UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

2026

University of Michigan Health Regional Network

Benefits Guide

UM Health-West
616-252-2100
Benefits@umhwest.org

UM Health-Sparrow
517-364-5333
Benefits@umhsparrow.org

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

U-M Health Regional Team Member,

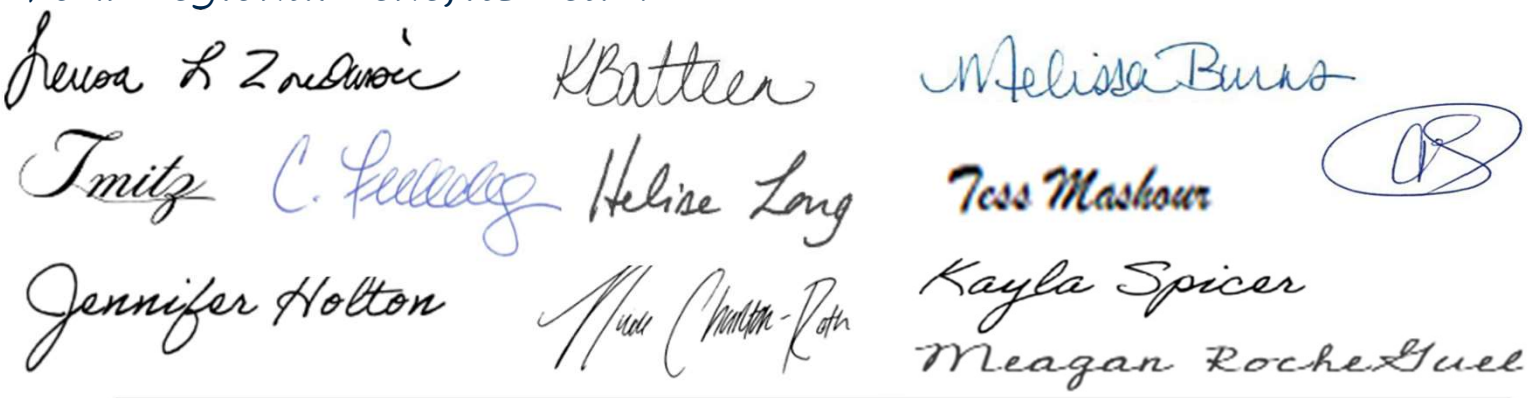
We are so proud to have you as a member of our team! Now is the time when you have the opportunity to review, update, or make benefit elections for the upcoming plan year. Whether it is health insurance, dental and vision coverage, retirement contributions, or other offerings, your active participation ensures your benefits meet the needs for yourself and your family.

It is extremely important to play an active role because the choices you make now will stay in place until the next enrollment period, unless you experience a qualifying life event. Taking a few moments to review your options helps you make the most of the benefits available and supports your well-being both at work and at home.

We encourage you to explore your options carefully and reach out to our team with any questions that you may have. Your participation ensures you are getting the coverage and support that is best to meet both you and your family's needs!

Thank you for making this a priority and playing an active role in this important decision.

Your Regional Benefits Team



2122 Health Dr SW, Ste. 260, Wyoming, MI 49519
benefits@umhwest.org
UofMHealthWest.org

1400 E. Michigan Ave, Lansing, MI 48912
benefits@umhsparrow.org
UofMHealthSparrow.org

Contacts

Questions about your Benefits?

Contact the Benefit Service Center Monday – Friday from 8 am – 4 pm

UM Health-West Benefits 616.252.2100 | benefits@umhwest.org

UM Health-Sparrow Benefits 517.364.5333 | benefits@umhsparrow.org

Or visit our ****NEW**** website at
https://benefits.umhinsider.org

Carrier	Phone	Web
ARAG	800.247.4184	AragLegal.com
Blue Cross Blue Shield (BCBSM)	877.790.2583	https://www.bcbsm.com
ComPsych (EAP)	877.595.5284	GuidanceResources.com (Web ID: UMHealth)
Delta Dental	800.482.8915	DeltaDentalmi.com
FMLA Source	844.888.9780	www.fmlasource.com
Norton LifeLock	800.607.9174	https:/www.gendigital.com/us/en/partner/employee-benefits/premier-plan
Principal Financial	800.547.7754	Principal.com
Rockefeller	616.305.2978	Rockco.com/axiom-wealth-partners
Rx Benefits	800.334.8134	Member.RxBenefits.com
TransAmerica	800.755.5801	SparrowRetirement@transamerica.com
UNUM – CI/AI/HI	800.635.5597	Unum.com/claims
UNUM – Life & AD&D Insurance	800.445.0402	Unum.com/claims
UNUM – STD/LTD Claims	888.673.9940	Unum.com/claims
VSP Vision	800.877.7195	VSP.com
Wagmo	855.836.8785	Wagmo.io
WEX	866.451.3245	BenefitsLogin.WEXHealth.com

Contents

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

How to Enroll

UM Health-Sparrow

Enroll:

New Hires/Rehires & mid-year status change team members:

- **Online form via https://benefits.shs.org/**
- **Email University of Michigan Health-Sparrow HR at Benefits@UMHSparrow.org**

The options above are required for team members who need to submit paper forms for qualifying life event changes or team members that hired or transferred into a benefit eligible status or to a new UM Health-Sparrow entity.

Open Enrollment:

- Online via My Team Member Record for Open Enrollment
  - Login with: **Username**: Computer Login
  - **Password**: Computer Login Password
- **On the Phone**
  - Call HR Service **Center Benefits Hotline 517-364-5333**
  - Call 855-421-9449 regarding Voluntary Benefits
- **Email UM Health-Sparrow HR at Benefits@UMHSparrow.org**

Note: Team members on a leave of absence, newly hired, with a mid-year status change, or have transferred between one UM Health-Sparrow entity to another on or after 6/1 of the current year must submit elections outside of the My Team Member Record via the online form found at: **https://benefits.shs.org/.**

UM Health-West

Online access 24/7 @ https://www.benefits.plansource.com

- **Enter Username:** your username is your system access login
- **Password:** your birth date (YYYYMMDD)
- **Electing Benefits:** You must select for each benefit, even to decline a benefit. All plans available to you will be listed.
- **Your Confirmation Selection:** This page lists all the benefits you selected for the plan year. Read this entire page carefully and keep a copy for your records. This is your source of truth.

PLANSOURCE®

All Team Members - Before You Enroll:

- Collect the date of birth, Social Security Number (SSN), and address for each dependent you wish to enroll. This information is **required** to enroll a dependent (including spouses).
- Consider your needs and the needs of your eligible dependents prior to choosing benefits.
- Review any benefits offered through your spouse's employer to avoid costly duplicate coverage.
- Carefully review the information in the benefit guide and other enrollment materials.

Welcome to Your Benefits Guide

This booklet helps you understand your health and financial benefits, enrollment deadlines, and key actions to take as a new hire.

Health Plan Options

U-M Health provides three comprehensive medical plan options designed to meet a variety of healthcare needs:

- **Bronze Plan**: Offers the lowest monthly premium. This High-Deductible Health Plan (HDHP) includes access to a Health Savings Account (HSA).
- **Silver Plan**: Balances cost and coverage, ideal for moderate healthcare usage.
- **Gold Plan**: Provides the highest level of coverage, best suited for individuals who require frequent medical care.

Tip: Review each plan's details to determine which option best aligns with your healthcare needs and financial goals.

Pharmacy Benefits

Prescription drug coverage is administered by our Pharmacy Benefit Manager (PBM), **Rx Benefits**. Coverage varies depending on your selected health plan tier and includes:

- Retail pharmacy services
- Specialty medications
- Convenient mail-order options (limitations)

Spending Accounts

To help manage healthcare and dependent care expenses, U-M Health offers several tax-advantaged accounts:

Effective January 1, 2026:
WEX will administer the following accounts for Sparrow & West team members:

- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (DCFSA)

Annual Enrollment & Re-enrollment

U-M Health provides structured opportunities for team members to enroll in or update their benefits:

- **New Hires**: Must complete benefits enrollment within **30 days of hire**.
- **Open Enrollment**: Occurs annually, allowing team members to select benefits for the upcoming calendar year.
- **FSA & DCFSA Elections**: These accounts **must be re-elected each year** during Open Enrollment. They do **not** automatically renew.

Qualified Life Events (QLEs)

Employees may update their benefits within **30 days** of experiencing a Qualified Life Event. Common QLEs include:

- Marriage
- Divorce
- Birth or adoption of a child

Important: Supporting documentation is required to process any benefit changes related to a QLE.

✅ Action Checklist

Whether you're a new hire, participating in Open Enrollment, or experiencing a QLE, be sure to:

- ☐ Review all health plan options
- ☐ Enroll in benefits within 30 days
- ☐ Make elections for HSA, FSA, and DCFSA (as applicable)
- ☐ Understand your benefit deduction schedule
- ☐ Retain documentation for any QLE-related changes

NEW IN 2026

UM Health-Sparrow Team Members

New Regional Health Benefits

All non-union team members at UM Health-Sparrow will be choosing from the regional Bronze, Silver and Gold health plans. Union represented team members may have different benefits. Applicable options are listed on new hire documents, the regional benefits website and will display in the enrollment site during open enrollment. Please defer to collective bargaining agreements for any clarification.

Benefit Deduction Schedule

All regional team members will have **biweekly benefit deductions** for all elected benefits.

Salary Banded Medical Premiums

Medical premium contributions for full-time non-union team members are now based on three salary ranges (referred to as “salary bands”). This means a team member’s premium contributions for medical coverage will be based on their annual base salary. Team members who earn less will pay less for their health insurance.

- The three salary bands are as follows:
    - Team members earning less than $50k annually
    - Team members earning $50k but below 100k annually
    - Team members earning $100k or more annually

UM Health-West Team Members

New Regional Health Benefits

All UM Health-West team members will be choosing from the regional Bronze, Silver and Gold health plans.

Salary Banded Medical Premiums

Medical premium contributions for **full-time team members only**. Part-time team members will only see one set of rates for 2026.

Flexible Spending and Health Savings Account Administration Change

WEX, Inc is the FSA/HSA/DCFSA administrator for all regional team members starting in 2026.
NO ROLL-OVER!

FMLA Source Go LIVE!!!

We are having a FMLA Vendor change from TELUS to FMLA Source effective January 1, 2026. They will also handle our call-in absence system known now as Total One Call.

Termination of Benefits

Medical, Dental, Vision, FSA, and DCFSA will now all end on the **last day of the month of termination**.

Who's eligible for benefits?

When you can enroll:

New team members are eligible for benefits on the first of the month following their hire date.
Enrollment must occur within 30 days of becoming eligible.
Existing team members can enroll during the annual open enrollment period or with an IRS Qualifying Life Event.

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section for more details.

Team members

- You are eligible if you are a part-time team member working 20 or more hours per week (UM Health-Sparrow 24 hours).

Eligible dependents

- Legally married spouse
- Biological, adopted, or stepchildren up to age 26 and legal dependents up to age 18
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

Dependent Verification

- You must provide verification of eligibility for your dependents if you are adding them onto the plan for the first time. Do this by submitting documentation for each eligible dependent. If you do not provide this documentation, the dependent will not be covered.
- Examples of documentation include:
  - Marriage certificate
  - Copy of your most recent joint filed income tax return
  - Birth certificate or official record of birth from the hospital of delivery for each dependent child.
  - Qualified Medical Child Support Order (QMCSO)
  - Court documentation of guardianship

If you miss the enrollment deadline, you'll need to wait until the next open enrollment period or experience a qualifying life event to enroll.

BRONZE Plan: HDHP + HSA Overview

A **High-Deductible Health Plan (HDHP)** paired with a **Health Savings Account (HSA)** offers:

- **Lower monthly premiums**
- **Higher deductibles**
- **Tax-advantaged savings** via the HSA
- **HSA Funds roll over** year to year
- **Only HDHPs qualify for HSAs** (per IRS rules)

HSA Contribution Limits
Self - $4,400
Family - $8,750
55+ Catch up - $1,000

IRS Criteria for HDHPs (2026)

- **Minimum Deductible**:
  - Individual: **$1,700**
  - Family: **$3,400**
- **Coverage Rules**:

Members pay **full cost** of medical services (including prescriptions) until deductible is met.

- **Preventive services** (e.g., annual physicals) are covered before deductible.
- **Non-embedded deductible**: For families, the **entire deductible** must be met before coverage begins.

Understanding Non-Embedded Deductibles

- **Family deductible** must be met **in full**, regardless of how many members contribute. Once met, the plan starts covering costs for **all family members**.
  - Two ways to meet it:
    - **Combined expenses** from multiple family members.
    - **One member's expenses** meet the full deductible.

What Sets This HDHP Apart?

U-M Health Tier 1 Network – 100% Coverage After Deductible

(Excludes pharmacy, which follows a 4-tier copay structure)

Includes:

- UM Health-West
- UM Health-Sparrow
- U-M Medical School
- Michigan Medicine providers
- Clinically integrated networks:
  - Metro Health Integrated Network (MHIN)
  - Sparrow Care Network (SCN)

💡 **Tip**: If you expect to use Tier 2 providers often, consider Silver or Gold Plans for better cost coverage.

BCBSM Tier 2 Network – National Coverage

- Full **BCBSM PPO network**
  - Offers flexibility for care outside Tier 1
- **Higher out-of-pocket costs** apply

Medical SILVER Plan & GOLD Plan

Note: These plans are **not available** to members of the **MNA PECSH** or **MNA Home Care RN** bargaining units. Applicable options are listed on new hire documents, the regional benefits website and will display in the enrollment site during open enrollment. Should any questions arise, contracts in effect will take precedence.

Growing Enterprise-wide U-M Health Tier 1 Network Coverage:

- **Coinsurance after reaching the deductible** (copays do not apply to the deductible but *do* apply to the out-of-pocket maximum).
  - **SILVER PLAN** – Reductions & Savings on copays + coinsurance
  - **GOLD PLAN** – Greater Reductions and Greater Savings on copays + coinsurance

    Includes:
    - UM Health-West
    - UM Health-Sparrow
    - U-M Medical School
    - Michigan Medicine providers
    - Clinically integrated networks:
      - Metro Health Integrated Network (MHIN)
      - Sparrow Care Network (SCN)

Large NATIONAL BCBSM Tier 2 Network Coverage:

- **Full BCBSM PPO network** available for team members to seek care with providers/facilities beyond our Tier 1 Network.
  - **SILVER PLAN** – moderate monthly premium but higher out of pocket costs if/when services are rendered.
  - **GOLD PLAN** – Increased monthly premium but lower out of pocket costs if/when services are rendered.

Note: This offers flexibility but also **risks high out of pocket costs** for care outside of Tier 1. Team members expecting to use Tier 2 coverage regularly may want to look at the Gold Health Plan.

Preventive care *refers to medical services that help detect, prevent, or manage health issues before they become serious. It includes routine checkups, screenings, immunizations, and counseling services aimed at maintaining wellness and catching potential problems early. Preventive care is considered* ***free healthcare*** *under most insurance plans, including HDHPs, because it is fully covered* ***before the deductible is met****—meaning you do not pay out of pocket for these services. This is important because early detection and proactive care can lead to better health outcomes, lower long-term costs, and reduced need for more intensive treatments later.* ***Examples*** *of preventive care include annual physical exams, flu shots, mammograms, cholesterol screenings, and screening colonoscopies.*

Prescription Drug Benefits

RxBenefits®

Maintenance Medications

UM Health-West team members maintenance medications must be filled at the UMHW pharmacy. One grace fill outside of the UM Health-West pharmacy is allowed. After that, your medication will not be covered unless it is filled at UM Health West. If you work off-site, you may request courier delivery to your UM Health-West location. You can call in a refill at extension RXRX (x7979). Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines.

Maintenance Medications

UM Heath-Sparrow team members on select maintenance medications must be filled at U-M Health pharmacies. Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Please visit the benefits.umhinsider.org for a list of maintenance medications which can only be filled at a U-M Health pharmacy.

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, do not forget to check your health plan's drug formulary. It is a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

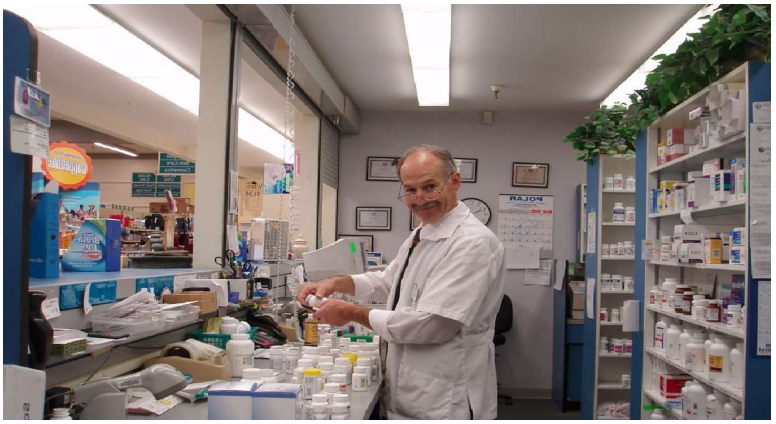
What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "Non-Preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit Member.RxBenefits.com website or call the customer service number on your ID card.



Prescription Drug Benefits cont.

Preventive Medications

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles, maximum out of pockets, or other limitations such as annual caps or limits. You may contact Rx Benefits Member services at 1.800.334.8134 if you have specific drug questions or register at https://www.rxbenefits.com/members/ to check cost and coverage.

SaveOnSP – Copay Assistance

Specialty medications are used to treat complex chronic conditions and have a high cost. Your employer is offering a copay assistant program coordinated by SaveOnSP. Enrolling in the program provides the opportunity for $0 cost on select specialty medications, If you choose not to enroll, your responsibility will be 30% coinsurance. Please contact SaveOnSP at 800.683.1074 so a patient advocate can assist you with completing your enrollment.

Generic Policy – Dispense as written (DAW)

If a Brand name drug is filled when generic equivalent is available, you will be required to pay the Brand cost share plus the difference in cost between the Generic and Brand name drug. The cost difference will not apply to the deductible, or the annual maximum out-of-pocket.

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through UMH-West Pharmacy. Some exceptions apply. These medications are limited to a 1-30 day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate copay / coinsurance as listed below.

Compound Drugs

For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial or coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

	Bronze Plan		Silver Plan		Gold Plan	
	HDHP w/HSA Tier 1 - Tier 2		PPO Tier 1 - Tier 2		PPO Buy-up Tier 1 - Tier 2	
Generic	$5	$10	$5	$10	$5	$10
Preferred Brand	$25	$40	$25	$40	$25	$40
Non-Preferred Brand	$50	$80	$50	$80	$50	$80
Specialty	$75	$100	$75	$100	$75	$100

Medical FSA

Can I enroll?
Yes, as long as you or your spouse are not actively enrolled and contributing to a health savings account (HSA).

Funds on Day One
Schedule that surgery, buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.

Discount
Think of an FSA like a discount on eligible healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens, and more. Dollars you contribute are taken out of your paycheck before tax which means a $100 purchase would actually cost you approximately $130 without a Medical FSA.

Plan Ahead
Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a Medical FSA and save 30%.

Dependent Care FSA

Save Money
The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You are spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save Strategically
Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus".

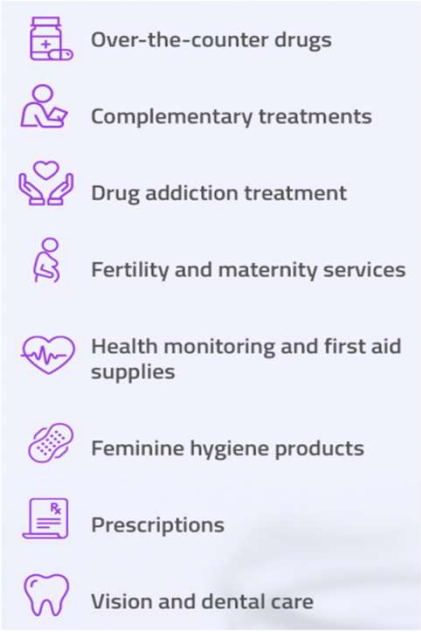
Health Savings Account

It's Yours
Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Easy to Use
Swipe your benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart Savings
The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

What's Covered?



Dental Coverage – 2026 Plan Highlights

University of Michigan Health remains committed to supporting the oral health of our team members and their families by offering flexible, comprehensive dental plan options through Delta Dental.

Dental Plan Options

U-M Health offers three dental plan tiers to meet a range of coverage needs:

- **Bronze Plan**
  Note: *This plan is **not available** to members of the **MNA PECSH** or **MNA* Home Care RN** bargaining units.
  - Utilizes the **EPO network**; limited provider access
  - Lower premiums, but less flexibility in provider choice
- **Silver Plan**
  - Access to both **PPO and Premier networks**
  - Moderate coverage with **higher out-of-pocket costs** compared to the Gold Plan
- **Gold Plan**
  - Access to **PPO and Premier networks**
  - **Highest level of coverage**, including **adult orthodontic services**
  - Ideal for those seeking comprehensive dental care

New & Noteworthy Enhancements for 2026

The following benefits have been added or expanded to enhance your dental care experience:

- **Posterior Composite Resin Fillings** – Now covered for back teeth
- **Porcelain Crowns & Bridges** – Expanded coverage for durable, aesthetic restorations
- **Special Health Care Needs Benefit** – Additional cleanings and services available for qualifying medical diagnoses
- **Occlusal Guard Replacement** – Covered once every five years to support long-term oral health
- **Adult Orthodontics** – Included under the **Gold Plan** for eligible members

Open Enrollment Reminder

You may make changes to your dental plan during the **annual Open Enrollment period**. Be sure to:

- Review plan summaries and coverage details
- Compare premium rates and provider networks
- Access plan documents for full benefit information

👉 Visit http://benefits.umhinsider.org/ for resources and enrollment tools.

Vision Coverage – 2026 Plan Overview

University of Michigan Health is committed to supporting the visual wellness of our team members and their families by offering a range of vision plans designed to meet diverse needs and preferences.

Vision Plan Options

Three plan tiers are available to eligible employees:

- **Bronze Plan**
  - *Note: This plan is **not available** to members of the **MNA PECSH** or **MNA** **Home Care RN** bargaining units.*
  - Offers basic coverage with lower premiums.
- **Silver Plan**
  - Provides enhanced coverage, including full coverage for annual vision exams.
  - Suitable for individuals seeking moderate benefits with affordable premiums.
- **Gold Plan**
  - Offers the most comprehensive coverage, including full annual exams and higher allowances for frames and lenses.
  - Ideal for those with ongoing vision care needs or preferences for premium eyewear options.

New & Noteworthy for 2026

Several enhancements have been added to improve the value and flexibility of your vision benefits:

- **LightCare Coverage**
  - New benefit covering **non-prescription blue-light filtering glasses** and **sunglasses**, supporting eye health in digital environments.
- **Annual Vision Exam**
  - Covered at **100%** under both **Silver** and **Gold** plans, ensuring access to routine preventive care.
- **Frame Allowance Match**
  - Participating retailers including **Walmart**, **Sam's Club**, and **Costco** now **match the VSP provider frame allowance**, expanding your options for eyewear purchases.

Open Enrollment Reminder

You may update your vision plan elections during the **annual Open Enrollment period**. Be sure to:

- Review plan summaries and coverage details
- Compare premium rates and provider networks
- Access plan documents for full benefit information

👉 Visit http://benefits.umhinsider.org/ for resources and enrollment tools.

Life Insurance

Basic Life Insurance

Pays a **lump sum** to your beneficiary if you pass away. The premium is fully paid by U-M Health.

- Check your benefit summary or enrollment site to view your coverage amount!
- Added benefit for many UM Health-West part time team members! Increased amount for UM Health-Sparrow non-union part time team members!
- **Do not forget to complete a beneficiary form!**

Supplemental Life Insurance

Who Is Eligible for Supplemental Life Insurance?

- **Active team members** of the employer are eligible if they meet the following criteria:
  - **UM Health-West**: FTE of **0.5 or greater**
  - **UM Health-Sparrow**: FTE of **0.6 or greater**

Coverage Amounts You Can Purchase

- Team members **supplemental life insurance options vary** by employment status of the covered individual:
  - Full time team member coverage: may elect an additional 7x salary to a max of $1M in $10,000 increments
  - Part time team member coverage: Elect up to $50k
- Spousal Life Insurance:
  - Full time: $5k increments up to max of $150k
  - Part Time: Elect up to $50k
  - Guaranteed issue of $25k
- Dependent Child Life Insurance: $2,500, $5,000, or $10,000 options- one election covers all dependent children, up to max age of 26 (all options guaranteed issue)

Guaranteed Issue

Guaranteed Issue refers to the maximum amount of insurance coverage you can elect **without needing to provide health information**.

- You can elect coverage **up to the guaranteed issue limit** with no medical questions.
- If you choose coverage **above the guaranteed issue** or apply/increase benefits **after your initial eligibility period,** you must complete **Evidence of Insurability (EOI)**.
- **EOI** is a health questionnaire used by the insurance provider to determine if you qualify for the additional coverage.

Union represented team members may have different benefits. Applicable options are listed on new hire documents, the regional benefits website and will display in the enrollment site during open enrollment. Should any questions arise, contracts in effect will take precedence.

Disability Insurance

Why Disability Insurance Matters

Most people underestimate the likelihood of becoming disabled at some point in their lives. Disability insurance replaces part of your pay while you are unable to work, ensuring you have a continuing income for living expenses. **New for 2026**: Buy-up LTD options added for UM Health-West, Voluntary STD now available to all non-union part-time hourly team members, with an increased weekly max benefit of $1,200 for the non-union part-timers!

Short-Term Disability (STD)

Protects your income during a temporary absence from work.

- **What It Is:** Income replacement if you are disabled and cannot work for a short period (weeks to months).
- **Why It Matters:** Shields your paycheck and helps maintain financial security for you and your family.
- **Who's Eligible:**
  - Automatically provided by University of Michigan Health Region for select job classifications
  - Available for purchase for other roles

Long-Term Disability (LTD)

Ensures continued income during an extended disability.

- **What It Is:** Ongoing income replacement if you are disabled long-term (months to years).
- **Core Benefit:** 60% of your basic monthly earnings, employer-paid after the waiting period.
- **Enhanced Options:**
  - **Buy-Up Coverage:** Boost your employer-paid benefit to 66.67%. Added option for UM Health-West team members!
  - **Base LTD Plan:** Benefit eligible team members can elect coverage if not provided coverage by U-M Health (eligibility by classification).

Union represented team members may have different benefits. Applicable options are listed on new hire documents, the regional benefits website and will display in the enrollment site during open enrollment. Should any questions arise, contracts in effect will take precedence.

Voluntary benefits are available to benefit eligible team members in addition to your core benefits package. You can buy the coverage that is unique to your needs. You pay 100% of the cost through convenient payroll deductions.

UM Health-Sparrow Team Members will enroll by calling 855-421-9449 or by visiting boss.employeenavigator.com

UM Health-West Team Members will enroll via PlanSource https://benefits.plansource.com/?umhwest

ACCIDENT INSURANCE

Can help you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit.

CRITICAL ILLNESS INSURANCE

Can help fill a financial gap if you experience a serious illness such as cancer, heart attack, or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness.

HOSPITAL INDEMNITY INSURANCE

Can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses.

ARAG LEGAL INSURANCE

Many of life's moments - big and small - call for legal guidance. It is not just handy for when trouble strikes, but for all kinds of reasons, from negotiating new home contracts to estate planning. ARAG Legal Plans makes it easy to get the legal help you need.

IDENTITY THEFT INSURANCE

Choose from two levels of protection to safeguard your personal and credit information and get help with restoring your credit - and your good name - if fraud occurs.

WAGMO

A new breed of pet benefit beyond the basic of pet insurance with benefits designed for everyday pet care. Wagmo Wellness provides reimbursements for routine and preventive pet care not typically covered by pet insurance, such as routine exams, bloodwork, vaccinations, grooming, and more!

Team Member Perks

All University of Michigan Health regional team members can enjoy health, happiness, and savings with the numerous discounts throughout our community in addition to programs such as LifeBalance, Working Advantage, ID.me, and GOVX.com. Combined, these programs offer thousands of exciting team member discounts! These programs are available with direct bill options, not applicable to payroll deductions, and can be found on U-M Health Insider via the UM Health-Sparrow SPA or UM Health-West Team Member Discounts page.

Examples of Savings:

Shop deals on exercise, electronics, apparel, travel, attraction admission, meal delivery, mortgage loans, insurance, childcare, gardening, healthcare products, and so much more!

- Samsung, Whirlpool
- Apple, LG, Dell, HP, Lenovo, Sony and Garmin
- Disney: special pricing on tickets
- Garmin: 20% savings on wearables, smartwatches, and scales
- Sportswear: Columbia, Under Armour, Adidas, Nike, Brooks, New Balance
- Traveling, Hotels, Cars, Cruises, Flights
- Meemic Insurance, AAA Insurance
- Mortgage discounts
- FTD: 25% savings on all orders
- Sam's Club and Costco
- NFL Tickets, Nascar Tickets, NBA Tickets
- Verizon, T-Mobile, AT&T and Virgin Mobile
- Pet Programs like: Ollie, Farmers, Badlands Ranch, Medications, CBD, Petco, Chewy, PetSmart, Spot Pet Insurance, Wisdom Panel
- More, more, and even MORE!!!

UM Health-Sparrow Retirement Plan Overview

401(k) Plan (Defined Contribution)

- **Eligibility:** Available to all newly hired team members, including Michigan Athletic Club and Michigan Athletic Club Restaurant team members effective 1/1/2026!
- **Tax Benefits:** Pre-tax and Roth (post-tax) contributions allowed.
- **Automatic Enrollment:** 6% auto-enrollment after 60 days unless opted out or modified by contacting Transamerica.
- **Withdrawals:** Allowed after age 59½ or upon employment termination. Team members must allow 60 days following separation of employment for withdrawals or rollovers. This is necessary for final pay checks and data transfers. Hardship withdrawals are available if the IRS criteria is met.

Contributions

Type	Details
Team Member	Elective deferrals each pay period (subject to annual IRS limits)
Employer Match	50% match on first 6% of your contribution per pay period
Safe Harbor	3% automatic annual contribution (after 1 year and 1,000+ hours in either the first anniversary year, or a subsequent plan (calendar) year)

Vesting

- **Immediate:** Team member contributions and Safe Harbor contributions
- **After 3 Years:** Employer match (requires 1,000+ hours per year for 3 years)

403(b) Plan (ERISA)

- **Eligibility:** Only for team members actively accruing a benefit under the DB Pension Plan.
- **Contributions:** Pre-tax, biweekly (team member only, no employer match).
- **Vesting:** Immediate for all team member contributions.

Defined Benefit (DB) Pension Plan

- **Eligibility:** Only for team members hired by participating entities prior to 2007.
- **Employer Contributions:** Based on prior year's eligible earnings and hours.
- **Vesting:** After 5 years with 1,000+ hours/year and 5 years with 1,800+ hours/year benefit service.

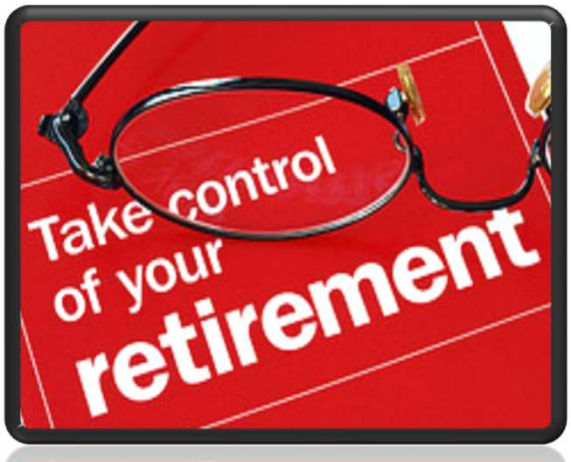
Beneficiaries

- Review and update anytime due to life changes (marriage, divorce, children).
- Update via retirement vendor website or customer service #.

Contacts & Resources

Type	Contact Info
Transamerica (TRS)	800-755-5801 · SparrowRetirement@transamerica.com
TRS Rep (Douglas Smith)	319-355-9547 · Douglas.Smith@transamerica.com
Transamerica Site	transamerica.com/portal/sparrow
Pension Center	800-921-0369 · sparrowmypensioncenter.com
U-M Health Insider Retirement Information	Retirement Resources Team Member login credentials required to view

UM Health- West Retirement – 403(b)



You can start contributing to the 403(b) Savings Plan with your first paycheck.

If you're 0.5 – 1.0 FTE (working 20+ hours/week):
- You will be automatically enrolled at a 3% pre-tax deferral.
- Your contributions will be invested according to the plan's default settings.

If you're below 0.5 FTE or a Resource employee:
- You will not be auto-enrolled, but you can still contribute.
- You will need to set up your contributions manually online via Principal.

Accessing Your Account:

Log in to your account at www.principal.com through the **Principal Retirement Service Center®**.
Once logged in, you can:
- View your account and balances
- Update beneficiaries
- Change investment directions
- Transfer funds between investment options
- Rollover funds from a previous employer
- Use planning tools like the Investor Profile Quiz and calculators

University of Michigan Health-West team members have access to retirement financial advisory services through Rockefeller Capital Management. Here's a summary of what is available:

Services Offered:

- Help accessing your UM Health-West 403(b) account
- Reviewing your investment mix
- Estimating retirement income
- Building a personalized retirement plan
- Planning for college expenses

To schedule a meeting with an advisor:
Call 616-305-2978 or scan the QR Code below

In-Person **Virtual**

On-Site Financial Advisors

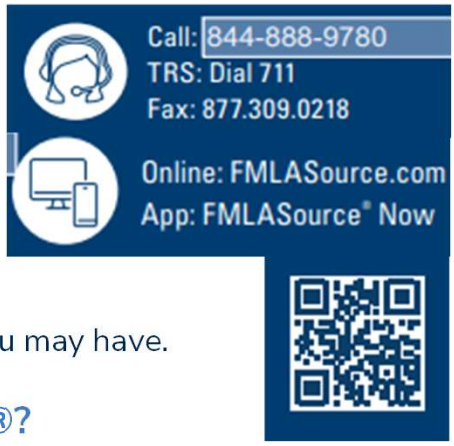
- Who: Rockefeller Financial Group
- When: Last Wednesday of every month
- Where to Schedule: Visit the Human Resources page on the M Net

To report a leave of absence, you can either

- Go to www.fmlasource.com or open the mobile app FMLASource® Now, log in and click on Add New Leave
- Call and talk to a representative during business hours

What information will FMLASource® need?

- Company name
- Your first and last name
- Employee ID #
- Reason for your leave
- Estimated dates of leave
- Attending physician phone number, fax and verbal authorization to contact them, if needed
- If caring for an immediate family member, their name, relation to you and birth date (if it is for a child)



When and how should I follow up with FMLASource®?

To provide the following info, visit our website or mobile app.

- Update information related to your leave
- Submit an extension
- Confirm your return-to-work date
- To report date of delivery or placement of your child
- Report intermittent absences
- Remember, you can contact FMLASource® with any questions you may have.

When should a leave of absence be reported to FMLASource®?

Contact FMLASource® and follow your internal call-off procedures if/or when:

- You or an immediate family member is hospitalized for any amount of time
- You are incapacitated for more than three calendar days and are seeking treatment by a health care provider
- You will be absent periodically due to a chronic or permanent disabling condition of your own or of an immediate family member
- You are pregnant or missing work due to anything medically related to your pregnancy
- You are bonding with a newly born child or a recently placed adopted or foster child
- You are caring for an immediate family member (spouse/domestic partner, parent or child) who is ill or injured
- You are caring for an injured servicemember
- You need to miss work due to a qualified exigency related to an immediate family member's active service duty

FMLASource® gives employees access to experts who will answer questions, review guidelines and provide information regarding a leave of absence.

Do you need a leave for one of these reasons?

- Birth of a child
- Care for an injured servicemember
- Adoption or foster care
- Care for your own serious health condition
- Care for a child, spouse or parent with serious health conditions
- Military service
- Civic volunteer

Wellbeing Benefits at U-M Health

This section provides resources for ongoing support resources provided regional by U-M Health to every team member.

Employee Assistance Program

Every team member can access support through the Employee Assistance Program (EAP) through ComPsych® GuidanceResources®.

This program is fully employer-paid and offers a range of support services, including:

- **Confidential Emotional Support:** You and every member of your household have access to eight fully covered therapy sessions (virtual or in-person) per issue, per person, per year.
- **Work-Life Solutions:** Specialists do the research for you, helping you find resources and referrals for everyday needs like childcare, home repair contractors, event rentals, and more.
- **Legal Guidance:** Talk with attorneys about legal issues and questions. If you need direct representation, get a free 30-minute consultation plus a 25% discount on additional fees.
- **Financial Resources:** Ask experts for help navigating your financial health ranging from budgeting, bankruptcy, retirement, taxes, etc.

Help is just a phone call or login away. Call 877-595-5284 or visit GuidanceResources.com to get started.

Intake professionals are ready to connect you with the right resources to guide you.

KOA Care 360

This smartphone app is offered with our Employee Assistance Program. Find confidential support and science-based tools for handling stress, building resilience, and tackling goals.

Create an account to take the next step for your mental wellbeing on your own terms, in the time and place that works for you:

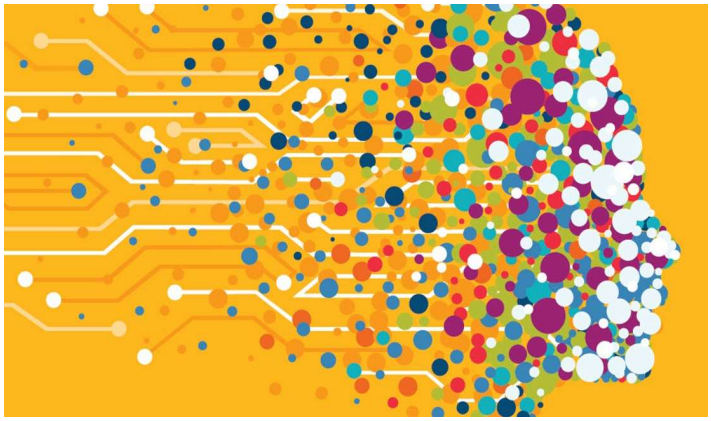
1. Log on to GuidanceResources.com or the GuidanceNow℠ app.
2. Select “Connect Me” or “Browse All”, then the “Digital Self-Care Tools” tile.
3. Complete your profile, select “Start.”

Contact Your ComPsych® GuidanceResources® Program for 24/7 Support

Call: 877-595-5284 **| TRS:** DIAL 711
Online: GuidanceResources.com **| App:** GuidanceNow
Web ID: UMHEALTH

Scan the QR code to access GuidanceResources®

Professional Development



The ability to pursue continued education is important to University of Michigan Health. U-M Health stands with our team members to promote and encourage continuous development with the following programs:

- Tuition Reimbursement
- Education Partnerships
- DDI Pinpoint
- Mentor Program
- Cohort Development Programs
- On-Demand Resources
- Annual Competency Education

On-Demand Resources

We have a wide range of recorded content within our on-demand library for team members to watch at their convenience for additional skill building.

Annual Competency Education

Team members participate in annual mandatory education to ensure we stay current on essential policies, safety practices, and regulatory requirements that protect both our team and the people we serve. They help create a consistent foundation of knowledge across our organization, strengthening our culture of accountability, respect, and high-quality care.

Tuition Reimbursement

U-M Health encourages continuous employee development by providing a portion of financial reimbursement for those who qualify for education and training. Please review the applicable Tuition Reimbursement policy. For more information, please reach out to your local Benefits team or the Tuition Support Programs page on U-M Health Insider.

Education Partnerships

U-M Health has unique education partnerships with select institutions providing opportunities for savings on tuition. This benefit is available to all team members, regardless of benefit eligibility and can be combined with the Tuition Reimbursement. Some partnerships also apply to spouses and dependents. For more information, please reach out to your local Benefits team or the Tuition Support Programs page on U-M Health Insider.

DDI Pinpoint

Our region is fortunate to partner with Development Dimensions International (DDI) – a global leader in talent development. Through this partnership, we have access to DDI Pinpoint, an online platform offering a robust library of research-based, self-paced development resources for all team members and leaders.

Mentor Program

Each year we offer the opportunity for all team members to participate in our Mentor Program called Mentor. Grow. Repeat. This offers you the opportunity to engage one-on-one with a mentor to challenge you to become the best version of yourself. Matched pairs meet routinely to discuss professional goals and challenges – learning from one another's experience and guidance.

Cohort Development Programs

We routinely offer leadership development cohorts to team members who aspire to be leaders. Nominated team members participate in an interview and selection process where they can continue their growth, and develop unique qualities needed to prepare for a successful leadership journey.

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally, includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as “ineligible,” “not covered,” or “not allowed.”

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In-Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out-of-Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan’s allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn’t require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a “formulary,” is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician’s assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet, or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as “immunizations,” vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available on the Insider and in this annual Benefit Guide. If you would like paper copies, please reach out to your benefits team.

Summary Annual Report: Provides information related to the welfare benefits offered by U-M Health, as filed annually with the U.S. Department of Labor as required under ERISA.

Medicare Part D Notice: Describes options to access prescription drug coverage for Medicare eligible individuals

Women's Health and Cancer Rights Act: Describes benefits available to those that will or have undergone a mastectomy

Newborns' and Mothers' Health Protection Act: Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery

HIPAA Notice of Special Enrollment Rights: Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment

HIPAA Notice of Privacy Practices: Describes how health information about you may be used and disclosed

Notice of Grandfathered Plan Status: Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions

Notice of Choice of Providers: Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): Describes availability of premium assistance for Medicaid eligible dependents

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Summary of Benefits and Coverage

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized summarized format. SBCs can be obtained from the benefits.umhinsider.org.

Summary plan descriptions (SPD)

- The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of benefits and coverage (SBC)

- A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. Please contact your plan administrator for SBC documents.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the University of Michigan Health-West and University of Michigan Health-Sparrow Health System Group Benefit Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Summary Annual Report

For

Metro Health Hospital d.b.a. University of Michigan Health-West Benefit Plans

This is a summary of the annual report for the metro health hospital employee benefit plan, (employer identification no. 38-0593405, plan no. 501) for the period January 1, 2024, to December 31, 2024. The annual report has been filed with the employee benefits security administration, as required under the employee retirement income security act of 1974 (ERISA).

Metropolitan Hospital has committed itself to pay the following types of claims incurred under the terms of the plan.

All medical, dental and employee assistance claims

Insurance information

The plan has contracts with ARAG insurance company, vision service plan, Cigna Health and Life Insurance company and Life Insurance Company of North America to pay the following types of claims incurred under the terms of the plan.

All short-term disability, long-term disability, vision, life insurance, accidental death, critical illness, and legal claims.

The total premiums paid for the plan year beginning January 1, 2024, and ending December 31, 2024, were $1,736,903.

Because they are so called 'experience-rated' contracts, the premium cost are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2024, the premiums paid under such 'experience-rated' contracts were $340,722 and the total of all benefit claims paid under these experience-rated contracts during the plan year were $275,890.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of
The plan sponsor metropolitan hospital
Po box 916
Grand rapids, mi 49509-0916
38-0593405 (employer identification number)
616-252-7200

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. These portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

Metropolitan hospital
po box 916
Grand rapids, mi 49509-0916

And at the U.S. Department of labor in Washington, D.C., or to obtain a copy from the U.S. Department of labor upon payment of copying costs. Requests to the department should be addressed to: U.S. Department of labor, employee benefits security administration, public disclosure room, 200 constitution avenue, NW, suite n-1513, Washington, D.C. 20210.

Summary Annual Report
For the
Sparrow Health System Group Benefit Plan, Plan No. 509

This is a summary of the annual report of the Sparrow Health System Group Benefit Plan, Employer Identification Number 38-2542859, Plan No. 509, for the period January 1, 2024, through December 31, 2024. The annual report has been filed with the U.S. Department of Labor's Pension and Welfare Benefits Administration as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The Plan provides welfare benefits through a cafeteria plan established under Section 125 of the Internal Revenue Code. The cafeteria plan component is not covered by ERISA and is not included in this ERISA-required summary. This summary reports on only the ERISA-covered components of the Sparrow Health System Group Benefit Plan listed below:

- Health Flexible Spending Arrangement
- Health (Medical and Rx) Insurance
- Employee Assistance Program (EAP)
- Dental Insurance
- Vision Insurance

As of January 1, 2017, Life Insurance and Disability benefits have been provided through the Sagewell Healthcare Benefits Trust which files a 5500 on behalf of all members of the Trust, accordingly.

Uninsured Components

Benefits under the Medical (Blue Cross Blue Shield of Michigan and PHP Service Company), Health Flexible Spending Arrangement (Health FSA), EAP and Dental components of the Plan are not funded. Sparrow Health System has committed itself to pay these benefits out of its general assets.

Insured Components – Insurance Information

The Plan has a contract with Delta Dental of Michigan to pay certain dental claims incurred under the terms of the plan. The total premiums paid for the year ending December 31, 2024, were $79,948. Because it is a so-called "experience-rated" contract, the premium costs are affected by, among other things, the size and number of claims. Of the total premiums and claims paid for the plan year ending December 31, 2024, the premiums paid under such "experience-rated" contracts were $79,948 and the total of all claims paid under the experience-rated contract during the plan year was $61,743.

The Plan has a contract with Vision Service Plan to pay certain vision claims incurred under the terms of the plan. The total premiums paid for the year ending December 31, 2024, were $1,392,973. Because it is a so-called "experience-rated" contract, the premium costs are affected by, among other things, the size and number of claims. Of the total premiums and claims paid for the plan year ending December 31, 2024, the premiums paid under such "experience-rated" contracts were $1,392,973 and the total of all claims paid under the experience-rated contract during the plan year was $1,062,166.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The item listed below is included in that report:

- insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Sparrow Health System, Human Resources Department, 1200 East Michigan Ave., Suite 235, Lansing, MI 48912, (517) 364-5858.

You also have the legally protected right to examine the annual report at the main office of the plan at Sparrow Health System, Human Resources Department, 1200 East Michigan Ave., Suite 235, Lansing, MI 48912, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-5638, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

UM Health-West ACA Look-Back Method

Look-back Measurement Method

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

- Under the ACA, employers are required to report specific benefits information to the IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. University of Michigan Health-West uses the look-back measurement method to determine group health plan eligibility.
- New employees hired to work full-time: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first day of the month following hire date.
- New employees hired to work a part-time, variable hour or seasonal schedule: If you are hired into a part-time position, a position where your hours vary and University of Michigan Health-West is unable to determine—as of your date of hire—whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on the first of the month following date of hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.
- Ongoing employees: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period during which The University of Michigan Health-West counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months.
- University of Michigan Health-West uses the standard measurement period and associated stability period annual cycle set forth below:
- Measurement period: STARTS: Hire Date DURATION: 11 months' Time to determine if you work 130+ hours per month on average—used to establish if you are "full-time" or "part-time" for medical eligibility.
- Stability period: STARTS: Hire Date. DURATION: 12 months' Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

UM Health-Sparrow ACA Look-Back Method

Look-back Measurement Method

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

- Under the ACA, employers are required to report specific benefits information to the IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 30 hours per week. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. University of Michigan Health-Sparrow uses the look-back measurement method to determine group health plan eligibility.
- New employees hired to work full-time: If you are hired as a new full-time employee (work on average 30 or more hours a week), you and your dependents are generally eligible for group health plan coverage as of the first day of the month following hire date.
- New employees hired to work a part-time, variable hour or seasonal schedule: If you are hired into a part-time position, a position where your hours vary and University of Michigan Health-Sparrow is unable to determine—as of your date of hire—whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of weekly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on the first of the month following date of hire. If, during your IMP, you average 30 or more hours a week, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.
- Ongoing employees: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period during which The University of Michigan Health-Sparrow counts employee hours to determine which employees work full-time. Those employees who average 30 or more hours a week over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months.
- University of Michigan Health-Sparrow uses the standard measurement period and associated stability period annual cycle set forth below:
- Measurement period: STARTS: Hire Date DURATION: 11 months' Time to determine if you work 30+ hours per week on average—used to establish if you are "full-time" or "part-time" for medical eligibility.
- Stability period: STARTS: Hire Date. DURATION: 12 months' Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

Medicare Part D Notice – Notice of Credible Coverage

Important Notice from University of Michigan Health – West & University of Michigan Health-Sparrow About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your University of Michigan Health – West coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under The health plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your University of Michigan Health – West prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: August 8, 2025
Name of Entity/Sender: UM Health-West & UM Health-Sparrow
Contact-Position/Office: Human Resources
Address:
UM Health-West 2122 Health Dr, Suite #260, Wyoming, MI 49519
UM Health-Sparrow 1400 E Michigan Ave, Lansing, MMI 48912
Phone Number:
UM Health-West 616-252-2100
UM Health-Sparrow 517-364-5333

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

Notice of Choice of Providers

The Medical Plans provided by University of Michigan Health – West generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

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

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

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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The University of Michigan Health's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in The University of Michigan Health's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in The University of Michigan Health's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

University of Michigan Health is committed to the privacy of your health information. The administrators of the U-M Health employer Sponsored Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Benefits@umhwest.org or Benefits@umhsparrow.org. The notice is also available online benefits.umhinsider.org.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 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: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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 HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send 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.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

https://benefits.umhinsider.org