/medicaid</td>
<td>Phone: 1-800-992-0900</td>
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<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td>Website: greenmountaincare.org</td>
<td>Phone: 1-800-250-8427</td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
<td>Website: <a href="https://www.dhhs.nh.gov/oi/hipp.htm">https://www.dhhs.nh.gov/oi/hipp.htm</a></td>
<td>Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid and CHIP</td>
<td>Website: coverva.org/hipp/</td>
<td>Phone: 1-800-432-5924</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
<td>Website: healthfirstwv.gov/healthcare/index</td>
<td>Phone: 1-800-543-7669</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>Medicaid</td>
<td>Website: mywwhipp.com/</td>
<td>Phone: 1-855-MyWVHIPP (1-855-699-8447)</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>Medicaid</td>
<td>Website: medicaidnc.gov/</td>
<td>Phone: 1-919-855-4100</td>
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<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td>Website: wss.dmi.gov/public-assistance/index.html</td>
<td>Phone: 1-800-400-362-3002</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Medicaid</td>
<td>Website: wyequalitycare.acs-inc.com/</td>
<td>Phone: 307-777-7531</td>
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</table>

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

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

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number. The Department further notes that a Federal agency cannot conduct or sponsor a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department requests comment on the validity of the OMB control number. The Department requests comment on the validity of the OMB control number. Additionally, the Department requests comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opp@dol.gov and reference the OMB Control Number 1210-0137.

**OMB Control Number 1210-0137 (expires 1/31/2023)**