UNIVERSITY OF MICHIGAN HEALTH SPOUSAL ACCESS PROVISION

University of Michigan Health's spousal access provision applicable to union groups states:

> ***If your spouse is employed and his/her employer offers medical coverage, your spouse must enroll in single coverage under his/her employer's health plan in order for the spouse to be eligible for secondary coverage under the U-M Health Medical Plan. If the contribution for the spouse's medical coverage is more than $75.00 per month, the spouse is exempt from this provision.***

If you have a spouse on your health insurance plan, you must complete the spousal access verification on the back of this form. Your spouse will be able to carry **PRIMARY** insurance (which means that Sparrow insurance will pay first) if:

1. Your spouse is not employed
2. Your spouse does not have health insurance available at their employer*****
3. Your spouse has health insurance available to them at a cost of MORE than $75.00 per month*****
4. Your spouse has health insurance available to them at a cost of $75.00 or LESS per month or a High Deductible Health Plan (HDHP) or Health Savings Account (HSA) with an employer contribution.*****
5. Your spouse works in a benefit eligible position at UM Health-Sparrow but does not carry any health insurance.

***Your spouse's employer must complete a "Request for Exemption" form to remain PRIMARY on U-M Health's insurance.**

Your spouse will be able to carry **SECONDARY** insurance (which means that U-M Health pays AFTER their insurance pays) IF:

1. Your spouse has their own insurance through their employer
2. Your spouse has insurance available to them at a cost of $75.00 or LESS per month and enrolls in this available coverage.
3. Your spouse works in a benefit eligible position at Sparrow and carries their own health insurance.

If your spouse is carrying U-M Health insurance as SECONDARY coverage, please complete the Coordination of Benefits Form available on the UM Health Intranet.

Please proceed to and complete the back of this form

U-M HEALTH UNION SPOUSAL ACCESS VERIFICATION FORM

Team Member Name:	Team Member #:
Spouse Name: ☐ Check box if spouse works at UMH-Sparrow	Spouse SSN:

PRIMARY COVERAGE: U-M Health coverage pays first. Spouse does not have coverage or has coverage that costs **MORE** than $75.00 a month.

SECONDARY COVERAGE: U-M Health coverage pays second. Spouse has coverage that costs $75.00 or **LESS** a month. Spouse must be enrolled in single coverage at their employer. HDHP or HSA plans with an employer contribution are excluded from this requirement.

Please answer the following questions on the grid below and return to Human Resources to determine if your spouse should have primary or secondary coverage through Sparrow. **Please circle your answer to each question as you go along:**

START HERE

Is your spouse currently employed?

YES → Is your spouse enrolled under Medicare?

YES → As long as you have **active** coverage, your spouse's coverage under U-M Health is **PRIMARY**. Please complete the Coordination of Benefits form found on the U-M Health Sparrow Intranet.

NO → Is your spouse enrolled under Medicare?

YES → As long as you have **active** coverage, your spouse's coverage under U-M Health is **PRIMARY**. Please complete the Coordination of Benefits form found on the U-M Health Sparrow Intranet.

NO → Your spouse's coverage under U-M Health is **PRIMARY**.

NO → Does your spouse have **access** to health insurance coverage?

YES → Does the coverage **available** cost $75.00 or **LESS** per month?

YES → Is the only plan that costs $75.00 or less per month a HDHP or HSA with an employer contribution?

YES → Your spouse's coverage under U-M Health is **SECONDARY**. Your spouse must enroll in the single coverage offered to them by their employer. Please complete the Coordination of Benefits section on the Change of Status form related to your current medical provider, located at sparrowbenefits.org.

NO → Your spouse's coverage under UMH-Sparrow is **PRIMARY**. Your spouse's employer must complete the **"Request for Exemption"** form and return to receive the exemption.

NO → Your spouse's coverage under UMH-Sparrow is **PRIMARY**. Your spouse's employer must complete the **"Request for Exemption"** form and return to receive the exemption.

I have been advised of the spousal access provision contained in the U-M Health Cafeteria Plan. I understand my spouse's failure to comply with this provision will result in no medical coverage for my spouse under U-M Health's plan from the date of non- compliance. I understand that by giving false or incomplete information on this form I may be subject to discipline up to and including termination.

Signature: _____ Date: _____

UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

REQUEST FOR EXEMPTION FORM
To be completed by Spouse's Employer's Human Resources Department

Dear Employer:

The spouse of your employee, _____, is employed in a benefit eligible position at U-M Health Regional Network and has requested to cover your employee primary on U-M Health's medical insurance. U-M Health has a spousal access provision that states:

> ***If your spouse is employed and his/her employer offers medical coverage, your spouse must enroll in single coverage under his/her employer's health plan in order for the spouse to be eligible for secondary coverage under the U-M Health Medical Plan. If the contribution for the spouse's medical coverage is more than $75.00 per month, the spouse is exempt from this provision.***

Please help us verify the coverage that your employee, _____, has available to them.

Employer Name:	Employee Name:
Contact Name:	Contact Number:

Is medical insurance **AVAILABLE** to this employee? ☐ YES ☐ NO

If yes, what is the employee cost for the lowest single medical coverage?

$ _____ per year or $_____ per month

Is the lowest cost plan an HSA or a HDHP with an employer contribution? ☐ YES ☐ NO

If yes, what is the employee cost of the lowest single medical coverage that is **not** an HSA or HDHP? $ _____ per year or $_____ per month

Is this employee currently enrolled in health insurance coverage? ☐ YES ☐ NO

If yes, plan name: _____ Group Number: _____

Do you offer a dollar amount for employees to opt out of health insurance coverage? ☐ YES ☐ NO

If yes, how much $_____ per year or $ _____ per month

Please add any additional comments:

I certify that the above information is complete and accurate.

Human Resources Representative Signature: _____ Date: _____