UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

University of Michigan Health Regional Network

Benefits Guide

2027

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616-252-2100
WestBenefits@UofMHealth.org

UM Health-Sparrow
517-364-5333
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U-M Health Regional Team Member,

We are so proud to have you as a member of our team! Now is the time to review, update and make benefit elections for the upcoming plan year, whether as a new hire, a newly eligible team member or during annual open enrollment. Whether it is health insurance, dental and vision coverage, retirement contributions or other offerings, our benefits guide and connected resources will help you understand your options.

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 which best meets your and your family's needs!

Thank you for continuing to choose U-M Health and making benefits a priority!

Your Regional Benefits & HR Service Teams,

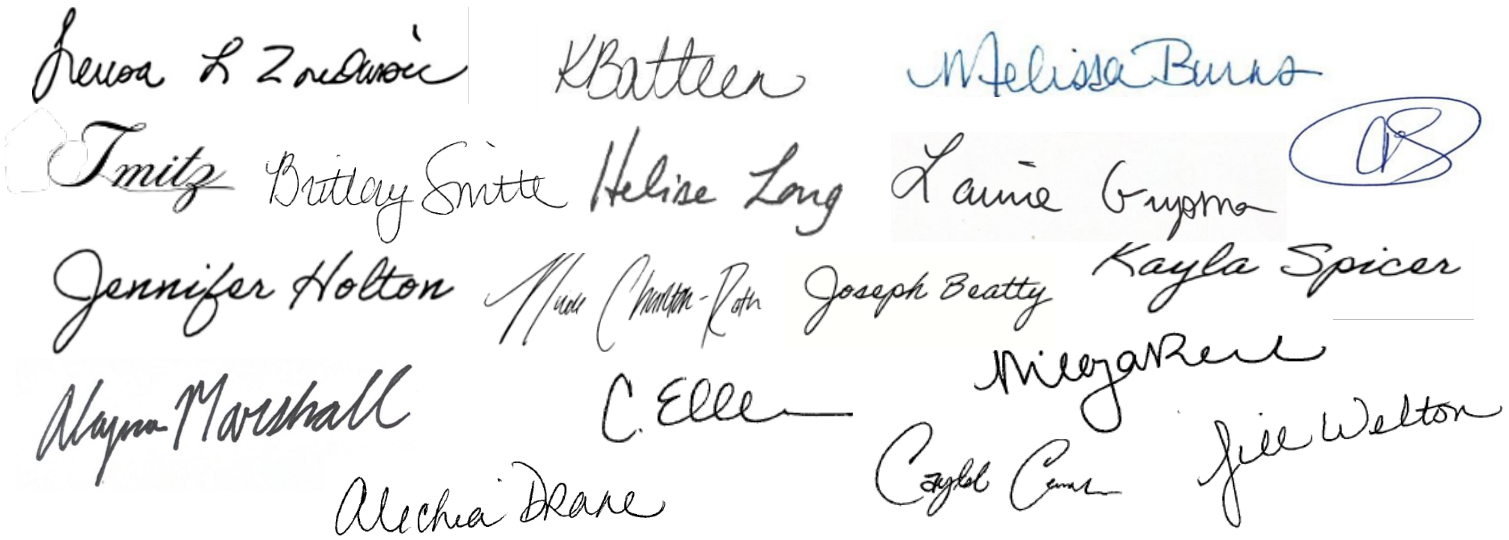

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Table of Contents

Welcome

4 Contacts
5 Employee Assistance Program (EAP)
6 Who's eligible for benefits?
7 How to Enroll

Medical, Dental & Vision

8 Medical Insurance Plans Overview
10 Prescription Drug Benefits
12 Bronze Health Plan Overview
14 Silver Health Plan Overview
16 Gold Health Plan Overview
18 Dental Insurance Overview
20 Vision Insurance Overview
22 Spending Accounts – HSA / FSA / DCFSA

Voluntary Benefits

24 Voluntary Benefit Options

Life & Disability

25 Life Insurance
26 Disability Insurance

Financial Wellness

27 Regional Retirement Plans Overview

Team Member Perks

28 Leaves of Absence
29 Team Member Discounts
30 Professional Development

Important Plan Information

31 COBRA Continuation Coverage
31 Key Plan Documents
31 Statement of Material Modifications
31 Health Plan Notices

- Notice of Choice of Providers
- ACA Disclaimer
- HIPAA Notice of Special Enrollment Rights
- Availability of Privacy Practices Notice
- Newborns and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- UM Health-West Summary Annual Report (SAR)
- UM Health-Sparrow Summary Annual Report (SAR)
- UM Health-West ACA Look-Back
- UM Health-Sparrow ACA Look-Back
- Health Insurance Marketplace Coverage Options and Your Health Coverage
- Medicare Part D Notice
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

46 Benefit Terms Glossary

This guide is an overview and does not provide a complete description of all benefit provisions.

Please visit Benefits.UMHInsider.org for more detailed information provided in your plan benefit summaries and other plan documents. The plan benefit contracts in effect determine how all benefits are paid.

Contacts

Questions about your benefits?

Contact the Benefit Service Center Monday-Friday from 8 a.m. - 4 p.m.

UM Health-West Benefits | 616-252-2100 | WestBenefits@UofMHealth.org
UM Health-Sparrow Benefits | 517-364-5333 | SparrowBenefits@UofMHealth.org

Visit **Benefits.UMHInsider.org** for detailed plan summaries and additional information.

Benefit Vendor Contact Information

Carrier Name	Phone	Website
ARAG	800-247-4184	AragLegal.com
Blue Cross Blue Shield (BCBSM)	877-790-2583	bcbsm.com
ComPsych (EAP)	877-595-5284	GuidanceResources.com (Web ID: UMHealth)
Delta Dental	800-482-8915	DeltaDentalMI.com
AbsenceResources (FMLA Source)	844-888-9780	AbsenceResources.com
Norton LifeLock	800-607-9174	Norton.com/BenefitPremier
PlanSource (West)	866-521-4755	Benefits.PlanSource.com/?UMHWest
Principal Financial	800-547-7754	Principal.com
Rockefeller Capital Management	616-305-2977	Rockco.com/Axiom-Wealth-Partners
RxBenefits	800-334-8134	Member.RxBenefits.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	866-451-3399	BenefitsLogin.WEXHealth.com

Employee Assistance Program (EAP)

ComPsych GuidanceResources

Every team member and member of your household has access to this fully employer-paid program, offering a range of support services:

Confidential emotional support

Get **eight (8) 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.

You also can create your will at no cost to you through GuidanceResources' free will template tool.

Financial resources

Ask experts for help navigating your financial health ranging from budgeting, bankruptcy, retirement, taxes, etc.

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.

Need help getting started?

The GuidanceResources "Assess Me" tool gives you a personalized plan to guide you to resources available, matched to what you need most.

Its question focus on six care pillars: Mental, Emotional, Physical, Social, Legal and Financial.

The assessment takes 5-15 minutes, is completely confidential, and can be taken multiple times if you ever want new suggestions.

How to connect to support

Help is just a phone call or login away. Intake professionals are ready 24/7 to connect you with the resources you need.

Call: 833-955-3403

TRS: 711

Online: GuidanceResources.com

App: GuidanceNow

Web ID: UMHealth

Scan or select the QR code to access GuidanceResources.com

Who's eligible for benefits?

Team members

If you are a Part-Time Benefit Eligible (.5-.89 FTE for West, .6-.89 for Sparrow) or Full-Time (.9 FTE or above) team member. Note: MNA team members consult your CBA.

Qualified life events (QLEs)

Team members may update their dependents and associated 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.

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.

Eligible dependents

- Legally married spouse
- Biological, adopted or stepchildren up to age 26 and minor wards 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

Important: 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.

How to Enroll

When can you enroll?

There are dedicated times for team members to enroll in or update their benefits:

- **New hires**: Must complete benefits enrollment within **30 days of hire.**
- **Annual open enrollment**: Allows team members to select benefits for the next calendar year.
- **Qualified Life Events (QLEs):** Must enroll in benefits within **30 days of the event date.**

UM Health-Sparrow Enrollment

Enrollment when newly eligible

New hires/rehires and team members with mid-year status change (i.e., QLEs, role transfers) must submit paper forms for enrollment. This can be done in two (2) ways:

- **Online form** via benefits.shs.org
- **Request Paper Form via Email** from UM Health-Sparrow HR at SparrowBenefits@UofMHealth.org

Annual Open Enrollment:

- Online via **My Team Member Record.*** Use your UM Health-Sparrow computer log in credentials to access.
- **On the Phone**
  - **HR Service Center Benefits Hotline:** 517-364-5333
  - **Voluntary Benefits information:** 855-421-9449
- **Email UM Health-Sparrow HR** at SparrowBenefits@UofMHealth.org

*Note: Team members on a leave of absence, with a status change or newly eligible for benefits on or after 6/1 of the current year must submit elections outside of My Team Member Record via the online form found at benefits.shs.org - Must be connected to the Sparrow network to access (on site or remotely).

Action checklist

- ❑ **Gather information and documents.** Have the date of birth, Social Security Number (SSN) and address for every person you wish to enroll (including spouses).

  Important: Retain documentation for any QLE changes.
- ❑ **Review all benefit plan options.** Use this benefit guide and regional benefits website enrollment materials to decide the best plans for your needs.
- ❑ **Consider the needs of you and your dependents.** What coverage tier are any specific providers or services you use? Does your spouse already have similar coverage?
- ❑ **Enroll on time.** Elect your benefits within 30 days of your eligibility or during the annual open enrollment period.
- ❑ **Make elections for HSA, FSA, and DCFSA** (as applicable). These accounts must be re-elected each year during Open Enrollment. They do not automatically renew.
- ❑ **Note biweekly benefit deduction schedule.**

UM Health-West Enrollment

During any enrollment period

Call 866-521-4755 or access 24/7 online at https://benefits.plansource.com/?UMHWest

Enter username and password: Username is your UMH-West IT system access username; password is your birthdate (YYYYMMDD)

1. **Elect benefits:** You must select for each benefit, even to decline a benefit. All plans available to you will be listed.
2. **Review and confirm selection:** This page lists the benefits you have selected for the plan year.
3. **Check Out:** Be sure to select check-out in your shopping cart.
4. **Confirmation statement:** Print, email etc. a copy of your confirmation statement.

   Important: Review this statement carefully and keep a copy for your records. This is the source of truth.

Overview of Medical Insurance Plans

Health Plan Options

U-M Health provides three medical plan options (MNA-PECSH plans vary) designed to meet a variety of healthcare needs:

Bronze Plan: Offers the lowest monthly premium) and pairs with a Health Savings Account (HSA).

Silver Plan: Balances cost and coverage, ideal for moderate health care usage.

Gold Plan: Provides the highest level of coverage, best suited for individuals who require frequent medical care.

Tip: Every plan has benefits and limitations. Review each plan's details to choose which option best aligns with your unique health care needs. All health plans are considered Qualified Health Coverage (QHC). Health insurance pays secondary to auto insurance on all regional plans and the MNA PPO Plus plan.

Network Tiers

Health plans cover providers in two networks, or "tiers" (Tier One (1) and Tier Two (2))

Tier One (1)

Enterprise-wide Hospitals, Providers and Pharmacies

These providers are within our U-M Health "family" and offer services at lower cost to you through our health plans. It includes providers within U-M Health and some in partnership:

- UM Health-West
- UM Health-Sparrow
- U-M Medical School and Academic Medical Center
- Michigan Medicine providers
- Members of U-M Health Clinically Integrated Network (CIN)

Tier Two (2)

Remainder of BCBS Nationwide Network

This tier includes the full network of providers covered by Blue Cross Blue Shield nationally. This means that team members can see a broader network of providers and receive covered services within and outside of Michigan. This tier offers standard coverage, meaning that services with Tier 2 providers are covered but don't offer the same savings as in Tier 1.

Note: All Tier 1 providers are also technically within Tier 2, but claims are processed as Tier 1 when billed from services and providers within the privileged Tier 1 network.

Important: Separate deductible and maximum out-of-pocket amounts apply to each tier.

Tier Three (3) is Out of Network

Providers and Facilities Not Participating with Blue Cross Blue Shield

Care provided by an out of network provider (Tier 3) is only covered in emergencies. Refer to health plan documents for more information.

What tier is my provider in?

You can search for new and existing providers on BCBSM.com – search for U-M Health to find our regional health plan network. Visit Benefits.UMHInsider.org to find provider lookup instructions.

Preventive Care

Preventive care refers to medical services that help detect, prevent or manage health issues before they become serious. Preventive care includes routine checkups, screenings, immunizations and counseling services aimed at maintaining wellness and catching potential problems early.

Preventive care is considered **free health care** under most insurance plans, including HDHPs, because it is **fully covered in Tier 1 and Tier 2 before the deductible is met,** meaning you do not pay out of pocket for these services.

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

- annual physical exams
- flu shots
- mammograms
- cholesterol screenings
- screening colonoscopies

Prescription Drug Benefits

Prescription drug coverage is integrated into our regional health plans but administered by our Pharmacy Benefit Manager (PBM), **Rx Benefits** (exception, MNA Legacy BCBS plan). Coverage varies by your selected health plan and includes:

- **Retail pharmacy services**
- **Specialty medications**

  Must be filled through U-M Health specialty pharmacies on all plans except MNA Legacy BCBSM plan.
- **Mail-order options** (limitations)
- **Home delivery from UM Health-West Pharmacy**

  Limitations apply with certain controlled medications and out of state locations – Call for more information: 616-252-RxRx (7979).

  Note: Not available on the MNA PPO Plus plan)

Preventive Medications

Our U-M Health plans are 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 RxBenefits.com/Members to check cost and coverage.

Filling Maintenance Medications

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.

UM Health-West Team Members

All maintenance medications must be filled at a U-M Health pharmacy.

UM Heath-Sparrow Team Members

Select maintenance medications must be filled at a U-M Health pharmacy.

Please visit the Benefits.UMHInsider.org for a list of maintenance medications which can only be filled at a U-M Health pharmacy. One grace fill outside of the U-M Health pharmacy is allowed. After that, your medication will not be covered unless it is filled through U-M Health.

Note: MNA Legacy BCBSM plan has pharmacy coverage through BCBSM

Prescription Drug Benefits

Overview of Prescription Drug Benefits

Prescription drug coverage is integrated into our regional health plans but administered by our Pharmacy Benefit Manager (PBM), Rx Benefits (exception, MNA Legacy BCBS plan).

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, do not forget to check the 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.

Prior Authorizations (PAs)

RxBenefits determines Prior Authorization requirements based on formulary and high-cost drugs (30-day cost over $1,000). Prior authorizations must be completed by your prescribing provider through PromptPA

To find out if a drug is on the plan formulary, check the Pharmacy Benefit Manager (PBM) information on Benefits.UMHInsider.org/Health-Insurance or call the customer service number 800-334-8134 on your RxBenefits (Evernorth) ID card or visit Member.RxBenefits.com.

RxBenefits®

SaveOnSP – Copay Assistance

Applies to Gold, Silver and MNA PPO Plus health plans only. 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.

Dispense as Written (DAW) Policy

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 a U-M Health Pharmacy. Some exceptions apply. These medications are limited to a 1-30 day supply. Specialty medications largely fall into their own category but may also include 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.

Prescription Coverage Highlights

Below is the prescription drug copay chart for our regional health plans..

Note: The Bronze Health Plan only provides prescription drug copays **after** the applicable tier deductible is met

Prescription Coverage Highlights for Regional Bronze, Silver and Gold Health Plans	Tier 1 Coverage	Tier 2 Coverage
Generic	$5	$10
Preferred Brand	$25	$40
Non-Preferred Brand	$50	$80
Specialty	$75	$100

Bronze Health Plan Overview

Bronze Plan Highlights

This is a High-Deductible Health Plan (HDHP) which pairs with a Health Savings Account (HSA):

- **Lower monthly premiums**
- **Higher deductibles** – meaning high out-of-pocket expenses for most care received before meeting this deductible
- **Non-embedded deductible** – meaning for families, the **entire deductible** must be met before coverage begins (required by the IRS for HDHPs)
- **Offers a Health Savings Account (HSA)** – a benefit only available with HDHPs (per IRS rules)
  - Tax-advantaged savings via HSA
  - HSA Funds roll over year to year
  - Team members enrolled in Medicare cannot make or receive HSA contributions

IRS criteria for HDHPs

HDHP must meet IRS rules, limits and guidelines:

- Members pay **full cost** of medical services (including prescriptions) until deductible is met.
- **Preventive services** (i.e., annual physical) covered before deductible.
- **Non-embedded deductible**: full plan deductible must be met, regardless of how many members contribute – individual deductibles apply only if one person is enrolled in a plan.

  Once met, the plan starts covering costs for all enrolled family members. There are two ways to meet the non-embedded deductible:
  - **Combined expenses** from multiple family members.
  - **One member's expenses** meet the full deductible.

Contribution limits (HSA)
- Self: $4,500
- Family: $9,000
- 55+ catch up: $1,000

Minimum deductible (for any HDHP)
- Individual: $1,750
- Family: $3,500

What sets this HDHP apart?

U-M Health Tier 1 Network

After reaching your Tier 1 deductible, Bronze plan offers 100% coverage for care received from Tier 1 providers.

Note: This does not include pharmacy coverage – prescription drugs follow a 4-tier copay structure after deductible is met.

Tier 1 network includes:

- UM Health-West
- UM Health-Sparrow
- U-M Medical School and Academic Medical Center
- Michigan Medicine providers
- Members of U-M Health Clinically Integrated Network (CIN)

BCBSM Tier 2 Network

After Tier 2 deductible is met, coinsurance (70%) applies for care in Tier 2 network.

- Full **BCBSM PPO network** (meaning flexibility for care outside Tier 1 – including a broad national network)
- **Higher out-of-pocket costs** apply

Tip: If you expect to use Tier 2 services often, Silver or Gold health plans may offer better coverage for your needs.

Note: J-1 Visa holders are not permitted to take this plan per visa deductible requirements.

Silver Health Plan Overview

Note: This plan is **not available** to members of the **MNA PECSH** bargaining unit. Applicable options are listed on new hire documents, the regional benefits website, and the enrollment site during open enrollment. Should any questions arise, contracts in effect will take precedence.

Silver Plan Highlights

Includes a lower deductible, offering copays and coinsurance to offset healthcare costs:

- **Moderate monthly premiums**
- **Moderate deductible**
- **Embedded deductible** – meaning that every person enrolled in a plan receives cost coverage when meeting their individual deductible or full plan deductible is – whichever is met first.
- **Option to pair with medical Flexible Spending Account (FSA)** for health-related expenses
  - Tax-advantaged savings via the FSA
  - FSA Funds expire on March 15th of the year following the plan year – they DON'T roll over year to year.

Note: Copays do not apply to the deductible but *do* apply to the out-of-pocket maximum.

Health Plan Comparison

- **Compared to Bronze Health Plan** – Silver plan has reduced cost on care via copays and coinsurance applying sooner because of a lower deductible but has higher monthly premium.
- **Compared to Gold Health Plan** – Silver plan has higher out of pocket costs if/when services are rendered but has lower monthly premium.

Network Considerations

U-M Health Tier 1 Network

After Tier 1 deductible is met, Gold and Silver health plans offer lower copays and coinsurance for care received from Tier 1 providers.

Tier 1 network includes:

- UM Health-West
- UM Health-Sparrow
- U-M Medical School and Academic Medical Center
- Michigan Medicine providers
- U-M Health Clinically Integrated Network (CIN) Members

BCBSM Tier 2 Network

After Tier 2 deductible is met, copays and coinsurance for care in Tier 2 network.

- Full **BCBSM PPO network** (a broad national network, available for team members to seek care with providers and facilities beyond the Tier 1 network).
- **Higher out-of-pocket costs** apply

Note on Tier 2 Care: Our national Tier 2 network offers flexibility to seek care outside of the U-M Health "family" but also **risks high out of pocket costs**. Covered services with an identified copay (i.e., office visits with PCP, specialists or behavioral health providers) **are not subject to deductible** on the Silver or Gold plans, so costs are contained.

If expecting to seek care in Tier 2 regularly, especially if subject to deductible and coinsurance (i.e., surgical procedure, inpatient hospital stay), the Gold plan may have better coverage for your needs.

Gold Health Plan Overview

Note: This plan is **not available** to members of the **MNA PECSH** bargaining unit. Applicable options are listed on new hire documents, the regional benefits website, and the enrollment site during open enrollment. Should any questions arise, contracts in effect will take precedence.

Gold Plan Highlights

Includes a lower deductible, offering copays and coinsurance to offset healthcare costs:

- **Greatest savings** on if/when services provided
- **Highest monthly premium**
- **Embedded deductible** – meaning every person enrolled in plan receives cost coverage when meeting their individual deductible or full plan deductible is – whichever is met first.
- **Option to pair with medical Flexible Spending Account (FSA)** for health-related expenses
  - Tax-advantaged savings via the FSA
  - FSA Funds expire on March 15th of the year following the plan year – they DON'T roll over year to year.

Note: Copays do not apply to the deductible but *do* apply to the out-of-pocket maximum.

Health Plan Comparison

- **Compared to Bronze Plan** – reduced cost on care via copays and coinsurance applying sooner because of a lower deductible but with highest monthly premium. Significantly lower cost if seeing Tier 2 providers compared to Bronze,.
- **Compared to Silver Plan** – lower out of pocket costs if/when services are rendered but has higher monthly premium.

Network Considerations

U-M Health Tier 1 network

After Tier 1 deductible is met, Gold and Silver health plans offer lower copays and coinsurance for care received from Tier 1 providers.

Tier 1 network includes:

- UM Health-West
- UM Health-Sparrow
- U-M Medical School and Academic Medical Center
- Michigan Medicine providers
- U-M Health Clinically Integrated Network (CIN) Members

BCBSM Tier 2 network

After Tier 2 deductible is met, copays and coinsurance for care in broad Tier 2 network.

- Full **BCBSM PPO network** (meaning flexibility for care outside Tier 1, with a national network, available for team members to seek care with providers and facilities beyond our Tier 1 Network).
- **Higher out-of-pocket costs** apply

Note on Tier 2 Care: Our national Tier 2 network offers flexibility to seek care outside of the U-M Health "family" but also **risks high out of pocket costs**. Covered services with an identified copay (i.e., office visits with PCP, specialists or behavioral health providers) **are not subject to deductible** on the Silver or Gold plans, so costs are contained.

If **not** expecting to seek care in Tier 2, especially if not subject to deductible and coinsurance (i.e., surgical procedure, inpatient hospital stay), you may want to consider the Silver plan.

Dental Insurance Overview

Dental Coverage – Plan Overview

U-M Health remains committed to supporting the oral health of our team members and their families by offering three (3) flexible, comprehensive dental plan options through Delta Dental.

Dental Plan Options

Bronze Plan

- Utilizes the **EPO network** (limited provider access)

Important: Check network before enrolling: search.providers4you.com/epo

- Lower premiums, but less flexibility in provider choice

Note: This plan is **not available** to members of the **MNA PECSH** or **MNA Home Care RN** bargaining units.

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

Noteworthy Plan Highlights

The following benefits have been added previously 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 update your dental plan during the **annual Open Enrollment period**. Be sure to:

- ❑ Review plan summaries and coverage details
- ❑ Compare premium rates and provider networks: **deltadental.com/member/find-a-dentist/**
- ❑ Access plan documents for full benefit information

Vision Insurance Overview

Vision Coverage – Plan Overview

U-M 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

Bronze Plan

- Offers basic coverage with lower premiums.

  Note: This plan is **not available** to members of the **MNA PECSH** or **MNA home care RN** bargaining units.

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.

Noteworthy Plan Highlights

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 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

Spending Accounts

To help manage health care and dependent care expenses, U-M Health offers several tax-advantaged accounts. WEX administers the following accounts for all regional team members:

Health Savings Account (HSA)

If you elect the Bronze Health Plan, U-M Health will establish an HSA in your name with our vendor, Wex Inc. Reference this overview of HSAs:

Note: You can only open an HSA if you are enrolled in a High Deductible Health Plan (HDHP). You can't make or receive HSA contributions if enrolled in other non-HDHP coverage or Medicare.

It's yours

Think of your HSA as a personal savings account. Set aside pre-tax dollars to pay for eligible health, dental or vision expenses. 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-health care expenses.

Note: There is a monthly account fee. While actively employed, U-M Health pays this fee for team members. The funds in your HSA are yours. If you leave your role – you will then be responsible for the fee or transferring the funds to a different HSA provider.

Easy to use

Use your benefits debit card when paying your expenses – purchases don't need to be verified as eligible. We recommend keeping receipts in case of an IRS audit.

Smart savings

An 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.

Note: HSA balances over $1,000 can be invested through your Wex account.

Employer contribution

Health Savings Accounts may be contributed to by both the employer and the team member. The IRS sets contribution limits for each year based on your enrollment level. Contribution limits apply to the combined total of what the team member contributes, as well as any employer contribution. U-M Health makes a one-time annual contribution.

New account holders:
Wex requires team members to verify their identity before gaining access to their HSA funds. This is a federal requirement under the U.S. Patriot Act.

If accounts are not validated timely, the account will be closed and any contributions will be returned.

Enrollment requirements:

- Team members covered by a non-HDHP may not make or receive HSA contributions.

  Reference: Non-HDHP coverage includes Medicare, Medicaid, Tricare.

  Team members may enroll in the Bronze health plan, however, should not make or receive contributions.
- Team members with J-1 Visas are not eligible for HDHP or HSAs due to visa requirements.

Search eligible expenses for HSAs or FSAs: WexInc.com/resources/benefits-toolkit/eligible-expenses

Flexible Savings Account (FSA)

Medical FSA

You may elect the medical FSA to set aside pre-tax dollars to pay for eligible health, dental or vision expenses if enrolled in any non-HDHP Health Plan such as the Silver or Gold health plans.

Note: You can enroll in a medical FSA as long as you or your spouse are not actively enrolled in an HDHP such as the Bronze Plan.

Funds on day one

All elected Medical FSA funds are available to spend on eligible health, dental and vision expenses on the benefit effective date. Use your benefits debit card at the point of purchase.

Tax advantaged

Dollars you contribute are taken out of your paycheck before tax which means a $100 purchase on eligible expenses could cost you approximately $130 without a Medical FSA.

Plan ahead

IRS rules require that money left unused in your account(s) at the end of the plan year be forfeited. To help you only set aside money that you will spend before it expires, think about the money you spent on health care expenses last year.

Grace period

The U-M Health Medical FSA allows for a grace period of 2 ½ months after the close of the plan. That means that if a team member has a balance in their Medical FSA as of December 31st, the team member may be reimbursed for eligible expenses incurred on or before March 15th of the following year.

Dependent Care FSA

Save money

The dependent care FSA lets you pay for eligible dependent care expenses, such as childcare center, babysitter, nanny or summer day camp, 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 using your pre-tax dollars.

Plan ahead

The money in a dependent care FSA expires at the end of the plan year. Be sure to elect only the amount of money you anticipate spending for eligible dependent care expenses – and plan to submit record of your expenses by the end of the plan year to be reimbursed with the money you set aside in this FSA.

Team members **must elect FSA benefits each year** – elections cannot roll over from year to year per IRS regulations.

Team members electing HSA or FSA benefit options are responsible to manage compliance with IRS rules.

Voluntary Benefits

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 premium cost through convenient payroll deductions.

UM Health-Sparrow Team Members
Enroll by calling 855-421-9449 or by visiting boss.EmployeeNavigator.com

UM Health-West Team Members
Enroll via PlanSource
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!

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 for all full- and part-time benefit eligible team members.

- Check your benefit summary or enrollment site to view your coverage amount!
- **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

Supplemental life insurance options vary by the employment status of the covered team member and their relationship with the dependent(s) to be covered.

Team Member Coverage

- Full time: May elect an additional 7x salary to a max of $1M in $10,000 increments
- Part time: Elect up to $50k

Spousal Life Insurance

- Full time: $5k increments up to max of $150k (age reduction applies)
- 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.

Short-Term Disability (STD)

Protects your income during a temporary absence from work.

Note: 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!

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 U-M Health Region to all full-time non-union team members!
- 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 for all non-union full-time team members after a 90-day 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.

U-M Health Regional Retirement

U-M Health Regional 401(k) Plan (Defined Contribution)

- **Eligibility:** Available to all newly hired regional team members effective 1/1/2027!
- **Loans:** Starting in January 2027, all regional team members may request a loan by contacting Principal. Repayment will be through ACH (no payroll deduction).
- **Withdrawals:** Allowed after age 59½ or upon employment termination. Team members must allow 60 days following separation of employment for withdrawals or rollovers – 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). Immediately vested.
Employer match	Per pay period match on first 6% of your contribution each paycheck, more details on benefits website and Insider! Vested after 1,000+ hours per year for 3 years.
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. Immediately vested.

Tax Benefits
Pre-tax and Roth (post-tax) contributions allowed.

Automatic Enrollment
6% auto-enrollment after 60 days unless opted out or by contacting Principal to modify.

Note: UM Health-Sparrow team members hired prior to 12/1/2026 must contact Transamerica to opt out prior to 1/1/201, if wanted.

Defined Benefit (DB) Pension Plan

Certain West and Sparrow team members hired prior to 2008 may have a legacy pension benefit. Starting January 2027, all DB benefits can be viewed by logging in to Principal. See the benefit website for more information on plan details.

Schedule a meeting with a Rockefeller Capital Management advisor to talk more about retirement. Virtual and in-person appointments available.

- Call 616-305-2977
- Email Axiom401k@RockCo.com

Legacy 403(b) Plan

UM Health-West Team Members hired prior to 1/1/2027 will have frozen 403(b) assets remaining in this plan, but no new contributions will go in.

- **Eligibility:** Only for UM Health-Sparrow team members actively accruing a benefit under the DB pension plan;
- **Contributions (Sparrow only eff. 1/1/2027):** Pre-tax, biweekly (team member only, no employer match).
- **Vesting:** Immediate for all team member contributions.

Beneficiary review

For all plan, it's critical to review and update your plan beneficiaries due to life changes (marriage, divorce, children). You can update at anytime via retirement vendor website or customer service #.

Leaves of Absence

FMLASource is now AbsenceResources® ComPsych

U-M Health partners with AbsenceResources, giving team members 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

When should a Leave of Absence be reported to AbsenceResources?

Contact AbsenceResources® 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

Online: AbsenceResources.com
App: AbsenceResources
Call: 844-888-9780
TRS: Dial 711
Fax: 877-309-0218

To report a Leave of Absence:

- **Anytime:** Log in to AbsenceResources online or via mobile app and select 'Add New Leave'
- **During Business Hours:** Call and talk to a representative

What information will AbsenceResources 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 AbsenceResources?

You can contact AbsenceResources online, via app, or by phone with any questions you may have. Common reasons to reach out:

- Update information related to your leave
- Submit an extension
- Confirm your return-to-work date
- Report date of delivery or placement of your child
- Report intermittent absences

Team Member Discounts

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, WorkingAdvantage, ID.me, and GOVX.com. Combined, these programs offer thousands of exciting team member discounts!

Note that the offers available through these sites change often. The availability and expiration of offers are controlled by the site administrators and not by U-M Health. Check back often to find different discount options you can purchase—making your wants and needs more affordable!

To access additional discounts from local and national businesses visit the U-M Health Insider:

UM Health-Sparrow SPA
UM Health-West Team Member Perks Program

Childcare Discounts

U-M Health partners with trusted childcare networks to support your family with exclusive savings and quality care for children ages 0–12 at over a thousand childcare centers nationwide.

- 10% Tuition Discount
- First-Year Registration Fee Waived for new enrollees
- Priority Enrollment (based on availability)

Find childcare centers near you with our partners:

Learning Care (Childtime, AppleTree, Gilden Woods, Tutor Time, and Everbrook Academy, and more)

UM Health-West | MyLearningCareGroup.com/UMHWest
UM Health-Sparrow | MyLearningCareGroup.com/Sparrow

Call Learning Care with questions at 877-747-2492.

KinderCare

UM Health Region | KinderCare.com/UMRegionalHealth

Call the KinderCare Family Support line with questions at 888-525-2780.

Home Care Support

Find quality home care support with CareScout, a resource offered through our EAP:

- Easy access to vetted, quality local care providers
- Guidance to help navigate aging care and options
- Dedicated support for ComPsych members
- Preferred pricing up to 15% off typical cost when going directly to home care providers

Learn more about this benefit by calling our EAP, ComPsych GuidanceResources at 833-955-3403 or searching “CareScout” at GuidanceResources.com

Professional Development

U-M Health values opportunities for continued education. Team members are encouraged to pursue continuous development with the following programs:

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.

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.

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.

DDI Pinpoint

Our region partners 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.

On-Demand Resources

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

Important Plan Information

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.

Key Plan Documents

- **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 or visit **Benefits.UMHInsider.org**.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the UM Health-West and UM 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.

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available on the regional benefits page at Benefits.UMHInsider.org and in this annual Benefit Guide in the following pages.

If you would like separate paper copies, please reach out to your Benefits Team.

Notice of Choice of Providers

This notice explains that your plan either requires you to designate a primary care provider (PCP) or allows you to select one.

The Medical Plans provided by UM Health-West and UM Health-Sparrow 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.

ACA disclaimer

This notice explains how insurance offered by UM Health-West & UM Health-Sparrow affects your eligibility for premium subsidies through the ACA Exchange.

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 9.96% of your modified adjusted household income in 2026.

HIPAA Notice of Special Enrollment Rights

This notice explains when you and/or your dependents can enroll in medical coverage outside of the annual open enrollment period.

If you decline enrollment in the U-M 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 U-M 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 U-M 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

This notice explains how to access the HIPAA Notice of Privacy Practices, which describes how health information about you may be used and disclosed.

U-M 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 WestBenefits@UofMHealth.org or SparrowBenefits@UofMHealth.org. The notice is also available online Benefits.UMHInsider.org.

Newborns and Mothers' Health Protection Act

This notice explains the rights of mothers and newborns to stay in the hospital 48–96 hours after delivery.

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.

Women's Health and Cancer Rights Act

This notice describes benefits available to people who have had or will have a mastectomy.

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.

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, 2025, to December 31, 2025. 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 (health, Rx, health FSA), dental and employee assistance claims

Insurance information

The plan has contracts with ARAG insurance company and Vision Service Plan, to pay the following types of claims incurred under the terms of the plan.

All vision and legal claims

The total premiums paid for the plan year beginning January 1, 2025 and ending December 31, 2025 were $576,953.

Because they are so called 'experience-rated' contracts, the premium costs 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, 2025, the premiums paid under such 'experience-rated' contracts were $505,428 and the total of all benefit claims paid under these experience-rated contracts during the plan year were $29,294.

*as of January 1, 2025. 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.

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 ATTN HR
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, Ste 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, 2025 through December 31, 2025. 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, 2025 were $165,257. 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, 2025, the premiums paid under such "experience-rated" contracts were $165,257 and the total of all claims paid under the experience-rated contract during the plan year was $66,771.

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, 2025 were $1,593,490. 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, 2025, the premiums paid under such "experience-rated" contracts were $1,593,490 and the total of all claims paid under the experience-rated contract during the plan year was $1,488,531.

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:

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 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 health care 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. UM 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 UM 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 UM 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.
- UM 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 health care 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. UM 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 UM 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 UM 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.
- UM 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.
Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer name	Employer Identification Number (EIN)
U-M Health (including UM Health-West and UM Health-Sparrow)	Multiple – email Benefits to confirm

Employer address	Employer phone number
1400 E Michigan Ave	517-364-5333; 616-232-2100

City	State	ZIP code
Lansing	MI	48912

Who can we contact about employee health coverage at this job?
Human Resources - Benefits

Email address
SparrowBenefits@UofMHealth.org; WestBenefits@UofMHealth.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ❑ All employees. Eligible employees are:
    N/A
  - ☑ Some employees. Eligible employees are:
    UM Health-West: 0.5 FTE and above;
    UM Health-Sparrow Non Union, UAW, SEIU & IUE: 0.6 FTE and above
    UM Health-Sparrow MNA: 0.4 FTE and above

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Legal spouses, dependent children to age 26, minor wards to age 18, disabled dependents over 26, children covered under a QMCSO
  - ❑ We do not offer coverage.
    N/A

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

> **Note:** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Medicare Part D notice – notice of credible coverage

This notice explains your options for accessing prescription drug coverage if you are eligible for Medicare.

Important notice from UM Health-West and UM 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 UM Health-West and UM Health-Sparrow 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. U-M Health has determined that the **prescription drug coverage offered by UM Health-West plans and UM 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 UM Health-West and UM Health-Sparrow 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 and UM Health-Sparrow 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 UM Health-West and UM Health-Sparrow 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 19 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 UM Health-West and UM Health-Sparrow 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 12, 2026
Name of Entity/Sender: UM Health-West & UM Health-Sparrow
Contact-Position/Office: Human Resources
Address:
UM Health-West 2122 Health Drive, Suite 260, Wyoming, MI 49519
UM Health-Sparrow 1400 E Michigan Ave., Lansing, MI 48912
Phone Number:
UM Health-West 616-252-2100
UM Health-Sparrow 517-364-5333

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

This notice describes premium assistance that may be available in your state for Medicaid-eligible dependents.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: myalhipp.com
Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: (866) 251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com
Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program website: dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance
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+)

Health First Colorado website: healthfirstcolorado.com
Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: (800) 359-1991 (TTY: 711)
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp
Phone: (877) 357-3268

Georgia – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: (678) 564-1162, press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, press 2

Illinois – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: abe.illinois.gov
HIPP Hotline Number: (217) 524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)
Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid
Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: (855) 459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP website: kynect.ky.gov
Phone: (877) 524-4718
Medicaid website: chfs.ky.gov/agencies/dms

Louisiana – Medicaid
Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid
Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage: maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid
Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid
Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid
Website: accessnebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid
Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP
Website: nj.gov/humanservices/dmahs/individuals-families/familycare
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid
Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid
Website: hhs.nd.gov/healthcare
Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP
Website: insureoklahoma.org
Phone: (888) 365-3742

Oregon – Medicaid
Website: healthcare.oregon.gov
Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP
Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: (800) 692-7462
CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP
Website: eohhs.ri.gov
Phone: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)

South Carolina – Medicaid
Website: scdhhs.gov
Phone: (888) 549-0820

South Dakota – Medicaid
Website: dss.sd.gov
Phone: (888) 828-0059

Texas – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: (800) 440-0493

Utah – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) website: medicaid.utah.gov/upp
Phone: (888) 222-2542
Email: upp@utah.gov
Adult Expansion website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program website: medicaid.utah.gov/buyout-program
CHIP website: chip.utah.gov

Vermont – Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: (800) 250-8427

Virginia – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid
Website: hca.wa.gov
Phone: (800) 562-3022

West Virginia – Medicaid and CHIP
Website: bms.wv.gov
Website: mywvhipp.com
Medicaid phone: (304) 558-1700
CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: (800) 362-3002

Wyoming – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 2026, 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

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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 health care 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. U-M Health benefit plans are all calendar year plan years..

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 health care 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 health care and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab or other health care professional or facility that provides health care 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.

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