2027





Employee Benefits Guide



MPHI®

January 1, 2027

WHAT'S INSIDE...

We understand how important having a sound benefit package is, and that is why we are **committed** to providing you and your family with competitive benefits that meet your needs and keep you living well, while balancing our obligation to be financially responsible as a company. Your employee benefits are an important part of your total compensation. This benefit guide includes important information describing your benefit plan offerings. Please read it thoroughly.

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 pages 32-33 for more details.

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THE BASICS

IMPORTANT INFORMATION

Benefits Enrollment

We appreciate the hard work put forth by our employees, and together, we make MPHI a great place to work. An important part of being a great place to work is having a benefit program that helps protect you and your family. MPHI's benefit program allows you to select the level of coverage you need from a menu of benefit options.

This Guide will help you select your benefits for the upcoming plan year.

Eligibility

Newly hired Regular Full-Time employees working at least 30 hours per week are eligible for benefits on the first of the month following their date of hire, except for the 403(b) plan, which begins on the date of hire.

For current employees, open enrollment changes are effective on January 1 each year, or upon the date of a qualified change in status (*see Making Mid-Year Changes*).

Dependent Eligibility

Eligible employees may enroll certain dependents for coverage under our health, dental, vision and FSA plans. Eligible dependents include:

- Your legal spouse
- Your children or your spouse's children by birth, legal adoption, or legal guardianship through the end of the year in which they turn 26
- Your child over age 26 who was totally and permanently disabled prior to age 19 due to either physical or mental disability; incapable of self-sustaining employment, unmarried and dependent on you for more than half of his or her support and reported as a dependent on your most recent federal income tax return. We must be notified of this condition before the end of the year in which the dependent turns 26. The disability must be certified by a physician.

> Adult children may be enrolled on the BCBS High-Deductible Health Plan; however, their claims may not be eligible for reimbursement from your HSA account unless the child qualifies as a tax dependent of the employee. Please contact your HSA administrator for more information.

Automatic Annual Re-enrollment

Prior to each plan year, there will be an open enrollment period available to employees to make benefit elections for the next plan year. Your current elections will automatically be continued unless you complete a new election form during the open enrollment period. If you are required to contribute to the cost of coverage, you will be considered to have agreed to pay the appropriate premiums for the subsequent plan year for this coverage. If one or more of the current elections in which you are enrolled are not being offered during the subsequent plan year, you will be enrolled in the most similar option.

Automatic re-enrollment does not apply to the Medical and Dependent Care Flexible Spending Accounts under the Institute's Section 125 Cafeteria Plan. Therefore, you must complete a new election form to continue your participation in the Flexible Spending Accounts.

THE BASICS

IMPORTANT INFORMATION

Making Mid-Year Changes

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's loss or gain of coverage through our organization or another employer
- Change in employment status

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 30 days.

2027 Employee Pre-Tax Contributions (monthly)

To participate in the medical, dental and vision plans, MPHI asks you to contribute a portion of the cost of coverage through payroll deduction. The 2027 monthly pre-tax costs are listed below.

	EMPLOYEE ONLY	TWO PERSON	FAMILY
BCBSM Simply Blue 1000 PPO with RX	$122.00	$290.00	$362.00
BCBSM Simply Blue High Deductible Health Plan (HDHP) PPO with RX	$76.00	$178.00	$222.00
Dental	$2.00	$14.00	$30.00
Vision	$0.00	$2.00	$4.00

YOUR OPTIONS

MEDICAL

Medical coverage is one of the most significant parts of your overall benefits package with MPHI, and it is important that you take the time to understand the details of the medical plan in which you enroll.

MPHI offers two comprehensive medical plan options through **Blue Cross Blue Shield of Michigan**:

- Simply Blue $1000 PPO
- Simply Blue PPO High-Deductible Health Plan (HDHP)

About Your Plans

All of your medical plan options use the same network, called the "PPO" network, through Blue Cross Blue Shield of Michigan. This means the list of doctors and hospitals you can choose from doesn't change no matter which plan you pick. PPO network doctors and hospitals have agreed to charge a discounted rate, so when you use them, your plan pays a bigger share of the bill, and you pay less.

You can still choose to see a doctor who is outside this network, but it will cost you more. In-network doctors agree to accept Blue Cross Blue Shield's approved rate as full payment, so you only ever owe your deductible and coinsurance share—nothing extra.

Out-of-network doctors have not agreed to that rate, so they can bill you for the difference between what they charge and what Blue Cross Blue Shield approves, on top of your deductible and coinsurance. There is no cap on how much an out-of-network doctor can bill you, so these visits can get expensive.

We recommend picking a primary care doctor you see regularly, but you're free to visit any provider you want, including specialists. To find doctors and hospitals in your network, go to www.bcbsm.com.

Deductible

The amount of expenses you pay each calendar year before the plan begins to pay for benefits that have a coinsurance.

Coinsurance

After you've met the deductible, the plan pays a major portion of the covered expenses, and you pay the remaining portion. This sharing of expenses is called "coinsurance." For example, if the plan pays 80% for a particular service, your coinsurance is 20%.

Out-of-Pocket Maximum

The out-of-pocket maximum provides you with financial protection by limiting the total amount you pay for covered expenses in a calendar year. If your out-of-pocket costs reach the out-of-pocket maximum for an individual or family, the plan will start to pay 100% of your remaining expenses for that individual or family for the remainder of the year. The out-of-pocket dollar maximum includes all medical and prescription drug out-of-pocket expenses, including the deductible, coinsurance and copays.

Important!

If your enrollment tier is employee + spouse, employee + child(ren) or family, then you are responsible for satisfying the full family deductible amount *before* you will begin to pay coinsurance. Unlike in a traditional PPO plan, there is not an "individual" deductible.

MEDICAL SUMMARY

	Simply Blue PPO $750 Plan		Simply Blue PPO HDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductibles and Coinsurance – calendar year				
Deductible	$1,000 Single $2,000 Family	$2,000 Single $4,000 Family	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family
			The plan combines deductible amounts paid under your Simply Blue medical coverage and your Simply Blue prescription drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract, with the exception of in-network preventive care services.	
Coinsurance – Applies once deductible is met (waived for covered services performed in an in-network physician's office)	• 20% of approved amount for most other covered services • 30% of approved amount for private duty nursing care	• 40% of approved amount for most other covered services • 50% of approved amount for private duty nursing care	None	20% of approved amount for most covered services
Coinsurance out-of-pocket maximum	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	Not applicable	Not applicable
	The family coinsurance requirement applies to a two-person or family contract.			
Annual out-of-pocket maximum – applies to deductibles, copays and coinsurance amounts for all covered services, including cost-sharing amounts for prescription drugs	$8,150 Single $16,300 Family	$16,300 Single $32,600 Family	$4,000 Single $8,000 Family	$8,000 Single $16,000 Family
Physician Services				
Office Visits – medically necessary	$20 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
Specialist Office Visit	$40 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
Urgent Care – medically necessary	$60 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
	Deductible and coinsurance apply for services outside of the exam			
Emergency Care				
Emergency Room	$250 copay		100% after deductible	80% after out-of-network deductible
Preventive Care				
Adult and childhood preventive services and immunizations	100% no deductible or copay	Not covered	100% no deductible or copay	Not covered
Hearing Care Benefits				
Audiometric exam – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Hearing aid evaluation – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Ordering and fitting the hearing aid – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Hearing aid conformity test – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
	Hearing care services are not covered when performed by nonparticipating providers unless the services are performed outside of Michigan and the local Bue Cross Blue Shield plan does not contract with providers for hearing care services. Simply blue Hearing Care Benefits are subject to the same deductible required under Simple Blue medical coverage. Benefits are not payable until after you have met the Simply Blue annual deductible.			

YOUR OPTIONS

PRESCRIPTION DRUG

Prescription Drug Coverage

The prescription drug benefits, including mail order drugs, are subject to the same deductibles, copays and annual copay dollar maximums required under the Simply Blue PPO or Simply Blue PPO HDHP medical coverage.

- Prescription drug claims apply towards the Simply Blue annual deductible requirement.
- Prescription drug benefits are not payable until the applicable Simply Blue annual deductible has been met.

Simply Blue $1000 PPO Plan—Prescription Drug Coverage

The Simply Blue 1000 PPO prescription drug plan has three different categories, or tiers, of drugs.

	Network Retail Pharmacy Copay for up to a 30 day	**OptumRx Mail Order Copay for up to a 90-day supply**
Tier 1 Generic/Formulary Preferred	$15 copay for each drug	$30 copay for each drug
Tier 2 Formulary Brand	$50 copay for each drug	$100 copay for each drug
Tier 3 Non-formulary Brand	50% ($70 min and $100 max) for each drug	50% ($140 min and $200 max) for each drug

Simply Blue PPO HDHP Plan—Prescription Drug Coverage

The Simply Blue PPO HDHP prescription drug plan has three different categories, or tiers, of drugs.

	Network Retail Pharmacy Copay for up to a 30 day	**OptumRx Mail Order Copay for up to a 90-day supply**
Tier 1 Generic/Formulary Preferred	After deductible is met, you pay $15 copay	$30 copay for each drug
Tier 2 Formulary Brand	After deductible is met, you pay $50 copay	$100 copay for each drug
Tier 3 Non-formulary Brand	After deductible is met, you pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $140 or 50% of the approved amount (whichever is greater), but no more than $200

- **Generic:** a drug whose formula is equivalent to that of a brand name drug
- **Brand:** an original formula with no generic equivalent
- **Non-Formulary:** a drug for which there is either a generic alternative or a cost cost-effective preferred brand

YOUR OPTIONS

PRESCRIPTION DRUGS

High-Cost Drug Discount Optimization Program

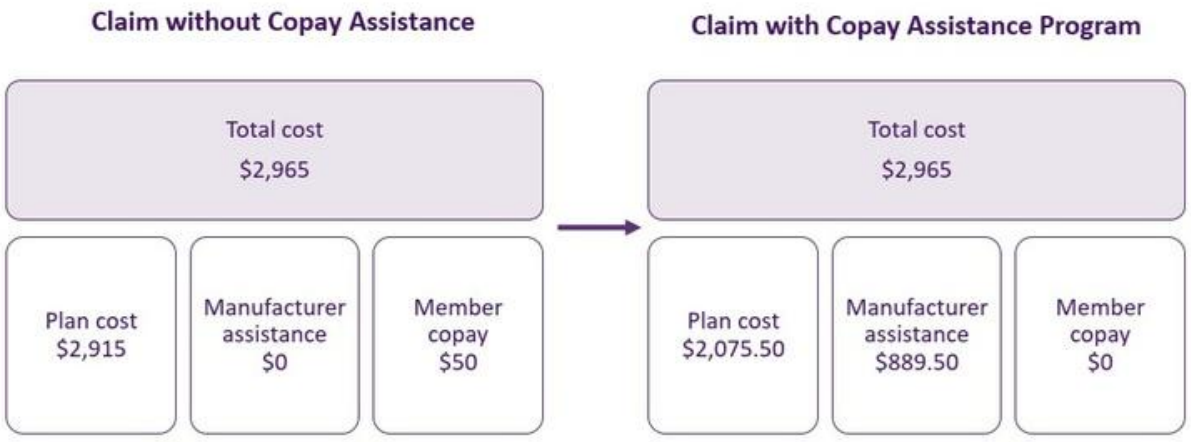
The PillarRx program will be in place for the Simply Blue $1000. BCBSM will be mailing letters to those enrolled in either plan who will be impacted.

BCBSM partners with OptumRx in a program in which drug manufacturers will assist in paying most or all of the member's copay on approximately 300 high-cost drugs.

If a member currently takes one or more medications for which copay assistance is available, he or she can expect a phone call from a OptumRx copay assistance team representative. The representative will help the member to enroll in the discount program, as well inform them how the program works, what they should expect at the pharmacy and answer any questions. **Members who take medications included in this program are required to enroll.**

- **Members who enroll** will have all or a portion of their out-of-pocket costs (copay) for the drug covered by the drug manufacturer. Hence, in the example it shares a $0 copay to the member.
- **Members who ignore the letter / calls** and who do not enroll in the program will be responsible for a 30% coinsurance on the affected medication.

As such, there is a financial incentive for members to enroll in the program.



Members can call the OptumRx copay assistance team at (800) 356-3477 or more information.

YOUR OPTIONS

Your Prescription Drug Benefits

Know Before You Fill

- **Generic drugs are required** under this plan. Choosing a brand-name drug when a generic is available means paying the brand copay plus the full price difference — even if your doctor writes "Dispense as Written." The only exception: your doctor requests and receives BCBSM approval, so you pay just the standard copay.
- **Prior authorization** for certain drugs before they can be dispensed, or they won't be covered. Have your doctor contact BCBSM directly for approval before prescribing anything on the prior authorization or step therapy list.
- **Step therapy** is a type of prior authorization required for some medications — BCBSM won't approve payment until you've tried other options first.

90-Day Retail: Fewer Trips, Lower Cost

Fill a 90-day supply of eligible prescriptions at a participating pharmacy for just two copays instead of three. Your state must allow 90-day dispensing and your doctor must write the prescription for that quantity — nearly every chain and independent pharmacy participates. Visit *www.bcbsm.com* to find a full list of approved pharmacies.

Mail Order: Delivered to Your Door

Save money by filling your prescriptions through the Mail Order Program with OptumRx. Keep at least a 14-day supply on hand before ordering — delivery typically arrives within 7 to 11 days. Ask your doctor for two prescriptions: one for an initial 14-day supply and one for a 90-day supply with refill options by mail. Some medications carry dispensing limits under state or federal law.

Quantity Limits

BCBSM may limit the initial fill of select specialty drugs. Your copay is cut in half for that first 15-day fill once your deductible is met. After that, specialty drugs are limited to a 30-day supply per fill — whether at a retail pharmacy or through Walgreens Specialty Pharmacy by mail — so you're never paying for a 90-day supply of costly medication you may not need to continue.

YOUR OPTIONS

FERTILITY, DIABETES & DURABLE MEDICAL EQUIPMENT SUPPORT

Infertility Benefits Coverage

Blue Cross's standard medical benefits cover testing to diagnose infertility, along with the specialist evaluation, corrective surgery, or other therapies needed to treat its underlying cause. As fertility care becomes a more openly discussed benefit in our community, MPHI offers enhanced fertility coverage for those in need, subject to BCBSM's medical criteria.
Covered services include:

- A medical evaluation
- Diagnostic services, such as laboratory studies, X-rays, and ultrasounds
- Oral and injectable drugs
- Artificial insemination
- Assisted reproductive technology, such as In Vitro Fertilization (IVF)

Exclusions and limitations:

- Third-party reproductive services (e.g., donor eggs, sperm, or embryos)
- Infertility services or treatments for female patients who are perimenopausal, menopausal, or postmenopausal
- Assisted reproductive technology for fertile individuals
- Experimental treatment

Livongo Diabetes Management Program

Diabetes management helps you build healthy habits and keep your blood sugar levels under control. Once enrolled, a Welcome Kit arrives at your home with a smart device set up and ready for testing, plus the ability to order unlimited testing strips and lancets at no out-of-pocket cost. The Livongo cellular-connected meter delivers real-time feedback on glucose readings, activity tracking, and coaching from certified diabetes care and education specialists, helping you understand the impact of your lifestyle habits. The meter also captures glucose readings and produces reports you can easily share with your care providers. Join today at www.teladochealth.com/livongo or call 800-945-4355.

Durable Medical Equipment Coverage

Blue Cross Blue Shield of Michigan works with a specialized network managed by Northwood, Inc. for durable medical equipment, prosthetics and orthotics (DME POS), and medical supplies — including items like crutches, wheelchairs, and diabetic testing supplies.

To find a Northwood network DME POS provider, log in to your Blue Cross member account and search using the "Find a Doctor" feature. Otherwise, visit www.bcbsm.com/dmesupplies and click Find a Doctor — look for the "Northwood" indicator in your results.

If you use a provider outside the Northwood network, those services will be considered out-of-network and the higher out-of-network cost-share will apply.

Hearing Care Coverage

Both of our health plans include hearing benefits, payable every 36 months through in-network (BCBS PPO) providers.

Hearing services are **not** covered when performed by nonparticipating providers, unless received outside Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care. See the benefit description at the back of this guide for full details.

YOUR OPTIONS

DENTAL

- Our dental plan is insured by Delta Dental of Michigan — you may see any dentist you choose.
- Find a PPO dentist near you at www.deltadentalmi.com or call (800) 524-3032.
- Using a PPO network dentist gives you the lowest out-of-pocket costs, since copays are based on a discounted rate.
- Visiting a nonparticipating dentist may result in a balance bill for the difference between the approved amount and the dentist's charge.

	PPO Dentist	Premier Dentist
Dental Benefits	**Plan Pays**	**Plan Pays**
Preventive & Diagnostic (No deductible to meet)	100%	100%
Annual deductible (Applies to Basic & Major services only)	None	None
Basic – fillings, root canals, extractions, crowns	75%	75%
Major – bridges, implants, dentures	50%	50%
Annual Benefit Maximum	$2,000 per person	$2,000 per person

Example savings for a crown by network	Submitted charge	Maximum allowed fee	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Total network savings
Delta Dental PPO	$950	$675	50%	$337.50	$0	$337.50	$275
Delta Dental Premier	$950	$898	50%	$449	$0	$449	$52
Out-of-network	$950	$744	50%	$372	$206	$578	$0

YOUR OPTIONS

VISION

Our vision plan is insured by Blue Cross Blue Shield of Michigan (BCBSM). Blue Vision benefits are provided by Vision Service Plan (VSP), one of the largest provider of vision care in the nation.

Benefits for exams, lenses and frames are available once per every 12 consecutive months. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.

Plus, members are eligible for discounts on additional prescription glasses and savings on lens extras when these are purchased from a VSP doctor.

Walmart and Sam's Club are now considered participating retail provider locations for our Blue Vision plans!

To find a VSP doctor, call (800) 877-7195 or log onto the VSP Website at www.vsp.com.

	Vision Care Coverage	
Vision Benefits	**VSP Network Doctor**	**Non-VSP Provider**
Exam Once every plan year	$5 copay	$5 copay applied to charge
Prescription Glasses	**Combined** $10 Copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically Necessary Contact Lenses Once every plan year	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Lenses & Frames Once every plan year **Standard Lenses**	$10 copay	Reimbursement up to approved amount based on lens type less $10 copay
Standard Frames	$130 allowance applied toward exam and contact lenses	Reimbursement up to $70 less $10 copay

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

YOUR OPTIONS

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) lets you pay for health and/or daycare expenses with **tax-free** dollars. You save money because you pay for those expenses with pre-tax money—how much you save depends on how much you pay in income tax. You choose how much to contribute (FSA elections do not rollover from year-to-year). Your contributions are withheld, in equal amounts, from your paychecks throughout the year. As you incur expenses you can file a claim to be **reimbursed** from your account.

If you enroll in an FSA, you will also receive a **debit card** that you can use at the point of service, so you have immediate access to your funds. You may still have to substantiate your expenses by providing proof that they are eligible, though, so be sure to keep all documentation. This includes Explanation of Benefits (EOBs), prescription drug slip, or an itemized statement from the provider.

There are two Health Care (HC) FSA options:

- **Full Scope**: use this FSA to pay for eligible medical, dental or vision expenses. *You cannot enroll in this option if you are contributing towards an HSA* .
- **Limited Purpose**: this FSA can be used to pay for eligible dental or vision expenses, and medical expenses *after* you have met your deductible. You are eligible to enroll in this option if you are covered by the Simply Blue HSA HDHP. You are not eligible to enroll in this option if you are covered by the Simply Blue 750 PPO.

2027 CONTRIBUTION LIMIT	$3,400

Dependent Care FSA

The Dependent Care (DC) FSA lets you pay eligible dependent care expenses with pre-tax dollars. Most childcare, eldercare and companion services are eligible expenses. Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves
- Spending at least 8 hours per day in your home
- Eligible to be claimed as a dependent on your federal income tax return
- Receiving care when you are at work and your spouse (if married) is at work, searching for work, is in school full-time or is mentally or physically disabled and unable to provide the care

If both you and your spouse work, the IRS limits your contribution to a DC FSA:

- If you file separate income tax returns, the annual contribution limit is $3,750 each for you and your spouse
- If you file a joint tax return and your spouse also contributes to a DC FSA, your combined limit is $7,500
- If your spouse is disabled or full-time student, special limits apply
- If you or your spouse earn less than $7,500, the maximum is limited to earnings under $7,500

With a DC FSA, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you will be reimbursed as new deposits are made.

Eligible dependent care expenses can either be reimbursed through the DC FSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually, the DC FSA will save you more money than the tax credit, but to find out what is best for you and your family, talk to your tax advisor or take a look at IRS Publication 503.

If you contribute to a DC FSA, you must file an IRS Form 2441 with your federal income tax return. Form 2441 is simply an informational form on which you report the amount you paid and who you paid for day care.

YOUR OPTIONS

FLEXIBLE SPENDING ACCOUNTS

If your health coverage choice is	You can enroll in the following accounts	Use the accounts to pay for the following	How is the account administered?
Simply Blue PPO HDHP	Health Savings Account (HSA)	Qualified health expenses (for yourself and your tax dependents) that are not covered by the High Deductible (HSA) Plan.	You will be set up with an HSA through WEX. You submit requests for reimbursement to your bank and keep receipts for tax records.
	Limited Purpose Medical FSA	Qualified dental and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	WEX administrates these accounts on behalf of MPHI. MPHI deducts the money from your paycheck on a pre-tax basis and forwards it to WEX. File a claim form with your itemized receipt to receive reimbursement. You can also claim they money in your Medical and Dependent Care FSA by using the WEX debit card.
	Dependent Care Reimbursement Account (DCRA)	Qualified dependent care expenses, such as day care.	
	If <u>not</u> contributing to an HSA: Medical Flexible Spending Account	Qualified medical, dental, and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	
Simply Blue $1000 PPO **OR** **Waiving coverage**	Medical Flexible Spending Account (FSA)	Qualified medical, dental, and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	WEX administers these account on behalf of MPHI. MPHI deducts the money from your paycheck on a pre-tax basis and forwards to WEX. File a claim form with your itemized receipt to receive reimbursement. You can also claim the money in your Medical and Dependent Care FSA by using the WEX debit card.
	Dependent Care Reimbursement Account (DCRA)	Qualified dependent care expenses, such as day care.	

FSA or HSA participants are able to use funds to cover over-the-counter medical products without a prescription. This provision also adds menstrual care products to the definition of “qualified medical expenses”.

What are examples of over-the-counter medical products that are eligible to be reimbursed?

- Cold and flu medications
- Nasal spray or drops
- Pain relievers
- Allergy medication
- Menstrual care products as defined as a tampon, pad, liner, cup, sponge, or similar products used with respect to menstruation
- And more!

YOUR OPTIONS

HEALTH SAVINGS ACCOUNT

When you enroll the Simply Blue PPO High-Deductible Health Plan, you have the option to open a Health Savings Account with WEX. An HSA is a tax-advantaged medical savings account. Like a Health Care Flexible Spending Account (FSA), you pay no federal taxes on your contributions (and, in most states, contributions are also tax-exempt).

You can use funds in your HSA to pay for eligible expenses incurred after the date the HSA is opened. It is possible for this date to be later than your benefits effective date if you delay opening your HSA. Unused funds roll over in your account year over year, so there is no "use it or lose it" requirement with an HSA.

You decide when to withdraw money from your HSA to reimburse yourself for qualified medical expenses. You can either request a disbursement from your account, transfer funds into a personal bank account, or use the debit card that is provided to HSA participants to receive immediate access to funds at the point of service. Or you can choose to pay for your care out-of-pocket until you reach your deductible and/or out-of-pocket maximum—this approach will let your HSA balance grow and earn interest toward future qualified expenses. There does not need to be a qualifying event to make a change to your HSA contribution. **To change your election amount, log onto Employee Self-Service (ESS) anytime of the year, as often as you would like. If you enroll in the Simply Blue PPO High-Deductible Plan, you may be eligible to contribute to an HSA if:**

- You are not enrolled in Medicare
- You are not covered by other health insurance that is not subject to the HDHP limits (such as a spouse's traditional medical plan)
- You have not received VA benefits or certain Indian Health Services at any time over the past three months
- You are not claimed as a dependent on someone else's tax return

2027 HSA Contribution Limits

Your total maximum cannot exceed the IRS indexed statutory maximums below.

	INDIVIDUAL COVERAGE	FAMILY COVERAGE
Employee Maximum Annual Contribution (minimum $100)	$4,500	$9,000
Catch-up	$1,000	$1,000

YOUR OPTIONS

HEALTH SAVINGS ACCOUNT

How Does it Work?

Open an HSA

When you enroll in the HDHP, you may open an HSA.

You can contribute

You are encouraged to contribute to your HSA through payroll deductions, online or by sending a check and contribution form.

Use your HSA

You decide when to withdraw money from your HSA to pay for qualified medical expenses, including your deductible and coinsurance payments. It works just like a bank account!

Or let it grow tax-free

If you'd rather let your HSA grow and earn interest for future qualified expenses, you can let it grow and just pay for your medical costs out-of-pocket.

Rollover unused funds

At the end of the year, your HSA balance will carry over for use to cover future eligible expenses or to grow into an investment.

Key Advantages of an HSA

- Triple tax savings – contributions to an HSA are not taxed, your savings grow tax-free, and the money is tax-free when used to pay for qualified health expenses today or in the future.
- Savings for retirement – start growing the balance in your HSA to help pay for health care expenses during retirement. It's going to cost far more than you imagined.
- Investment opportunities – You can invest your contributions in stocks, mutual funds and other investment vehicles.
- Use your HSA to pay for eligible medical expenses including deductibles, co-insurance, prescriptions, vision, and dental care.
- Unused funds will roll over year to year. There's no "use it or lose it" penalty.
- After age 65, funds can be withdrawn for any purpose without penalty, but may be subject to income tax if not used for IRS-qualified medical expenses.

YOUR OPTIONS

LIFE/AD&D

Basic Life/AD&D

Life and Accidental Death and Dismemberment (AD&D) insurance offers financial protection in the event of your death. MPHI provides Basic Life/AD&D coverage for eligible employees at no cost through UNUM.
The below items are part of your Basic Life/AD&D benefit.

- For you: 2x your annual salary up to a benefit amount, with a minimum of $50,000 and a maximum of $450,000
- For your spouse: $10,000
- For Your Child(ren) (6 months to age 19, 23 if full-time student): $2,000

Your Basic Life and Optional Life insurance benefits reduce to 65% at age 65, 50% at age 70, then 35% at age 75. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled or hospital confined on the date coverage is scheduled to take effect.

Optional Life

Voluntary Life insurance is additional life insurance that you can purchase from Unum for yourself and your dependents at a discounted group rate. The chart below provides an overview of the voluntary benefits being offered.

WHO CAN HAVE IT?	WHAT'S THE BENEFIT AMOUNT?	HOW LONG CAN THEY KEEP IT?
Employee Any full-time employee that is benefit eligible; during the first 30-days of eligibility or open enrollment	In increments of $10,000 of 5x's your annual salary up to a benefit amount of $500,000. **Amounts over $150,000 are subject to medical underwriting**	You can keep the coverage as long as you would like, even if you leave MPHI the coverage can be ported. However, the benefit does reduce at ages 70 and 75.
Spouse Available with purchase of employee coverage during the first 30 days or open enrollment;	In increments of $5,000 up to 100% of the employee benefit amount. **Amounts over $25,000 are subject to medical underwriting**	Your spouse can keep coverage as long as you keep yours, no matter where (or if) you work.
Child Available with purchase of employee coverage for eligible dependent children, which may include stepchildren and legally adopted children, age birth through 23 years.	In increments of $2,000 up to $10,000,	Ends when employee policy ends or when children turn 19 (or 23 if full-time students). At that time, children can purchase an individual policy, not to exceed the original children's benefit amount

YOUR OPTIONS

LONG TERM DISABILITY

Long Term Disability

MPHI offers a Long-Term Disability plan to provide income to employees who are disabled for an extended period. This coverage is insured through Unum. MPHI pays the full cost of this coverage.

FEATURE	DESCRIPTION
Amount	60% of your monthly covered earnings to a maximum monthly benefit of $11,000 per month.
Elimination Period	Benefits for approved claims begin after 90 days for illness or injury.
Benefit Duration	Benefits are payable up to age 65 or longer in some cases. Benefits are limited to 24 months in a person's lifetime for mental/nervous or substance abuse conditions.
Definition of Disability	You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • You have a 20% or more loss in your indexed monthly earnings fur to the same sickness or injury. • You must be under the regular care of a physician in order to be considered disabled.
Pre-existing Condition Definition	You have a pre-existing condition if: • You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; ***and*** • The disability begins in the first 12 months after your effective date of coverage.



YOUR OPTIONS

LONG TERM CARE

Long Term Care

This benefit is only available to employees hired and benefit eligible prior to February 1, 2026. Base coverage for the employee is fully paid by MPHI. Employees may also purchase additional protection for themselves, and for family members. Evidence of Insurability may be required for buy up coverage. Please see the Unum flyers for more details.

FEATURE	DESCRIPTION
Elimination Period	Benefits for approved claims begin after 90 days.
Benefit Period	Three years
Definition of Disability	Loss of two or more Activities of Daily Living (bathing, dressing, eating, toileting, continence, and transferring) or Cognitive Impairment
Employer Paid Base Plan	• Monthly Benefit $3,000 • Assisted Living Facility Benefit $1,800 • Professional Home Care Benefit $1,500 • Facility Benefit Duration 3 years
Medically Underwritten Buy-Up Options	• Facility Monthly Benefit $7,000 or $8,000 • Unlimited Facility Benefit Duration
Employees must already participate in the buy-up option. No new enrollments in the buy-up options are allowed.	

This is only a summary of some of the key terms and conditions found in the insurance policy with Unum. It is not a guarantee of benefits. See the UNUM contract for details. If there are any discrepancies between this Guide and your Unum contract, the policy terms will govern.

ADDITIONAL INFORMATION

BCBSM MEMBER RESOURCES

With Virtual Care by Teladoc Health, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer. Virtual Care is included with your BCBSM health care plan.

24/7 Care

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children. Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need to make an appointment, and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Mental Health

With Virtual Care by Teladoc Health, you can have virtual visits with licensed therapists, psychologists, social workers and counselors, and U.S. board-certified psychiatrists from the comfort of your home at a convenient time. This option provides ongoing support for stressful situations or issues such as grief, anxiety and depression, This is in addition to the 24/7 virtual urgent care you have with Virtual Care. Mental Health visits are available by appointment with many providers offering extended hours, including nights and weekends.

How does it work?

Create an account so you're ready whenever you need care. It doesn't take long, so don't wait until you're sick to set up your account.

- Visit www.bcbsm.com/virtualcare for a link to download the Teladoc Health app. You can also open the BCBSM mobile app, click "Find a Doctor" and then "Virtual Care" or call (800)835-2362.
- You will need your Blue Cross member ID card. Remember to choose your health plan and enter your member ID number when updating or creating your account so your coverage is applied correctly.
- Choose a service: 24/7 Care or Mental Health
- Meet with the doctor or therapist online and get a prescription sent to your preferred pharmacy, if needed.
- At the end of your visit, you'll get a full report to share with your family doctor or other health care providers.

Virtual Care by Teladoc

(previously Blue Cross Medical Online Visits)

Allows members to seek care for non-emergencies with board-certified physicians available 24/7/365 when your PCP is not available .

Telemedicine Medical Online Visits

Allows members to seek care with their providers on a virtual basis versus seeking care in a provider's office includes PCP and Specialists.

Start a visit or sign up today!

Download the Virtual Care by Teladoc app Or Visit www.bcbsm.com/virtualcare You will need your Blue Cross ID card to sign up. Choose your health plan and enter your enrollee ID number

ADDITIONAL INFORMATION

BCBSM MEMBER RESOURCES

BCBSM Mobile App

BCBSM has a mobile app for its participants to use. The app mirrors the member portal but also provide on-the-go enhancements. In addition to 24/7 access, the app will offer participants:

- Access a virtual ID card
- On-the-spot doctor and hospital search
- A personal snapshot of your plan using easy to understand graphics that will provide a quick indication of your deductibles, coinsurance and claims.

As a registered BCBSM.com participant, you will use your current username and password to login. Once you are logged in, you will be able to see all of your medical and vision benefits. To use the mobile app, you will need to register for web access at www.BCBSM.com. Once you are registered, your personal ID stays with you even if you change plans, jobs or retire.

Blue365

BCBSM members can save on a variety of healthy products and services in Michigan and across the United States.

Member discounts with Blue365 offer exclusive deals on things, such as:

- **Fitness and wellness:** Health magazines, fitness equipment and gym memberships
- **Healthy eating**: Cookbooks, classes, and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

View all of the savings in one place through your member account through the mobile app or by logging in at www.blue365deals.com/BCBSMI/join.

Blue Cross Blue Shield Global Core - Healthcare coverage wherever you go

Through the Blue Cross Blue Shield Global Core, formerly BlueCard Worldwide Program, you have access to medical assistance services, doctors and hospitals around the world. You can even look up a provider directory before your trip!

If you need to locate a doctor or hospital, or need medical assistance services, call the BCBS Global Core Services Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. You can also email for assistance at customerservice@bcbsglobalcore.com.

An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

In most cases, you should not need to pay upfront for inpatient care at Blue Cross Blue Shield Global Core hospitals except for the out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance) you normally pay. The hospital should not submit your claim on your behalf.

ADDITIONAL INFORMATION

SUPPORT SERVICES

Health Advocate

The Health Advocate program is available to you, your spouse and dependent children, *as well as your parents and parents-in-law, at no additional cost!*

To support you and your family in navigating the health care system and maximizing your benefits, the services offered by Health Advocate can assist with health care issues and treatment decisions and address time-consuming claims or other concerns.

How does the Health Advocate program work?

Personal Health Advocates can help with a wide variety of concerns, ranging from helping you understand claims and uncovering billing errors, to finding specialists and locating eldercare.

You can work with the same Personal Health Advocate until the issue is completely resolved. Personal Health Advocates are also available to address any follow-up needs. The staff follows careful protocols and complies with government privacy standards. Your medical and personal information is strictly confidential.

Contact Health Advocate

- **Call Toll-free:** (866)695-8622
  Monday-Friday 8am-7pm EST
- **Email**: Answers@healthadvocate.com
- **Visit:** www.HealthAdvocate.com/michiganpublichealth
- **Client Code: B57FYD8**

Evaluating Benefit Plan Options with ALEX

There is a lot to consider when choosing a medical plan for you and your family. That's why we offer ALEX; a helpful online decisions support tool. ALEX is designed to evaluate your health care needs, crunch some numbers and point out what makes the most sense for you, so you can choose the best benefit plan for you and your family.

How long will it take and how should I prepare?

Most users spend about 7 minutes with ALEX, but it really depends on how much guidance you would like. ALEX can save your place, so you don't have to re-enter your information. You can pick up from where you left off. ALEX will ask you to estimate what type of medical care you and your dependents might need throughout the year. These include doctor's visits, surgeries, ER visits and prescriptions.
You will want to think about what you and your family have experienced in the past and use that information to help you answer the questions. If you are having a hard time coming up with estimate, ALEX can help you with that as well.

How does ALEX know what is best and can I trust ALEX with the information I give?

ALEX applies the contribution amounts for each plan and adds the estimated out-of-pocket expenses you would incur based on the information you give ALEX. ALEX will then recommend the least expensive plan for your needs and additional benefits that will help you save money. Your ALEX experience is completely anonymous and private. ALEX does not maintain personal information so he cannot pass it back to anyone, including MPHI.

How can I access ALEX?

You can access ALEX by using any tablet, computer or Smartphone.

ADDITIONAL INFORMATION

SUPPORT SERVICES

HelpNet

HelpNet is available to help you or your family members resolve any personal problem. There are many types of personal problems that affect employees. Some may require only a phone call to the EAP to resolve them. Others may require that you meet in person with a professional for one or more sessions. Contact HelpNet at (800)969-6162.

Your HelpNet EAP Work-Life Website

Your work-life service provides online access to a wide range of resources regarding the work and life topics of interest to you and your family—all available on one website. **Just login to www.bronsonhealth.com/helpnet, click: "WorkLife Login" and enter "MPHI123" for the company code**. You can navigate through articles, links, interactive content, self-searches, self-assessments and much more".

- Self-search provider databases for summer camps, education resources, pet sitters, attorneys, financial advisors, volunteer opportunities, and more
- Legal and medical encyclopedias
- Financial and daily living calculators
- Savings Center providing 25 to 70 percent discounts on name-brand merchandise

Legal, Financial, and ID Recovery Resource and Referrals

When a legal issue, financial matter, or an instance of identity fraud disrupts your life, it can create substantial stress for you and your family. To help minimize the impact, your work-life service offers programs to assist you with managing the many complexities of these events. Through professional consultation, these programs can save you time, while providing valuable information and peace of mind.

Legal Assist:
Provides a free half-hour consultation with an attorney on most legal issues. In most cases, discounted rates are available if further legal representation is required.

Financial Assist:
Provides a free telephonic consultation with a financial professional qualified to advise on a range of financial issues.

ID Recovery:
Provides a free telephonic consultation with an ID recovery professional. The program also provides a 25% discount on Enhanced ID Recovery, whereby the specialist not only provides a consultation, but also handles the paperwork and negotiations on your behalf.

ADDITIONAL INFORMATION

SUPPORT SERVICES

Calm.com

We've partnered with Calm to provide you with tools that can help you meditate, relax, focus, and improve sleep. Now more than ever, it's important that we continue to find ways to manage stress and stay strong in the face of uncertainty. Whether you have 30 seconds or 30 minutes every day, Calm's resources are designed to seamlessly integrate with your schedule and needs.

Your Calm subscription gives you unlimited access to their full library of resources at www.calm.com and in the Calm app.

Here's a sneak peek as to what you can expect:

- Calm's Masterclasses taught by world-renowned experts
- Guided breathing exercises such as the Breathe Bubble
- Music tracks designed to promote focus, relaxation, and sleep
- 100+ guided meditations that cover anxiety, stress, gratitude, and much more
- Brand new daily meditations and movement sessions as part of their Dailies series
- The entire library of Sleep Stories which contains soothing bedtime tales that's suitable for both grown-ups and children (new stories added every week!)

Activate Your Calm Subscription in 4 Steps!

1.Visit this link: www.calm.com/b2b/mphi/subscribe
2.Sign up with your personal email address (or log in to an existing account)
3.Validate your work email address
4. Download Calm on your iOS or Android devices. Alternatively, you can access the web-based version of Calm at www.calm.com!

Care.com

Finding the right care for your family can be hard, especially when you are balancing your personal and work life. MPHI has partnered with Care.com to help working families find and manage care for kids, adults, pets, homes and more. Your premium with Care.com provides you access to the world's largest network of vetted caregivers.

With your membership, employees will have the opportunity to:

- Message caregivers they may be interested in interviewing and hiring, including the private calling feature
- Access to background check options
- Post jobs for the specific services they are looking for
- Through your Care.com membership you also have access to exclusive discounts to goods and services with LifeMart

Activate your Care.com account by visiting www.care.com/yourbenefits. Once you create your account you can download the Care app from the Apple or Google Play store.

ADDITIONAL INFORMATION

ID THEFT

Norton ID

Norton LifeLock Benefit Solutions believe everyone around the world deserves a clear and easy way to live their digital lives safely, privately, and confidently. More than 500 million users globally trust Norton, LifeLock, and the rest of our family of consumer brands. Through our innovative and comprehensive benefit plans, we bring you leading technology solutions in cybersecurity, privacy, and identity protection. Our combined heritage is rooted in providing safety for the first digital generations but with an eye on powering digital freedom and wellness for the next generation of digital life.

All products include: By partnering with Norton, we are able to offer three different options for you to consider and choose the option that best fits your needs. Below is a description of each of the three plans. Listed below that are the monthly contributions to participate in any of the elected plans.

Online Privacy

- Secure VPN
- Data broker scanning and removal assistance (Privacy Monitor)
- Solicitation reduction, ad blocker

Identity Theft Protection

- LifeLock Identity Alert™ System
- Financial protections
- Lifestyle protection
- Social protection
- Protective lock & freeze dashboard

Device Security

- Norton Device Security
- Online threat protection
- Password manager
- Child online safety tools (Parental Controls)

Service & Support

- Restoration & remediation services
- Dedicated phone line and email support
- $3 Million Protection Package

Benefit Essential

All Product Features, Plus:

- 1 Bureau Credit Monitoring +
- 1 Bureau Credit Application Alerts
- 1 Bureau Report & Score (monthly)
- Norton Device Protection (3EE/6FM)

Benefit Premier

All Essential Features, Plus:

- 3 Bureau Credit Monitoring
- 3 Bureau Report + Score
- Monthly Credit Score Tracking
- Norton Device Protection (5EE/10FM)
- Bank Account Takeover Alerts
- New Checking & Saving Application
- Home Title Monitoring

Benefit Premier Plus

All Premier Features, Plus:

- Norton Device Protection (Unlimited)
- Cyber Crime Coverage*
- Norton AntiTrack
- Private Email

	Employee Only	Employee + Family
Benefit Essential	$6.99	$13.98
Benefit Premier	$7.99	$14.98
Benefit Premier Plus	$12.49	$21.48

ADDITIONAL INFORMATION

PET INSURANCE

Pet Insurance

A MetLife Pet Insurance plan helps cover the costs when unexpected accidents or illnesses occur, so nothing gets in the way of caring for your pet when they need it most. You can enroll in MetLife Pet Insurance and feel confident that their health and your wallet are protected if you're faced with an unexpected trip to the vet.

With MetLife Pet Insurance, you can get:

- Flexible insurance plans that can cover the entire pet family with no breed exclusions
- Freedom to visit any U.S. veterinarian and reimbursement up to 90% of the cost of services
- Family plans covering multiple cats and dogs on one policy –a benefit exclusive to MetLife Pet
- 24/7 access to Telehealth Concierge Services for immediate assistance
- Discounts up to 30% and additional offers on pet care, where available
- Optional Preventive Care coverage
- Coverage of previously covered pre-existing conditions when switching providers



Choose the coverage that's right for you.	Download our mobile app.	Visit any U.S. licensed veterinarian or emergency clinic.	Pay the bill within 90 days and send it with your claim documents to us via our mobile app, online portal, email, fax, or mail.	Get a percentage of your money reimbursed by check or direct deposit if the claim expense is covered under the policy.

With MetLife Pet Insurance, pet parents have the **power of choice** to customize their pet insurance to meet their needs.

Essential Needs	**Sophisticated Care**	**Policy Features** where available	**Optional Preventive Care Coverage**
• Accidents and illness • Diabetes • Ear infections • Pancreatitis • Cancer • Hip dysplasia • Cruciate ligament • And more…	• Laser therapy • Holistic care • Acupuncture • Hydrotherapy • IVDD • And more…	• Telehealth • Mortality benefits • Discounts and rewards • Deductible savings • And more…	• Flea and tick • Spay and neuter • Heartworm • Behavioral training • Teeth cleaning • And more…

ADDITIONAL INFORMATION

EAP & TRAVEL ASSISTANCE

Unum Work-Life Balance EAP

When you have questions, concerns or emotional issues surrounding either your personal or work life, there are resources that can help you. Through MPHI's Unum policies, you have unlimited access to consultants by telephone, resources and tools online, and up to three face-to-face visits with counselors for help with a short-term problem.

Master's level consultants can assist you when you need confidential information to:

- Locate childcare and eldercare services.
- Speak with financial experts by phone regarding budgeting, controlling debt, teaching children to manage money, investing for college and preparing for retirement.
- Work through complex sensitive issues such as personal or work relationships, depression and substance abuse. Get advice on how to deal with a conflict between you and a co-worker.
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation. You'll have access to an attorney for state-specific legal information and services. (If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.)

You may contact a professional ***confidentially,*** 24 hours a day. You can also log onto the Work-Life Balance website, to view or request printed information on a variety of topics.

Call (800) 854 – 1446 confidentially 24 hours a day for assistance or log on to www.lifebalance.net
(Username: lifebalance, Password: lifebalance)

Travel Assistance

Travel Assistance through Assist America is also part of the Unum Long Term Disability Insurance benefit. Travel Assistance offers medical assistance to people traveling 100 miles or more away from home. If you, your spouse or dependents experience a medical emergency while traveling, Travel Assistance can help. Services are available for simple to extreme travel emergencies:

- Hospital admission coordination
- Emergency medical evacuation
- Critical care monitoring
- Medical repatriation
- Emergency message service
- Transportation for a friend or family member to join the hospitalized patient Care of minor children
- Emergency trauma counseling
- Prescription assistance
- Assistance in the return of a vehicle
- Legal and interpreter referrals

All services are arranged by Assist America. Medical expenses such as care and treatment in a hospital are paid for by you or your health insurance policy if care received is covered in your policy. Visit www.assistamerica.com or call (**800) 872-1414** to get more detailed information regarding their services. You can download their mobile app off the website so that you have that with you while you travel. If you need their assistance outside of the USA, you can reach them by phone at (**609)986-1234.** Reference number for MPHI employees: **01-AA-UN-762490.**

ADDITIONAL INFORMATION

ADDITIONAL BENEFITS

Retirement Savings Plan

The 403(b) Plan was established to provide employees the potential for future financial security for retirement. Employees have the opportunity to contribute and direct the investment of a portion of their income into a 403(b) retirement savings account on a pre-tax basis or Roth Post-Tax basis. Note: The Roth after-tax if a part of your current 403(b) account and not a separate retirement savings account.

MPHI will automatically contribute 6% of the employee's gross wages into their 403(b) account regardless of whether or not the employee elects to make their own contributions. MPHI will also match the first 2% of the employee's contribution at 100%, allowing for a combined 8% employer contribution maximum.

MPHI partners with Fidelity to administer our 403(b) plan. Currently, the IRS allows employees to contribute up to $24,500 on an annual basis (does not include employer contribution). The 2027 maximum catch-up contribution for participants age 50 and over is $8,000.

Complete details of the 403(b) Plan, including eligibility requirements, are described in the Summary Plan Description provided to eligible employees.

Tuition Reimbursement

MPHI will provide tuition reimbursement to all Regular Full-Time employees immediately upon hire. To maintain eligibility, employees must remain on the active payroll and remain classified as a Regular Full-Time employee.

A Request for Tuition Reimbursement Funds form must be completed in advance and must be approved by the Human Resources and Payroll & Benefits departments.

Seventy five percent of the eligible expenses will be reimbursed, upon documented successful completion (i.e. grade "C" or better, or "pass" if a pass/fail course), up to $4,000 per calendar year per employee.

For classes that overlap calendar years, these expenses are applied to the year in which the class ends. Individual course or courses that are part of a degree must be related to the employee's current job duties or a foreseeable future position in the organization in order to be eligible for tuition reimbursement.

Please refer to the Summary Plan Description for additional information.

Employee Assistance Program (EAP)

MPHI offers two EAP options, Unum and HelpNet. They both provide similar services, helping you to manage stress and deal with personal and family issues ranging from everyday to severe.

- **Health Resources**
- **Financial Issues**
- **Child Care and Elder Care**
- **Education & Schooling**
- **Legal Issues Addiction & Recovery**

Both the HelpNet and Unum WorkLife Balance programs are available to you and your family members at no additional cost.

LEAVES & TIME OFF

PAID TIME OFF

MPHI Recognized Holidays

• New Years Day	• Veterans Day
• Martin Luther King Day	• General Election Day (observed in even numbered years)
• President's Day	• Thanksgiving Day
• Memorial Day	• Friday Following Thanksgiving
• Juneteenth	• Day Before Christmas Day
• Fourth of July	• Christmas Day
• Labor Day	• Day before New Years day

Employees shall receive holiday pay, provided the employee works their scheduled work day immediately prior to and following the holiday. Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

Vacation Leave

Years Worked	**Vacation Leave Accrued**	**Maximum Number of Accumulated Hours**
0 - 2 years	2 weeks per year – 3.08 hours/pay	160
After 2 years	3 weeks per year – 4.62 hours/pay	160
After 4 years	4 weeks per year – 6.15 hours/pay	160
After 15 years	4.5 weeks per year - 6.92 hours/pay	180
After 20 years	5 weeks per year - 7.69 hours/pay	200
After 25 years	5.5 weeks per year - 8.46 hours/pay	220
After 30 years	6 weeks per year - 9.23 hours/pay	240

Regular Full-Time employees working less than 40 hours per week will accumulate Vacation Leave on a pro-rata basis. Please reference the MPHI Employee Handbook for additional information regarding Paid Time Off.

PAID TIME OFF, CONT.

Sick Time

MPHI provides paid sick leave benefits for periods of temporary absence due to illness or injury. Regular Full-Time employees working 40 hours per week shall accumulate .93 hours of sick leave per bi-weekly pay period. Regular Full-Time employees working less than 40 hours a week will accumulate Sick Leave on a pro-rata basis. A maximum of 520 hours may be accumulated. See MPHI Employee Handbook for additional information.

Paid Medical Leave Benefits

All full-time employees will receive 72 hours of paid medical leave benefits on January 1st of each calendar year. Part-time employees will receive a proportional amount that reflects the part-time employee's expected hours in comparison to full-time status.

Paid medical leave benefits can be used for the following reasons;

(1) For a mental or physical illness, injury, or health condition of the employee or the employee's family member; or for the medical diagnosis, care, or treatment of such a condition

(2) For preventative medical care for the employee or the employee's family member

(3) For medical or psychological care, victim services, relocation, or legal proceedings, related to domestic violence or sexual assault against the employee or the employee's family member

(4) For meetings at a child's school or place of care related to the child's health or disability, or the effects of domestic violence or sexual assault on the child

(5) If a public official has ordered the employee's primary workplace to close due to a public health emergency

(6) If the employee needs to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency

(7) If health authorities or a health care provider has determined that the presence of the employee or the employee's family member in the community would jeopardize the health of others because the employee or the employee's family member has been exposed to a communicable disease.

See MPHI Employee Handbook for additional information.

Personal Time Leave

Regular Full-Time employees working 40 hours per week who are active on payroll as of December 31st will be granted 3 days of Personal Leave for the following calendar year, credited on January 1st.

New employees are granted Personal Leave on a prorated basis based on their month of hire.

- Employees hired between January 1st and April 30th receive 2 Personal Leave days.
- Employees hired between May 1st and August 31st receive 1 Personal Leave day.
- Employees hired on or after September 1st will be eligible for Personal Leave days as of January 1st of the following year.

Regular Full-Time employees working less than 40 hours per week will accumulate Personal Leave on a pro-rata basis. Please reference the MPHI Employee Handbook for additional information regarding Paid Time Off.

PAID TIME OFF, CONT.

Parental Leave

Twelve weeks of paid parental leave will be available to regular full-time employees, who have completed 12 months of continuous employment, immediately after the birth or placement of a child (17 years or younger) for adoption. Regular full-time employees employed less than 12 months will receive four weeks of paid parental leave immediately after the birth or placement of a child (17 years or younger) for adoption. Employees may be asked to provide documentation of the birth or adoption.

Full-time regular employees working less than 40 hours per week as specified in their current appointment letter shall be allowed parental leave time proportional to the amount of time regularly employed. All other employment categories are not entitled to parental leave.

This benefit runs concurrently with FMLA and may only be used once per a 12-month period. Intermittent leave requires advance supervisor approval and may be an option for paternal/adoption leave, or if the employee has been released to return to work by their doctor. Adoption of children related by marriage is not a qualifying event for this benefit.

Jury Duty

All MPHI employees are eligible for jury duty pay. To receive jury duty pay, employees must show the jury duty summons to their supervisor as soon as possible so the supervisor may make arrangements to accommodate their absence. Employees are expected to report for work whenever the court schedule permits.
If the employee is serving over 80 hours of jury duty, the employee will be required to submit the jury duty fee, less mileage, with the Payroll & Benefits Department in order to receive jury duty pay. Either MPHI or the employee may request an excuse from jury duty if, in the MPHI's supervisor's judgment, the employee's absence would create serious operational difficulties.
*Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

Bereavement Leave

A maximum of five days of paid bereavement leave may be utilized per event, in addition to sick time, for attendance at the funeral of an employee's: father; mother; step-parent; spouse; child; or step-child. Three days of paid bereavement leave may be utilized per event, in addition to sick time, for attendance at the funeral of an employee's: sister; brother; grandparent; grandchild; father-in-law; and mother-in-law. Bereavement leave must generally be taken in the days leading up to and immediately following the funeral.

A maximum of five days of sick leave may be utilized per event for attendance at a non-immediate family member's funeral, only upon specific permission from the supervisor in each case. Additional unpaid time off may be granted at the discretion of the supervisor. The supervisor is to be notified immediately of a death in the family and the extent of the employee's expected absence.

*Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

*Please refer to the employee handbook for state specific leave types.

FMLA

FMLA Administration

Unum manages our leaves under the Family and Medical Leave Act (FMLA), state leave laws and corporate leave policies.
We have chosen Unum because they have a dedicated team of highly-trained specialists who are well-versed in claims management, FMLA regulations and state leave laws. Unum is committed to excellent customer service and makes the process of reporting an absence simple by allowing you to report a claim or leave by telephone.

When to Call UNUM:

- When you are unable to work due to illness, injury or pregnancy.
- When you need to be absent from work to care for a family member who has a serious health condition.
- When you need to care for a child due to birth, adoption or foster care placement.
- When you need to be absent from work for a qualifying exigency leave because your spouse, son, daughter or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, child, parent or next of kin undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for a serious illness or injury incurred or aggravated in the line of duty on active duty in the Armed Forces (includes the National Guard or Reserves). This includes a veteran who was discharged from the Armed Forces for reasons other than dishonorable within the 5 year period before the employee's first day of leave.
- When you need any other type of leave that may be covered by applicable state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for you or your family member, or the expected birth, adoption or foster care placement of a child.

What to do Next:

- Notify your manager or supervisor of your absence from work.
- **Contact Human Resources directly by phone or by emailing HR@MPHI.org.** You will receive detailed instructions on how to submit your FMLA claim with UNUM as well as additional instructions.

Please be prepared to provide the following information to UNUM when you submit your claim/leave:

- Name of the company where you work
- Your name and Social Security number or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)

Please be prepared, if filing for a leave, your employer must provide you a minimum of 15 days from the date the leave is filed to complete the certification of healthcare provider form. If eligible, this form will be mailed in your initial leave packet within 2 business days of filing your leave.

LEGAL NOTICES

IMPORTANT NOTICES

Qualified Changes in Status/Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation. These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change. *These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.*

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment in Michigan Public Health Institute (MPHI) group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.
To request special enrollment or obtain more information, contact the Payroll and Benefits Department.

LEGAL NOTICES

IMPORTANT NOTICES

Protecting Your Privacy Protecting Your Privacy

The Michigan Public Health Institute Welfare Benefits Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Payroll and Benefits Department.

Women's Health and Cancer Rights Act of 1998

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call the Customer Service number on your member identification card.

Summary of Material Modification

The information in this document and in the benefit guide applies to the Michigan Public Health Institute Welfare Benefit Plan, Plan Number 501.This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

Benefit Enrollment Communications Disclosure

The benefit enrollment communications (the Benefit Guide, the Health and Welfare Benefits Notices, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Michigan Public Health Institute reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

LEGAL NOTICES

IMPORTANT NOTICES

Important Notice from MPHI
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 Michigan Public Health Institute 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. **Michigan Public Health Institute has determined that the prescription drug coverage offered by the Michigan Public Health Institute Welfare Benefits Plan is, 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 while enrolled in Michigan Public Health Institute coverage as an active employee, please note that your Michigan Public Health Institute coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Michigan Public Health Institute coverage as a former employee.

You may also choose to drop your Michigan Public Health Institute coverage. If you do decide to join a Medicare drug plan and drop your current Michigan Public Health Institute coverage, be aware that you and your dependents may not be able to get this coverage back.

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 **Michigan Public Health Institute** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

LEGAL NOTICES

MEDICARE PART D NOTICE

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 Michigan Public Health Institute 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 www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	September 2026
Name of Entity/Sender:	MPHI
Contact--Position/Office	Payroll and Benefits Department
Address:	2436 Woodlake Circle, Suite 300 Okemos, MI 48864
Phone Number:	(517) 324-8300

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).

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 1-678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/hip/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicai	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov/
Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

Benefit summaries

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MPHI
0070122320000
Simply Blue℠ PPO LG
Effective Date: On or after January 2027
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Prior authorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

155050%CRXCMLG;ADM PLANYR JAN;HC (A) LG;INFS LG;PDRX LG;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-MTC $30 LG;SB-OCSM-24 LG;SB-OT-60 LG;SBD-IN 1K/2K LG;SBD-ON 2K/4K LG;SBOPM IN $8150;SBOPM ON $16300;SBTCP305060250L

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations with a **primary care physician** • $30 copay for **virtual primary care** visits • $50 copay for office visits and office consultations with a **specialist** • $30 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $60 copay for urgent care visits	• $250 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.

155050%CRXCMLG;ADM PLANYR JAN;HC (A) LG;INFS LG;PDRX LG;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-MTC $30 LG;SB-OCSM-24 LG;SB-OT-60 LG;SBD-IN 1K/2K LG;SBD-ON 2K/4K LG;SBOPM IN $8150;SBOPM ON $16300;SBTCP305060250L

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$8,150 for one member, $16,300 for the family (when two or more members are covered under your contract) each calendar year	$16,300 for one member, $32,600 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note:** This includes mental health and substance use disorder services equivalent to medical office visits. **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• $30 copay for each office visit with a **primary care physician** (in person or virtual) • $30 copay for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor • $50 copay for each office visit with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$30 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	• $30 copay for each office consultation with a **primary care physician** • $50 copay for each office consultation with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	$60 copay for each urgent care visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted)	$250 copay per visit (copay waived if admitted)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods -provided through a **participating** hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home healthcare: • must be medically necessary • must be provided by a **participating** home healthcare agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization- consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100%(no deductible or copay/coinsurance) in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your Physician Office Services.

Benefits	In-network	Out-of-network
Inpatient mental healthcare and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental healthcare: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	80% after in-network deductible	80% after in-network deductible
• Online visits - for services equivalent to a medical online visit **Note:** Online visits by a non-BCBSM selected vendor are not covered.	$30 copay per online visit	60% after out-of-network deductible
• Physician's office **Note:** For services equivalent to a medical office visit. See "**Physician Office Services**".	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	$30 copay for each office visit	60% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible	60% after out-of-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	80% after in-network deductible	60% after out-of-network deductible

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Preferred Rx Program LG
Effective Date: On or after January 2027
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

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Benefits		90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $30 copay	No coverage	No coverage
	84 to 90-day period	You pay $30 copay	You pay $30 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay $50 copay	You pay $50 copay	You pay $50 copay	You pay $50 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $100 copay	No coverage	No coverage
	84 to 90-day period	You pay $100 copay	You pay $100 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	84 to 90-day period	You pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	You pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
Generic specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay $15 copay **Note:** No coverage for 31-90 day supply.			
Preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay $50 copay **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100 **Note:** No coverage for 31-90 day supply.			

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.
* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers.

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Covered services

Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Maximum allowable cost drugs	For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Hearing Care Coverage
Effective Date: On or after January 2027
Benefits-at-a-glance

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Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid)- one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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Blue Cross Blue Shield of Michigan

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Simply Blue℠ HSA PPO with Rx
Effective Date: On or after January 2027
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Prior authorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,500 for a one-person contract or $5,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$5,000 for a one-person contract or $10,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$4,000 for a one-person contract $8,000 for a family contract (two or more members) each calendar year	$8,000 for a one-person contract $16,000 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits	In-network	Out-of-network
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the Same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• 100% after in-network deductible for each office visit (in person or virtual) • 100% after in-network deductible for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM-selected vendor	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible
Home healthcare: • must be medically necessary • must be provided by a **participating** home healthcare agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental healthcare and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility: • covered mental health services must be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental healthcare: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	100% after in-network deductible	100% after in-network deductible
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	100% after in-network deductible	80% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.

Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	100% after in-network deductible	80% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	100% after in-network deductible	80% after out-of-network deductible
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	100% after in-network deductible	80% after out-of-network deductible

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Simply Blue℠ HSA PPO with Rx LG
Effective Date: On or after January 2027
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

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Benefits		90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $15 copay	After deductible is met, you pay $15 copay	After deductible is met, you pay $15 copay	After deductible is met, you pay $15 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $30 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $30 copay	After deductible is met, you pay $30 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	After deductible is met, you pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	After deductible is met, you pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
Generic specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $15 copay **Note:** No coverage for 31-90 day supply.			
Preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $50 copay **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay $70 or 50% of the approved amount (whichever is greater), but no more than $100 **Note:** No coverage for 31-90 day supply.			

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.
* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers.

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Covered services

Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty

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Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Maximum allowable cost drugs	For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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MICHIGAN PUBLIC HEALTH INSTI
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Hearing Care Coverage
Effective Date: On or after January 2027
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Member's responsibility (deductible and copay/coinsurance)

Benefits	Participating provider	Nonparticipating provider
Deductible **Note**: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage **before** using your hearing care benefits.	**Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage.** Hearing care benefits are **not** payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Coinsurance	**Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.**	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid)- one every 36 months	100% of approved amount after Simply Blue HSA deductible	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group #12224-0001, 9999
Michigan Public Health Institution

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Major Restorative Services – crowns	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to prosthetic appliances	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	through age 18 and under		

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

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.

- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 19 and under. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids, and bicuspids once per tooth in any five-year period for people age 12 and older when necessary due to fracture or decay.
- Composite resin (white) restorations are payable on all teeth, including posterior teeth.
- Metallic inlays are Covered Services.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $2,000 per Member total per Benefit Year on all services except orthodontic services. $2,000 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following the date of hire.

Eligible People – All full-time employees of the Contractor working at least 30 hours per week who choose the dental plan and all Enrollees who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar non-preempted state law ("COBRA").

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and Dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which your employment is terminated.

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Effective Date: 01/01/2026

Vision Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $50 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	

Benefits	VSP network doctor	Non-VSP provider
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

Contact Information

Provider	Benefit	Type of Contact	Contact Information
BCBSM	Medical	Claim and eligibility questions	(877)354-2583 www.bcbsm.com
		Locating a provider	www.bcbsm.com
		Virtual Care	(844)606-1608 www.bcbsm.com/virtualcare
		General Pharmacy Questions	(877)354-2583 OptumRx: (855)811-2223
		PillarRx	(636)614-3126
	Vision	To locate a provider	(800)877-7195 www.vsp.com
Delta Dental	Dental	Claim and eligibility Questions	(800) 524-3032 www.deltadentalmi.com
WEX	Flexible Spending & Health Savings Accounts	All Issues	(866)451-3399 www.wexinc.com
Unum	Life, Disability & LTC	Claim and Service Questions	(800)421-0344 www.unum.com
	FMLA	Claim and Service Questions	(888)873-9940 www.unum.com
Health Advocate	Health Advocacy Program	All Issues	(866) 695-8622 www.HealthAdvocate.com membersanswers@healthadvocate.com
Unum LifeBalance	Employee Assistance Program (EAP)	All issues	(800) 854-1446 www.unum.com/worklifebalance
HelpNet	Employee Assistance Program (EAP)	All issues	(800) 969-6162 www.bronsonhealth.com/helpnet
Calm.com	Employee Resource	All issues	www.calm.com www.calm.com/b2b/mphi/subscribe
Care.com	Employee Resource	All issues	www.care.com
Unum Assist America	Travel Assistance Program Reference #: 01-AA-UN-762490	Within the U.S.A. Outside the U.S.A. Website	(800) 872-1414 (609) 986-1234 www.assistamerica.com
Fidelity	403(b)	Customer Service	(800) 343-0860 www.fidelity.com