2026 health care plan options

A BENEFIT COMPARISON GUIDE FOR BARGAINING UNIT EMPLOYEES

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EMERGENT HOLDINGS

Dear Colleagues,

Our annual health care open enrollment is a chance for you to make the best benefit decisions for you and your family for the 2026 plan year. This year's open enrollment period will be held November 10 – December 1. This window provides an opportunity for employees to choose their medical, dental and vision benefit plans. LifeSecure will continue to offer optional products. These products are offered on a voluntary basis and are not part of your employer-sponsored benefit package. Additional details can be found in this booklet.

For 2026, no changes to employee premium sharing for the medical, dental and vision plans, per the conditions outlined in the Collective Bargaining Agreement. The employer contribution for those who enroll in the Simply Blue Health Savings Account (HSA) will remain the same. The contribution amount can be found in this booklet. We encourage you to look for more information via webinars and in your open enrollment materials to help you learn more above how to maximize the employer contribution and grow your savings.

When you are well, you can thrive at work and beyond. We're committed to supporting your health and wellbeing, and we offer a range of programs to help you take ownership of it. We'll continue to offer employees the opportunity to participate in our corporate wellness program, The Well. We encourage you to participate in the live, weekly well-being webinars and access downloadable health resources through **Blue Cross Virtual Well-Being**. The program provides employees with a convenient way to prioritize their personal well-being. Additional details can be found in this booklet.

As in prior years, you'll make your benefit elections through the Oracle Cloud HR self-service system. If you don't take action, you'll be automatically enrolled in the 2026 plan that most closely matches your 2025 election. Be sure to review your open enrollment materials, including your default elections and confirmation statement, and make any updates before the enrollment deadline.

Selecting the right coverage for you and your family is an important decision, and several resources are available to assist you with your open enrollment elections. These include a dedicated open enrollment webpage, webinars and enhanced educational resources and decision-making tools.

Our health plans include a wide range of behavioral health services, along with access to the employee assistance program, to support your mental and emotional wellbeing whenever you need it. Blue Cross EAP provides 24/7 confidential services to you and eligible members of your household whenever a need arises. Call 877-674-3133 (888-307-0539 in Canada) or visit their **website**.

We're focused on offering high-quality and affordable benefits that work for you and your family and encourage you to review the available resources before finalizing your 2026 choices.

Laura Byars
Senior Vice President,
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Senior Vice President
Human Resources, Emerging Markets

Questions or concerns? Don't hesitate to contact us!

Employee Benefits
Email: **hrrequest@emergentholdingsinc.com**
Phone: **517-708-5400**

For claim questions:
BCBSM products, call the Employee Inquiry Unit at **1-888-288-1718**
BCN products, call the Ombudsman at **1-888-265-4703**

Open enrollment key dates

Open enrollment period:	November 10 - December 1, 2025
All elections due by:	11:59 p.m., Monday, December 1, 2025
Effective date of elections:	January 1, 2026

2026 Benefit highlights and changes

- If you choose to enroll into the Simply Blue HDHP, the HSA annual contribution limit for employer and employee combined has increased to $4,400 for individual and $8,750 for family. If you would like to contribute to the HSA, **you must re-enroll**.
- The Simply Blue HDHP in-network deductible has increased to $1,700 for single and $3,400 for family. The out-of-network deductibles were also increased. These plan design changes align to the minimum level required by the IRS for high-deductible health plans and are needed to maintain HSA compatibility. Employees who continue to be enrolled in this coverage in 2026 will receive an updated ID card due to these deductible increases.
- If you would like to have the Dependent Care or Health Care Flexible Spending Account, **you must re-enroll**.
- EH will be offering the same three medical, two dental and one vision plans that were available in 2025.
- Teladoc Chronic Condition Support will continue to be offered for diabetes, prediabetes and hypertension at no additional cost if you or your dependents are enrolled in a BCBSM or BCN employer health care plan and meet the specific health criteria.
- The Exclusive Specialty Network is being added to the Simply Blue HDHP and Simply Blue PPO plans in which requires members to fill prescriptions for specialty drugs at Walgreens Specialty Pharmacy or a Walgreens retail store. Members who don't use the Exclusive Specialty Network may be responsible for the full cost of their specialty medications. Impacted members will receive notification from BCBSM in November on actions needed to ensure specialty medications are filled in 2026. Additional information can be found within the **Specialty Drug Program Benefit Member Guide**.
- Enhanced educational resources, decision making tools and helpful links are now available to assist you in making the best benefit enrollment decisions for you and your family. A dedicated 2026 Open Enrollment web page is available where you can find:
  - On-demand product overview videos
  - Links to virtual open enrollment fairs, benefits booklets, and more
  - Quick answers to simple questions
- Opportunity to participate in live weekly well-being webinars and access downloadable health resources through Blue Cross Virtual Well-Being.

Learn before you choose

Calendar of events

Several resources will be available to assist you in making your enrollment decisions. These resources include a dedicated 2026 Open Enrollment webpage, webinars, enhanced educational resources and decision-making tools. Please take a look at the open enrollment calendar of events below to make sure you don't miss any opportunities to learn more about your options.

November 2025

Monday	Tuesday	Wednesday	Thursday	Friday
3	4 HSA educational webinar: Level up your HSA 1 to 1:30 p.m. Register Here	5	6 Benefits explained: FSA and DCFSA 1 to 1:30 p.m. Register Here	7
10 Open Enrollment Begins	11	12 2026 BU Benefits Overview Noon –1 pm Register Here	13	14

December 2025

Monday	Tuesday	Wednesday	Thursday	Friday
1 Open Enrollment Closes	2	3	4	5

January 2026

Monday	Tuesday	Wednesday	Thursday	Friday
			1 Coverage Effective Date	2

Health plans at a glance

Simply Blue HSA

Simply Blue HSA pairs a PPO health plan with a health savings account (HSA). It combines the comprehensive benefits and provider network of a PPO plan with a valuable saving tool to set aside money for health care expenses today, tomorrow and in retirement.

	Employee cost per pay	Annual deductible	Annual out-of-pocket maximum
Employee only	$0	$1,700	$2,700
Employee + spouse	$0	$3,400	$5,600
Employee + child(ren)	$0	$3,400	$5,600
Family	$0	$3,400	$5,600

Annual deductible and out-of-pocket maximum refer to in-network coverage only. For out of network figures please see the table on page 8. To calculate what you can contribute to your HSA, deduct the applicable annual employer contribution listed above from the applicable annual limit on page 5 to make sure the IRS annual limit is not exceeded.

BCN Healthy *Blue* Living HMO

The BCN Healthy *Blue* Living HMO plan combines BCN's HMO network coverage with a wellness incentive health care plan for members committed to living a healthy lifestyle. Members are required to designate a primary care physician (PCP) upon enrollment. Within 90 days of enrollment, subscribers are required to complete the online Health Assessment, and meet with their PCP to have a qualification form completed. Subscribers that meet required health measure levels OR follow the doctor's treatment plan will be enrolled in the Enhanced plan and rewarded with lower out-of-pocket costs.

	Employee cost per pay	Annual deductible	Annual out-of-pocket maximum
Employee only	$4.00	$0.00	$1,250
Employee + spouse	$8.00	$0.00	$2,500
Employee + child(ren)	$8.00	$0.00	$2,500
Family	$12.00	$0.00	$2,500

Annual deductible and out-of-pocket maximum refer to enhanced coverage only. For standard plan figures please see the table on page 8.

Simply Blue PPO $500

The Simply Blue PPO $500 plan is Blue Cross Blue Shield of Michigan's standard PPO medical plan. Members enrolled in the Simply Blue PPO $500 plan are free to utilize any medical provider they choose when the need for medical services arises. Members will pay the lowest cost if their chosen provider is in BCBSM's PPO Network. BCBSM's PPO Network consists of 95% of all providers in Michigan, and 80% of all providers and 90% of all hospitals nationwide.

	Employee cost per pay	Annual deductible	Annual out-of-pocket maximum
Employee only	$8.00	$500	$1,250
Employee + spouse	$16.00	$1,000	$2,500
Employee + child(ren)	$16.00	$1,000	$2,500
Family	$24.00	$1,000	$2,500

Annual deductible and out-of-pocket maximum refer to in-network coverage only. For out of network figures please see the table on page 8.

How to enroll online

Annual open enrollment is your once-a-year opportunity to make changes or selections for the 2026 benefit plan year. Review your current elections, covered dependents and available options for 2026 closely. You must make your elections online beginning November 10 through December 1, 2025 by 11:59 p.m.

How to enroll using an "Emergent Holdings" computer:

1. Access the Benefits Enrollment system at **https://intranet.cobx.com/**.
2. Click on *Oracle Cloud (OneFusion)*.
3. Click *Company Single Sign-On*.
4. Click on *Home* in the upper right hand corner.
5. Click on *Benefits*.
6. Click on *Enroll Now*.
7. Before you enroll, choose how you want to enroll, verify and add additional people you'd like to cover on your benefits or as a beneficiary and then select *Edit* under enroll in benefits that matter to you.
8. Once all of your enrollment choices have been made, click on *Submit* to finalize the process. If you do not submit, your enrollment will not be processed and your 2025 benefits will remain except as indicated in this booklet.

Using a "non Emergent Markets" computer:

You can also use Oracle Cloud from a non company issued computer during open enrollment to select benefits for the upcoming year. Follow these steps to complete the multifactor authentication process:

1. Enter the following into your browser: **https://ejko.fa.us2.oraclecloud.com** or scan the QR Code:
2. Click the *Company Single Sign-On* button.
3. Enter your Company Email address and Network Login Password, then click on *Sign In*.
4. Click on the *Setup* button under the *SMS Authentication* section.
5. Enter the Phone Number for the mobile device where the Authentication Code should be sent, then click the *Send Code* button.
6. Once you receive the Authentication Code enter it in the *Enter Code* field, then click the *Verify* button.
7. Confirm that your multifactor authentication has been set up, then click the *Finish* Button. You will be logged in to the website.
8. Continue with steps 4 through 8 (under Using a "Emergent Markets" computer) to complete the enrollment process. Each subsequent time you need to connect, follow the steps above and request a new code. Enter the new code sent to your mobile device, then click the *Verify* button and you will be logged in.

If you do not make an election during this open enrollment period…

If you do not take action during the 2026 open enrollment period or if you do not submit your changes by the deadline, the default plans below will apply for you and your enrolled dependents for 2026.

Current 2025 plan	Default plan for 2026
Medical plan	2025 election
Simply Blue HSA employee contributions	No account
Dental/Vision	2025 election
Dependent Care Reimbursement Account	No account
Health Care FSA	No account

Spending accounts

Does a Health Savings Account or Dependent Care Flexible Spending Account make sense for you?

Health Savings Account

"Having a Health Savings Account (HSA) has been a game-changer for my family over the past 8.5 years that I have been with the company. The HSA's absence of premiums has helped ease any financial burden on our family, allowing us to save and invest our money, rather than spending it on higher cost plan options. We have been able to save funds in our HSA to ensure that we have financial security for any future medical expenses. In fact, we have had a couple years where we had several unexpected medical expenses and without the HSA, we would have lost focus on addressing the medical conditions and thought about what financial burden we may incur. Speaking of maintaining our well-being, we have peace of mind also knowing that we can prioritize preventive care because essential services like annual physicals and well women exams are covered at no cost! Overall, opting for an HSA not only helps my family manage costs but also empowers us to make informed healthcare decisions for our family's long term physical and financial health!"

EH Employee (2025)

Dependent Care Flexible Spending Account

"The dependent care FSA helps my family set aside an amount each month tax free to pay for my daughter's summer camp. It is a great way to help save money and budget costs for other families that have preschoolers, before and after school childcare expenses and even registration fees."

EH Employee (2025)

Healthcare Flexible Spending Account

"Utilizing the HCFSA account is one of the smartest decisions I've made when it comes to managing my healthcare costs. The Health Equity app is super user friendly and makes tracking and the reimbursement process easy."

EH Employee (2025)

2026 contribution limits

Account type	Single coverage	Family coverage (2 or more)	Over 55 catch-up
HSA	$4,400	$8,750	+ $1,000
Dependent Care FSA	$7,500	$7,500	N/A
Healthcare FSA	$3,300	$3,300	N/A

EH reserves the right to make adjustments to your Health Savings Account (HSA) employee contribution deduction amount through payroll when you reach the IRS HSA contribution limit. By enrolling in the HSA, you agree to allow EH Health and Wellbeing Benefits to adjust your HSA payroll deduction amount to prevent you from exceeding the IRS HSA limit. If your HSA payroll deduction is stopped by the Benefits team, your final deduction may differ from your previous deductions. Also, be aware that if you make contributions to your HSA outside of your payroll deduction, you could also exceed the HSA limit.

Dependent Care Flexible Spending Account (DCFSA)

Learn about saving pre-tax dollars for dependent care expenses

(Please note: This benefit is not available to COBRA participants.)

Features and Highlights:

- The Dependent Care Reimbursement Account (also known as a Dependent Care Flexible Spending Account (DCFSA)) allows you to set aside **tax-free dollars** for out-of-pocket costs associated with eligible dependent care expenses. By participating in this account, you do not pay Federal, State, and Social Security taxes on the qualifying dollars you contribute.
- You determine how much you want to contribute to the account for the plan year. You may contribute an annual maximum of $7,500 per family.
- The contributions are deducted from your pay before taxes are calculated and your annual contribution is withheld in equal amounts from your paychecks.
- You then incur and submit expenses for reimbursement. The reimbursement is also pre-tax.
- **The run-out period for submitting eligible expenses is March 15, 2027 or 60 days after an employee's termination or loss of eligibility**. Expenses must have service dates in 2026 or during active employment.
- **You must enroll in this benefit for the 2026 plan year, even if you are a current participant!**

Eligible expenses must meet these requirements:

Expenses that qualify for reimbursement under the Plan must meet these requirements:

- The services provided enable you (and your spouse, if married) to be gainfully employed.
- If you are divorced, you have custody of your child(ren) **and** you pay for their childcare. Eligibility is not determined by parental tax exemption.
- The services are provided for your eligible dependent(s). This includes children under age 13, physically or mentally impaired children age 13 or older, and/or a disabled spouse, or dependent parent residing in your home.
- The amount to be reimbursed is not greater than your income, or that of your spouse, whichever is lower.
- For a complete list of eligible expenses go to **https://healthequity.com/qme**.

Eligible providers:

Providers that qualify under this plan include, but not limited to:

1. Babysitters
2. Licensed facilities and latchkey programs
3. Day care centers
4. Relatives that are not a tax dependent

The IRS requires that you provide the Social Security or Tax Identification number of the dependent care provider. You need to provide this number on **Form 2441** – "Child and Dependent Care Expenses" and attach it to your Federal Income Tax return. Your W-2 will reflect the total benefits provided for the taxable year.

IRS regulation:

Your decision to participate is a binding election for the plan year, January 1 – December 31, 2026. Federal law governing flexible benefits specifies that any funds remaining in your account at the end of the year will be forfeited.

Important:
If you terminate employment from EH, or lose eligibility during the plan year, you will have 60 days from the date of termination or the loss of eligibility to submit your claims.
Services must be from a date in which you were an active employee or prior to loss of eligibility.

Flexible Spending Account (FSA)

Learn about saving pre-tax dollars for healthcare expenses

(Please note: This benefit is not available to those enrolled in Simply Blue HSA.)

Features and highlights:

- A Healthcare Reimbursement Account (also known as a Flexible Spending Account (FSA)) allows you to set aside tax-free dollars for out-of-pocket costs associated with eligible healthcare expenses. By participating in this account, you do not pay Federal, State, and Social Security taxes on the qualifying dollars you contributed.
- You determine how much you want to contribute to the account for the plan year. You may contribute an annual maximum of $3,300.
- The contributions are deducted from your pay before taxes are calculated and your annual contribution is withheld in equal amounts from your paychecks.
- You then incur and submit expenses for reimbursement. The reimbursement comes out of your FSA and is also on a pre-tax basis.
- Any dollars not reimbursed by year-end 2026 can be used in 2027 for reimbursements for eligible expenses with service dates through March 14, 2027.
- Any 2026 dollars not reimbursed for eligible expenses with service dates through March 14, 2027 will be forfeited.
- **The run-out period for submitting eligible expenses is 60 days after March 14, 2027 or 60 days after an employee's termination or loss of eligibility. Submitted expenses must have service dates prior to March 15, 2027 or during the time of active employment or eligibility to qualify for reimbursement.**
- **You must enroll in this benefit for the 2026 plan year, even if you are a current participant!**

FSA debit card information:

You will also receive a Visa debit card from HealthEquity, which you may use to pay for your healthcare expenses at point of service. However, please note it's important to keep your invoice, receipt, and/or Explanation of Benefits from BCBSM, as you must submit this information to HealthEquity to substantiate the FSA claim.

Debit cards will automatically be sent to those who are enrolling in the FSA. The debit card is usable for 3 years. Grace period claims can be uploaded to your HealthEquity member portal for reimbursement.

Eligible expenses:

Eligible medical, dental, and vision expenses not reimbursed by insurance plans are eligible. Generally, these are the same types of services you could deduct on your individual income tax return. Some examples of eligible expenses are:

1. Office visit and prescription drug copays
2. Deductible, copay and coinsurance responsibilities
3. Contacts/eye glasses

Important:
If you terminate employment from EH, or lose eligibility during the plan year, you will have 60 days from the date of termination or the loss of eligibility to submit your claims. Services must be from a date in which you were an active employee or prior to loss of eligibility.

For a complete list of eligible expenses go to **https://healthequity.com/qme**.

2026 health care premium sharing

The charts below provide the total per pay cost for all bargaining unit employee medical, dental and vision coverage options as well as the employer annual contribution to the HSA. If the number is in parentheses, the company will pay you that amount for selecting that coverage.

Medical Bi-weekly Premium Sharing:

Simply Blue PPO $500	Employee cost per pay
Employee only	$8.00
Employee + spouse	$16.00
Employee + child(ren)	$16.00
Family	$24.00

Simply Blue HDHP	Employee cost per pay
Employee only	$0.00
Employee + spouse	$0.00
Employee + child(ren)	$0.00
Family	$0.00

BCN Healthy *Blue* Living	Employee cost per pay
Employee only	$4.00
Employee + spouse	$8.00
Employee + child(ren)	$8.00
Family	$12.00

Dental Bi-weekly Premium sharing:

Exclusive Dental	Employee cost per pay
Employee only	$1.00
Employee + spouse	$2.00
Employee + child(ren)	$2.00
Family	$2.00

Traditional Dental	Employee cost per pay
Employee only	$1.00
Employee + spouse	$2.00
Employee + child(ren)	$2.00
Family	$2.00

Vision Bi-weekly Premium sharing:

Vision coverage	Employee cost per pay
Employee only	$0.50
Employee + spouse	$1.00
Employee + child(ren)	$1.00
Family	$1.00

2026 health care premium sharing *(cont'd)*

Employer Lump Sum and Bi-weekly HSA Contributions:

HSAs are available to employees enrolled in the Simply Blue HDHP plan.

- Employees hired prior to January 1, 2010 receive a lump sum credit of $1,200 for employee only coverage and $1,400 for employee + 1 or more coverage for staff.
- Emplyees hired on or after January 1, 2010 receive a lump sum credit of $1,700 for employee and $1,900 for employee + 1 or more plus an additional $750 lump sum credit for first time HDHP enrollees.
- All HDHP participants receive a per pay period contribution based on coverage tier:

Coverage Tier	HSA Credit Per Pay
Employee only	$28.85
Employee + spouse	$57.69
Employee + child(ren)	$57.69
Family	$86.54

Simply Blue HDHP (Hired Before 1/1/2010)	Employee cost per pay	Employer HSA Annual Contribution (Lump Sum and Bi-weekly)
Employee only	$0.00	($1,950)
Employee + spouse	$0.00	($2,900)
Employee + child(ren)	$0.00	($2,900)
Family	$0.00	($3,650)

Simply Blue HDHP (Hired After 1/1/2010)	Employee cost per pay	Employer HSA Annual Contribution (Lump Sum and Bi-weekly)
Employee only	$0.00	($2,450)
Employee + spouse	$0.00	($3,400)
Employee + child(ren)	$0.00	($3,400)
Family	$0.00	($4,150)

Simply Blue HDHP (Hired After 01/01/2020 + First Time HSA Enrollee)	Employee cost per pay	Employer HSA Annual Contribution (Lump Sum and Bi-weekly)
Employee only	$0.00	($3,250)
Employee + spouse	$0.00	($4,150)
Employee + child(ren)	$0.00	($4,150)
Family	$0.00	($4,900)

The amounts above are employer direct annual contributions to the HSA in one lump sum and are not payroll credits. When calculating contributions, remember to deduct the employer contribution from the annual limit to make sure the IRS annual limit is not exceeded.

Please note that these amounts will be pro-rated for those enrolling after the start of the plan year.

High-level comparison of medical benefit plans

Benefits	Simply Blue℠ PPO $500*		Simply Blue℠ HDHP**		BCN Healthy *Blue* Living℠ HMO	
	Network providers	Non-network providers	Network providers	Non-network providers	Enhanced plan	Standard plan
Medical benefits: deductibles, copays and dollar maximums						
Deductibles	**$500** for one member, **$1,000** for the family each calendar year	**$1,000** for one member, **$2,000** for the family each calendar year	**$1,700** for a one-person contract or **$3,400** for a family contract (2 or more members)	**$2,700** for a one-person contract or **$5,600** for a family contract (2 or more members)	None	**$250** per member, **$500** per family per calendar year
Fixed dollar copays	• **$20** for office visits • **$20** for urgent care • **$150** for ER	• **$150** for ER	None	None	• **$10** for office visits • **$10** for urgent care • **$50** for ER	• **$5** for allergy injections • **$20** for office visits • **$0** for outpatient mental health and substance abuse visits • **$20** for urgent care • **$100** for ER
Percent copays/ coinsurance amounts	10% of approved amount for private duty nursing care 10% of approved amount for mental health care and substance use disorder treatment 10% of approved amount for most other covered services	10% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services	20% (includes ER, office visits, urgent care) of approved amount	40% of approved amount	100% coverage • 50% for select services	10% and 50% for select services
Annual out-of-pocket maximums*	**$1,250** for one member, **$2,500** for the family each calendar year	**$2,500** for one member, **$5,000** for the family each calendar year	**$2,600** for a one-person contract or **$4,600** for a family contract (2 or more members) each calendar year	**$5,200** for a one-person contract or **$9,200** for a family contract (2 or more members) each calendar year	**$1,250** per member, **$2,500** per family per calendar year for medical and pharmacy cost sharing	**$1,250** per member, **$2,500** per family per calendar year for medical and pharmacy cost sharing
Preventive care services	Covered at 100%	Not covered except for routine mammogram and colonoscopy – subject to deductible/copay	Covered at 100%	Not covered	Covered at 100%	Covered at 100%
Copay for retail drugs	30 Day Supply **$5** for generic drugs, **$20** for preferred brand name drugs **$40** non-preferred 90 Day Supply **$10** for generic drugs, **$40** for preferred brand name drugs 40% – non-preferred ($100 min/$200 max)	30 Day Supply **$5** for generic drugs, **$20** for preferred brand name drugs **$40** – non-preferred plus additional 25% of BCBSM approved amount 90 Day Supply No coverage	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount	30 day supply **$5** for Tier 1 drugs, **$20** for Tier 2 drugs 84-90 day supply **$10** for Tier 1 drugs, **$40** for Tier 2 drugs	30 day supply **$15** for Tier 1 drugs, **$50** for Tier 2 drugs 84-90 day supply **$30** for Tier 1 drugs, **$100** for Tier 2 drugs
Copay for mail order drugs	90 Day Supply **$10** for generic drugs, **$40** for preferred brand name drugs **$80** for non-preferred	No coverage	Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.	No coverage	30 day supply **$5** for Tier 1 drugs, $20 for Tier 2 drugs 31-90 day supply **$10** for Tier 1 drugs, $40 for Tier 2 drugs	30 day supply **$15** for Tier 1 drugs, **$50** for Tier 2 drugs 31-90 day supply **$30** for Tier 1 drugs, **$100** for Tier 2 drugs

**Annual out-of-pocket maximums applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable*

***Simply Blue HSA deductible combines the deductible amounts paid under the Simply Blue medical coverage and Simply Blue prescription drug coverage. Simply Blue copay dollar maximum combines the copay amounts paid under the Simply Blue medical coverage **and** Simply Blue prescription drug coverage. The Simply Blue provider network is the same as the Community Blue provider network.*

Network comparison of medical benefit plans

Benefits		Simply Blue℠ PPO $500*	Simply Blue℠ HDHP**	BCN Healthy *Blue* Living℠ HMO	
				Enhanced plan	Standard plan
Preventive care services	Health maintenance exam	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100%	Covered at 100%
	Routine gynecological exam	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100%	Covered at 100%
	Well-baby/child care visits	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
	Routine adult and childhood immunizations	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Covered at 100%	Covered at 100%
	Simple sigmoidoscopy exam and fecal occult blood screening	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100%	Covered at 100%
	Prostate specific antigen (PSA) screening	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100%	Covered at 100%
	Ovarian cancer screening	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100%	Covered at 100%
	Pap smear screening	Covered at 100% – one per calendar year	Covered at 100% – one per calendar year	Covered at 100% – one every 12 months	Covered at 100% – one every 12 months
	Routine colonoscopy	Covered at 100% – one routine colonoscopy per calendar year	Covered at 100% – one routine colonoscopy per calendar year	Covered at 100% when recommended by your PCP	Covered at 100% when recommended by your PCP
	Routine mammogram	Covered at 100% – one routine mammogram per calendar year	Covered at 100% – one routine mammogram per calendar year	Covered at 100% – one every 12 months	Covered at 100% – one every 12 months
Physician office services	Office visits and office consultations	**$20** copay	Covered at 80% after deductible	**$10** copay	**$20** copay; deductible applies to specialist visit
	Urgent care			**$10** copay	**$20** copay
	Outpatient consultations	Covered at 90% after deductible	Covered at 80% after deductible	Covered – office visit copay may apply per visit	Covered – office visit copay may apply per visit after deductible
	Online Visits	**$20** copay per online visit	Covered at 80% after deductible	**$10** copay	**$20** copay

**Annual out-of-pocket maximums applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable*

***Simply Blue HSA deductible combines the deductible amounts paid under the Simply Blue medical coverage and Simply Blue prescription drug coverage. Simply Blue copay dollar maximum combines the copay amounts paid under the Simply Blue medical coverage **and** Simply Blue prescription drug coverage. The Simply Blue provider network is the same as the Community Blue provider network.*

Network comparison of medical benefit plans *(cont'd)*

Benefits		Simply Blue℠ PPO $500*	Simply Blue℠ HDHP**	BCN Healthy *Blue* Living℠ HMO	
				Enhanced plan	**Standard plan**
Emergency medical care	Hospital emergency room	**$150** copay for facility charges (copay waived if admitted or if injury is the result of an accidental injury) – covered at 100% for emergency room professional fees	Covered at 80% after deductible	**$50** copay	**$100** copay after deductible
	Professional ambulance services (ground or air) – when medically necessary	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 90% after deductible
Diagnostic and radiation services	Laboratory and pathology tests	Covered at 90% of approved amount in physician's office after deductible	Covered at 80% after deductible	100% Covered	100% Covered
	Diagnostic radiology and radiation therapy	Covered at 100% of approved amount in physician's office (covered at 90% after deductible in other locations)	Covered at 80% after deductible	100% Covered	100% after deductible
Maternity services	Maternity care (delivery)	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 100% after deductible for professional services. Covered at 90% after deductible for facility charges.
	Prenatal and postnatal care visits	Covered at 100%	100% (no deductible or copay/coinsurance)	$10 Copay	$20 Copay
Inpatient hospital care	Semi-private room, meals, general nursing care, hospital services, intensive care units	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 100% after deductible
	Inpatient consultations	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 100% after deductible

**Annual out-of-pocket maximums applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable*

***Simply Blue HSA deductible combines the deductible amounts paid under the Simply Blue medical coverage and Simply Blue prescription drug coverage. Simply Blue copay dollar maximum combines the copay amounts paid under the Simply Blue medical coverage **and** Simply Blue prescription drug coverage. The Simply Blue provider network is the same as the Community Blue provider network.*

Network comparison of medical benefit plans *(cont'd)*

Benefits		Simply Blue℠ PPO $500*	Simply Blue℠ HDHP**	BCN Healthy *Blue* Living℠ HMO	
				Enhanced plan	Standard plan
Alternatives to hospitalization	Home health care	Covered at 90% after deductible – must be medically necessary	Covered at 80% after deductible – must be medically necessary	**$10** copay	**$20** copay after deductible
	Individual case management	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 100%
	Skilled nursing facility admission	Covered at 90% after deductible – limited to 120-day maximum per member per calendar year	Covered at 80% after deductible – limited to 90-day maximum per member per calendar year	Covered at 100%	100% after deductible
	Hospice care (in approved facilities)	Covered at 100% – up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods; limited to dollar maximum that is reviewed and adjusted periodically	Covered at 80% after deductible – up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods; limited to dollar maximum that is reviewed and adjusted periodically	100% (When authorized)	100% (When authorized) after deductible
Human organ transplants	Kidney, skin and cornea transplants	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100% when authorized (subject to medical criteria)	Covered at 100% after deductible when authorized
	Bone marrow transplants	Covered at 90% after deductible (subject to program guidelines)	Covered at 80% after deductible (subject to program guidelines)	Covered at 100% when authorized (must be non experimental and subject to medical criteria)	Covered at 100% after deductible when authorized (must be non-experimental and subject to medical criteria)
	Specified human organ transplants	Covered at 100% – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800 242-3504)	Covered at 80% after deductible – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered at 100% when authorized (subject to medical criteria)	Covered at 100% after deductible when authorized (subject to medical criteria)
Mental health care and substance abuse treatment	Inpatient mental health care and substance abuse treatment	Covered at 90% after deductible	Covered at 80% after deductible	**Mental Health:** Covered at 100% when authorized **Substance Abuse:** Covered at 100% when authorized	**Mental Health:** Covered at 90% after deductible when authorized **Substance Abuse:** Covered at 90% after deductible when authorized
	Outpatient mental health care	Covered at 90% after deductible	Covered at 80% after deductible	$10 copay	**$20** copay for each visit
	Facility and clinic	Covered at 90% after deductible	Covered at 80% after deductible	$10 copay	**$20** copay after deductible for each visit
	Physician's office	**$20** copay		$10 copay	**$20** copay after deductible for each visit
	Outpatient substance abuse treatment	Covered at 90% after deductible	Covered at 80% after deductible	$10 copay	**$20** copay after deductible for each visit when authorized

**Annual out-of-pocket maximums applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable*

***Simply Blue HSA deductible combines the deductible amounts paid under the Simply Blue medical coverage and Simply Blue prescription drug coverage. Simply Blue copay dollar maximum combines the copay amounts paid under the Simply Blue medical coverage **and** Simply Blue prescription drug coverage. The Simply Blue provider network is the same as the Community Blue provider network.*

Network comparison of medical benefit plans *(cont'd)*

Benefits		Simply Blue℠ PPO $500*	Simply Blue℠ HDHP**	BCN Healthy *Blue* Living℠ HMO	
				Enhanced plan	**Standard plan**
Surgical care in hospital or outpatient	Surgery and related services	Covered at 90% after deductible Includes surgery in BCBSM-approved ambulatory facilities Includes Lasik eye surgery	Covered at 80% after deductible – includes surgery in BCBSM-approved ambulatory facilities	Covered at 100%	100% after deductible
	Voluntary sterilization	90% after in-network deductible	Covered at 80% after deductible	Male and Female – Covered at 100%	Male and Female covered 100%
Other medical care	Disease management programs	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100%	Covered at 100%
	Contraceptive devices – includes injections	Covered at 100%	Covered at 80% after deductible	Office administered contraceptives – Covered at 100%	Office administered contraceptives – Covered at 100%
	Infertility counseling and treatment includes assisted reproductive technologies	Covered at 80% after deductible	Covered at 80% after deductible	Covered at 50%	Covered at 50%
	Outpatient physical, speech and occupational therapy	Covered at 90% after deductible – limited to a combined maximum of 60 visits per calendar year	Covered at 80% after deductible – limited to a maximum of 60 visits per calendar year per member	**$10** copay limited to a combined benefit maximum of 60 consecutive days per medical episode	**$20** copay after deductible; limited to a combined benefit maximum of 60 consecutive days per medical episode
	Chiropractic services	**$20** copay	Covered at 80% after deductible	**$10** copay – when referred by your PCP.	**$20** copay after deductible – when referred by your PCP.
	Spinal manipulation	**$20** copay – limited to12 visits per calendar year	Covered at 80% after deductible – limited to 12 visits per calendar year	**$10** copay – when referred by your PCP.	**$20** copay after deductible – when referred by your PCP.
	Private duty nursing services	Covered at 90% after deductible	Covered at 90% after deductible	Not covered	Not covered
	Allergy testing and therapy	90% after in-network deductible	Covered at 80% after deductible	Covered at 100%	100% after deductible
	Prosthetic and orthotic devices	Covered at 90% after deductible – includes wigs and un-attachable shoe inserts (subject to medical criteria)	Covered at 80% after deductible (wigs and un-attachable shoe inserts are not covered)	100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary.	100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary.
	Durable medical equipment (DME)	Covered at 90% after deductible	Covered at 80% after deductible	Covered at 100% (includes coverage for breast pump)	Covered at 100% (Breast pump covered at 100%)

**Annual out-of-pocket maximums applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable*

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Network comparison of medical benefit plans *(cont'd)*

Benefits		Simply Blue℠ PPO $500*	Simply Blue℠ HDHP**	BCN Healthy *Blue* Living℠ HMO	
				Enhanced plan	Standard plan
Prescription drug coverage Prescription drugs • FDA-approved and state-controlled drugs • Injectable insulin, needles and syringes • Oral contraceptives	Network pharmacies	**30 day supply** **$5** for generic drugs, **$20** for preferred brand name drugs **$40** for non-preferred ($50 min/ $100 max) **90 day supply** **$10** for generic drugs, **$40** for preferred brand name drugs **$80** for non-preferred ($100 min/$200 max)	**90 Day Supply** After deductible is met, you pay $10 copay	**90-day retail network pharmacy:** **30 Day Supply:** Tier 1: $5 copay Tier 2: $20 copay Tier 3: Not covered **84-90 Day Supply:** Tier 1: $10 copay Tier 2: $40 copay Tier 3: Not covered **Note:** Tier 1 contraceptives covered at 100%	**90-day retail network pharmacy:** **30 Day Supply:** Tier 1: $15 copay Tier 2: $50 copay Tier 3: Not covered **84-90 Day Supply:** Tier 1: $30 copay Tier 2: $100 copay Tier 3: Not covered **Note:** Tier 1 contraceptives covered at 100%
	Mail services (home delivery) prescription drugs	**90 day supply** **$10** for generic drugs, **$40** for preferred brand name drugs **$80** for non-preferred ($100 min/$200 max)	After deductible is met, you pay $10 copay	**Network mail order provider:** **30 day supply:** Tier 1: $5 copay Tier 2: $20 copay Tier 3: Not covered **31-90 day supply:** Tier 1: $10 copay Tier 2: $40 copay Tier 3: Not covered	**Network mail order provider:** **30 day supply:** Tier 1: $15 copay Tier 2: $50 copay Tier 3: Not covered **31-90 day supply:** Tier 1: $30 copay Tier 2: $100 copay Tier 3: Not covered

Notes

- BCN members can get a 90-day supply of a brand-name drug from a participating retail pharmacy after filling an initial 30-day supply.
- BCBSM and BCN will not pay for drugs obtained from non-network mail order providers, including Internet providers.
- If you obtain a brand name drug (including mail order and 90-day retail drugs) when a generic equivalent drug is available, you may be required to pay the difference between maximum allowable cost for the generic drug and the BCBSM-approved amount for the brand name drug (even if the prescription is marked "DAW") **plus** your copay. **Exception:** If your physician requests and receives authorization for a brand name drug from the BCBSM Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copay.
- Step-therapy and prior authorization applies to certain medications for BCN members. BCN members who receive a brand-name drug when a generic equivalent is available will be required to pay the difference in cost between the brand-name drug and the generic version, in addition to the applicable brand-name copay amount.

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Dental benefit plans

Benefits	Exclusive Dental	Traditional Dental
Preventive services – Class I		
• Teeth cleaning – twice per calendar year	Covered at 100% (benefits are payable up to 4 times per calendar year for member with documented periodontal condition)	Covered at 100% (benefits are payable up to 4 times per calendar year for member with documented periodontal condition)
• Fluoride treatment – twice per calendar year	Covered at 100%	Covered at 100%
• Space maintainers (under age 18)	Covered at 100%	Covered at 100%
• Pit and fissure sealants (age 19 or under)	Covered at 100%	Covered at 100%
Diagnostic services – Class I		
• Oral exams – twice per calendar year • A set (up to 4) of bitewing x-rays – twice per calendar year • Full-mouth x-rays – once every 60 months	All services listed are covered at 100%	All services listed are covered at 100%
Restorative services – Class II		
• Fillings (child and adult) • Stainless steel crowns • Crowns (porcelain or metal)	All services listed are covered at 100%	All services listed are covered at 75%
Adjunctive procedures – Class II		
• Office visits or consultation • General anesthesia or iv sedation	All services listed are covered at 100%	All services listed are covered at 75%
Oral surgery – Class II		
• Routine extractions • Minor surgical procedures • Removal of exostosis • Incision and drainage of abscess	All services listed are covered at 100%	All services listed are covered at 75%
Periodontics – Class II		
• Osseous surgery (per quadrant) • Scaling and root planning • Soft tissue surgery	All services listed are covered at 100%	All services listed are covered at 75%
Endodontics – Class II		
• Pulpotomy • Root canal therapy	All services listed are covered at 100%	All services listed are covered at 75%
Prosthodontics – Class III (dentures and bridges)		
• Full dentures (each) – lower and upper • Partial dentures (each) – lower and upper • Cast metal bridges (per pontic or abutment) • Porcelain fused to metal bridges (per pontic or abutment) • Endosteal implants (members age 16 or older who are covered at the time of the actual implant replacement)	All services listed are covered at 85%	All services listed are covered at 50%
Annual maximum (based on calendar year)	**$2,600** Per member	**$2,600** Per member
Orthodontic services – Class IV	Covered at 70% up to **lifetime** maximum benefit of **$2,400** per member	Covered at 50% up to **lifetime** maximum benefit of **$2,400** per member

Notes

- Under the Exclusive Dental Plan you must select a provider from the Blue Dental Tier 1 PPO dental network. Services received by out-of-network providers will not be covered. To locate a Tier 1 PPO dental provider, visit mibluedentist.com and select Blue Dental PPO, from the Tier 1 menu, to search your search.
- Services covered by the Exclusive Dental and Traditional Dental plans plans are paid according to the BCBSM-approved amount, less applicable copays. Some services may be subject to medical/dental review.

Vision benefit plan

Benefits	Blue Vision℠ VSP	
	VSP network doctor	**Non-VSP provider**
Eye examination	**$5** copay	**$5** copay applies to charge
Frames & lenses	**Combined $7.50** copay for both frames and lenses	**$7.50** copay
Medically necessary contact lenses	**$7.50** copay	**$7.50** copay
Eye exams **– Complete eye exam**	Reimbursement up to **$35 less $5 copay** (member responsible for any difference)	**$5** copay
Eyeglasses **– Eyeglass frames**	**$7.50** copay (one copay applies to both frames and lenses), up to a **$150** allowance	Reimbursement up to **$45 less $7.50** copay (member responsible for any difference)
Eyeglass lenses **– Includes scratch guard coating and ultraviolet (UV) coating**	**$7.50** copay, includes progressive and blended lenses	Reimbursement up to approved amount based on lens type less **$7.50** copay (member responsible for any difference)
Contact lenses – Prescribed, non-therapeutic	Up to a maximum of **$200**	**$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 – Medically necessary	**$7.50** copay	Reimbursement up to **$210 less $7.50** copay (member responsible for any difference)

Notes

- Vision care benefits are payable once every **12 consecutive months**. During this time, benefits are payable for either eyeglasses or contact lenses, **but not both**.
- The VSP network includes over 1,100 provider locations in Michigan and 24,000 locations nationwide. VSP is an independent company providing vision benefit services for Blue Cross members. To locate a network provider, call VSP's Member Services at 1-800-877-7195 or visit their Web site at vsp.com.

Simply Blue HDHP HSA

Basics

Simply Blue HSA pairs a PPO health plan with a health savings account (HSA). It combines the comprehensive benefits and provider network of a PPO plan with a valuable saving tool to set aside money for health care expenses today, tomorrow and in retirement.

Here's how it works

Your contributions

- If you select Simply Blue HSA coverage, an HSA will automatically be opened for you. EH will deposit a lump sum and bi-weekly contribution directly into your HSA. These funds will be available for use at the beginning of the year. See page 9 for the 2026 employer contribution amount.
- In addition, during open enrollment you'll be asked to determine an amount, if any, that you'd like to contribute to your HSA. Each pay period your pre-tax payroll contribution will be deposited into your HSA.
- The 2026 Internal Revenue Service (IRS) contribution limit is $4,400 for self-only coverage and $8,750 for family coverage. You can use the contribution calculator at **bcbsm.com** to help determine the amount you'd like to contribute.
- Individuals 55 and older can make an additional $1,000 catch-up contribution to their HSA each year. This increases the total contribution maximum to $5,400 for self-only coverage and $9,750 for family coverage.
- When calculating contributions, remember to deduct the annual employer contribution from the annual limit to make sure the IRS annual limit is not exceeded.

Your health plan

- When you start using your coverage, you'll pay 100 percent of your medical and prescription drug expenses until you reach your plan deductible. In-network preventive services are covered at 100 percent and are not subject to the deductible.

Your HSA

- HealthEquity, Inc. administers your HSA on behalf of EH.
- You may choose to use money in your HSA to pay for qualified medical expenses applied toward your deductible, or save the money for future medical expenses. There's no use it or lose it rule like with a flexible spending account (FSA). So, you don't have to use money in an HSA by the end of the year.
- An HSA debit card will be provided to allow you to conveniently pay for services.
- Once your HSA reaches $2,000, you may choose to invest in a selection of mutual funds available through HealthEquity.
- You can conveniently manage your HSA through your member account at **bcbsm.com**. First-time visitors will need to register. Once registered, log in using your Username and Password, click the *My Coverage* tab and then click the *Go to your health spending account* link. You can also use the BCBSM mobile app.

Eligibility

To open and make contributions to an HSA, you must be enrolled in the Simply Blue HSA, which is an HSA-compatible health plan. In addition:

1. You cannot be covered by other health insurance, such as a spouse's coverage. (Does not apply to specific injury/accident, disability, dental care, vision care and long-term care)
2. You cannot be enrolled in Medicare or be a dependent on another person's tax return. If you plan to enroll into Medicare in 2026 or are currently enrolled in Medicare you will need to elect one of the other two available health care plan options.
3. You cannot have received Veterans Affairs medical benefits at any time over the past three months.
4. You cannot be enrolled or covered by a health care FSA or full health reimbursement arrangement.

Note: Eligibility guidelines apply to opening and contributing to an HSA. Once the account is open, money in the account can be used to pay for qualified medical expense as defined by the IRS.

HSA frequently asked questions

Q. Am I required to sign up for an HSA?

A. No, but it's recommended that you sign up for an HSA in order to take advantage of its full benefits, including the opportunity to fund it with pre-tax money and receive the employer contribution.

Q. Where do I start?

A. After your HSA is opened, you'll receive a Welcome Kit from our HSA administrator, HealthEquity. Your kit will include:

1. Information on how to access and use your HSA.
2. A HSA Visa Debit card with instructions for activation.
3. Member services contact information for live support and online access to HSA-related information 24 hours a day, seven day a week.

Q. How do I make pre-tax contributions to my HSA?

A. Your pre-tax contribution election must be made online during open enrollment. Simply designate the amount of your pre-tax contribution by selecting the Health Savings Account (HSA) option on the enrollment page. Your pre-tax contribution amount will be divided and payroll deducted in equal amounts each pay period over the course of the year. Your total annual (employee plus employer) contribution cannot exceed annual IRS limitations of $4,400 for self only and $8,750 for family coverage.

Q. Is the Company providing any money to fund my HSA?

A. Yes. EH will make an annual contribution to your HSA. See page 9 for 2026 employer contribution amounts. **Note:** When calculating contributions, remember to deduct the annual employer contribution from the annual limit to make sure the IRS annual limit is not exceeded.

Q. If I am currently enrolled in Medicare or plan to enroll in Medicare in the upcoming year, can I enroll into the HSA plan and receive contributions to my HSA?

A. No, you will need to elect one of the other two available health care plan options if you are currently enrolled or plan to enroll in Medicare in 2026.

Q. To be eligible for an HSA, you cannot have coverage through your spouse. What happens if your spouse doesn't have coverage at the time of open enrollment, but six months later gets a full-time job with health coverage?

A. The U.S. Treasury Department sets the requirements for HSA eligibility. Any individual who meets these requirements is eligible to open and contribute to an HSA. One of the requirements is that the account holder (employee) must be covered under a HSA-compatible health plan (like Simply Blue HSA) and cannot be covered by any other health insurance coverage. As long as your spouse does not add you to his or her health care plan, you will meet this eligibility requirement to contribute to your HSA. If you choose to go under your spouse's health insurance, you are able to use funds in your HSA for qualified medical expenses but are not able to contribute any additional funds until covered under a HSA-compatible plan like Simply Blue HSA.

Q. How will I access my HSA?

A. You can view your balance, pay claims, view monthly statements, invest your funds and manage your HSA through your member account at **bcbsm.com** or through the BCBSM mobile app.

Q. How will the company's annual HSA contribution be paid to me?

A. The company will despot the lump sum and bi-weekly contribution directly into your HSA account. The lump sum will take place the first pay of the year. The bi-weekly employer contribution will be deposited each pay period. You are not required to open your HSA. It will be automatically opened when you elect the HSA.

Q. What are the funds used for? What are qualified medical expenses?

A. If you are under the age of 65, HSA funds must only be used to pay for qualified medical expenses for you, your spouse and any tax dependent children. These include most medical, dental and vision care services as defined in the Treasury Department IRS publication 502 at **irs.gov/publications/p502/**. Any amounts used for a purpose other than to pay for qualified medical expenses are taxable as income and subject to an additional 20 percent tax penalty. Save your receipts for all expenses paid out of your HSA in case of an IRS audit. After you turn age 65, the 20 percent additional tax penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without being taxed as income and without paying the additional 20 percent penalty. More information can be found online at **treas.gov** (Health Savings Accounts).

Q. Can I pay for qualified medical expenses with a debit card?

A. Yes, a Visa debit card will be provided. If you need additional debit cards, contact Health Equity Member Services at 877-284-9840. You may receive up to three debit cards free of charge.

Q. Do qualified medical expenses need to be deducted from the HSA within the calendar year in which they occur or do other timeframes apply?

A. According to current Department of Treasury regulations, qualified medical expenses must be incurred on or after the date the HSA was established. There is no time limit on when the distribution must occur. Individuals must keep records sufficient to prove that the expenses were incurred and they were not paid for or reimbursed by another source or taken as an itemized deduction.

Q. What if I have questions about my HSA?

A. Please contact Health Equity Member Services at 877-284-9840.

Healthy *Blue* Living℠ HMO

Healthy *Blue* Living℠ HMO is a well-being healthcare plan that rewards you with lower healthcare costs for committing to work toward health targets. HBL has two benefit levels — enhanced and standard. Enhanced has lower out-of-pocket costs, such as copays, deductible and coinsurance. Standard has higher out-of-pocket costs.

Flexibility to help achieve healthier living (first 90 days)

New members will automatically receive the enhanced level for the first 90 days of their plan year. Renewing members start the plan year in the benefit level they were at the end of 2025. In order to remain or return to the enhanced level, renewing members must complete the following tasks during the first 90 days of the plan year:

- Log in to your account at **bcbsm.com** to complete a 10-minute personal health assessment.
- Go to your primary care provider for a health evaluation to check six health measures. After your appointment, tell your doctor to submit your results electronically on a qualification form before your deadline.

For the enhanced level, you must score A's and B's on these six health measures.

Health measure	Wellness target to score an "A"	If you don't score an "A", do this for a "B"
Tobacco	Non tobacco user (must be confirmed by primary care physician through blood or urine test)	Enroll within 120 days in our new Tobacco Coaching program* and actively participate until you quit using tobacco
Weight	Body mass index below 30	*Enroll within 120 days and participate in one of our new two weight-management programs — Triple Tracker and Lifestyle Coaching — until your BMI falls below 30
Blood pressure	Below 140/90	Commit to and follow doctor's treatment plan
Cholesterol	LDL C below target (based on risk factors: <100, <130 and <160)	Commit to and follow doctor's treatment plan
Blood sugar	At or below target (fasting blood sugar or A1C)	Commit to and follow doctor's treatment plan
Depression	Any depression in full remission or commit to and follow doctor's treatment plan	Commit to and follow doctor's treatment plan

***We've upgraded the Healthy *Blue* Living℠ plan to include our new Blue Cross Well-Being℠ services. As part of the upgrade, our weight-management and tobacco coaching programs are transitioning to Personify Health™, formerly Virgin Pulse®. You have the first 120 days of your plan year to sign up for a weight management and/or tobacco coaching program if necessary.**

Weight management resources

If your qualification form shows your BMI is 30 or higher, enroll and participate in one of these weight-management programs. You must enroll through your online member account at **bcbsm.com** or BCN customer service.

Option 1: 20-day Triple Tracker	Option 2: Lifestyle Coaching
• Members enroll using their online member account. • Complete 20 days of physical activity each month. Choose any combination of these activities: – 7,000 steps – 15-minute workout – 15 active minutes	• Members enroll using their online member account. • Completes one session per month — either by phone or messaging. • Receives unlimited messaging with health coach. • Requires no self-reporting attendance or re-enrollment.

**If you're a renewing member currently participating in one of the Healthy Blue Living weight-management program options from the previous plan year, make sure you continue to meet the program requirements so you don't drop to the standard level.*

Personify Health is an independent company that provides health and well-being services on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

Additional Health Care Benefits

All employees and their eligible dependents enrolled in a BCBSM or BCN employer health care plan are invited to sign up for the programs listed below. These programs are offered at no cost to you and your eligible dependents.

Teladoc Chronic Condition Management

Teladoc for chronic condition management is a one-of-a-kind approach to chronic condition management using virtual care that inspires lasting changes.

With our program, you get unlimited access to connected health monitoring devices, certified health coaches and support from physicians and mental health specialists — all to help manage conditions like diabetes, hypertension and prediabetes.

You'll receive the program at no additional cost if you or your adult dependents are enrolled in a BCBSM or BCN employer health care plan and meet the specific health criteria. To register, visit **TeladocHealth.com/Smile/EMERGINGMARKETSBU** and answer a few simple questions about your health. You may also enroll by calling Teladoc Health Member Support at 800-835-2362.

Virtual Care

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.

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 an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Mental Health

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression. Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

Sign Up Today! Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app.

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call 1-800-835-2362 with any questions about your account or to arrange a telephone visit.

Blue Cross Virtual Dental Care

Blue Cross Virtual Dental Care provides employees with more options for 24/7 urgent dental care.

You can experience urgent dental needs at any time, prompting emergency room visits when your regular dentist is unavailable. Virtual Dental Care provides you with 24/7 guidance and support until you can get into to see your regular dentist, helping you avoid the emergency room, when possible, and saving you money.

Virtual Dental Care is a standard, in-network benefit with either dental plan, at no additional cost. Employees are responsible for coinsurance, if any, from their visit.

You can access Virtual Dental Care when searching for a dentist in your **member account**, through **mibluedentist.com**.

the Well

Employees can earn a maximum of $550 annually!

If you are looking to maintain or adopt healthy habits, access free educational resources, or simply make some extra spending cash, then check out The Well.

The Well is our holistic wellbeing program that is available for all regular employees. This program offers you access to fitness, financial wellness, healthy habit tracking (nutrition, sleep, activity) and stress management programs just to name a few.

Get active with your friends, get inspired to live better — and get rewarded along the way!

Program Overview

Get ready to live your best life with:

- An enhanced virtual experience that delivers personalized daily content based on your interests, health risks and demographics.
- Seamless integration with more than 100 fitness tracking devices and apps, including Apple Health and Google Fit.
- A checklist to help you stay on top of recommended preventive health care based on your specific needs.
- A detailed health assessment with more guidance for modifiable health risks.
- Self-guided well-being courses called Journeys® to help you build healthy habits that stick.
- A best-in-class tobacco cessation coaching program to help you stop smoking, vaping and using nicotine.

Reward Highlights

Beginning in 2026, employees can earn up to a maximum of $550 in rewards.

The Well is a program that rewards you for taking an interest in your health. Complete fun health and wellness activities to earn rewards. Then, redeem for gift cards to retailers, Personify Health™ store or charities.

Points + Levels Game	Level 1	Level 2	Level 3	Level 4
Points	10,000	20,000	35,000	50,000
Rewards	$55	$110	$165	$220

Have Questions?

- Check out **support.personifyhealth.com**
  Live chat: Monday – Friday, 2am – pm EST
- Give Personify Health a call: **888-671-9395**
  Monday – Friday, 8am – 9am ET
- Send Personify Health an e-mail: **support@personifyhealth.com**

Attention Healthy *Blue* Living Members

Your primary care physician must electronically submit the HBL qualification form if you scored all A's on your most recent HBL qualification form, you don't need to complete a qualification form. Not sure? Check your to-dos by logging in to your account at bcbsm.com to see if you need to submit one.

Note: The Well program requirements and deadlines differ from the Healthy *Blue* Living plan requirements and deadlines.

Questions? Contact **BlueCrossHealthandWellness@bcbsm.com** or the Engagement Center at 1-800-775-BLUE (2583).

Financial Protection Voluntary Products

The following products are offered on a voluntary basis and are not part of your employer sponsored benefit package.

Supplemental Benefits

Supplemental benefit plans are 100% paid by you and the following options are set-up as payroll deductions. These individual plans are optional and established between you and the provider.

Dearborn Group is a proud ancillary subsidiary of Health Care Services Corporation (HCSC), the largest non-investor owned health care insurer in the United States, which is an independent licensee of the Blue Cross and Blue Shield Association.

Supplemental Life insurance is additional employee coverage above the companypaid benefit of two (2) times your annual salary. You can also elect spousal or dependent life insurance coverage. Supplemental AD&D would be additional coverage to your company paid policy of $100,000. Supplemental AD&D is affordable coverage that can help protect your family's way of life and offer financial security if you or a dependent pass away. This is additional coverage to your company paid policy of $100,000.

Critical Illness provides cash for the unexpected costs of a critical illness. This optional benefit is in addition to and independent of any other benefits you may be eligible for. You can use the money as you wish — to help cover your medical plan deductible and coinsurance, pay for uncovered medical treatment, or use it for your regular day-to-day living expenses.

LifeSecure group accident insurance*

As a EH employee, you have access to best in class, top quality medical insurance and coverage. You know when you pull out your Blues ID card, you have excellent health insurance coverage. However, you may find yourself with unexpected living expenses following an accidental injury.

What is Group Accident insurance?

LifeSecure's Group Accident Insurance is an affordable insurance plan designed to:

- Pay you a cash benefit following an accidental injury for your actual medical and/or recovery expenses *(up to your Annual Benefit Bank Amount).* The amount of expenses that we'll provide benefits for takes into account the adjustments or discounts your health care plan may have negotiated with your providers. Once the actual cost of your covered medical services exceeds your $100 Accident deductible, you'll start receiving cash benefits for remaining expenses. **Benefits from this plan pay in addition to your EH coverage and require no coordination of benefits.**

- Assist you while healing from an accidental injury. Benefits can be used for: rehabilitative services, housekeeping assistance, child care, home care assistance, transportation to and from appointments, yard work… *or anything else!*

Choosing a Plan

Only ONE simple decision point – Select an Annual Benefit Bank Amount

	Benefit Bank
Plan A	**$5,000**
Plan B	**$10,000**
Plan C	**$15,000**

Note: Accident Insurance has a $100 for individual/$200 family deductible.

The Annual Benefit Bank represents the total dollar amount available to you or your family for covered services provided each calendar year. On Jan. 1 of each year, your Annual Benefit Bank will restore to its full amount.

Benefit Payout Example (for $10,000 Benefit Bank Amount)

You chose an Accident Plan with a $10,000 Annual Benefit Bank. You break your collar bone while skiing with friends and require immediate medical attention.

Reimbursable Expenses		Accident Deductible		Cash Benefit Payout
$8,000	**-**	**$100**	**=**	**$7,900**

Group Accident Insurance Bi-Weekly Premiums

Annual Benefit Bank	Self	Self + Spouse/Partner	Self + Children	Self + Family
$5,000	$11.13	$13.07	$14.84	$16.09
$10,000	$14.28	$17.70	$20.80	$23.52
$15,000	$16.36	$21.00	$25.12	$29.06

Premium amounts may include slight variations when rounding figures.

For more information, email: OEinfo@yourlifesecure.com

LifeSecure Insurance Company (New Hudson, MI) *is majority-owned and a subsidiary of BCBSM. The Group Accident Insurance product has exclusions and limitations.*
**These products are offered on a voluntary basis and not part of your employer sponsored benefit package.*

LifeSecure Group Accident products is not available for BCBSM employees residing in the following states: Alaska, Arkansas, California, Florida, Idaho, Kansas, Maine, Maryland, Mississippi, Missouri, Montana, New York, Oklahoma, South Dakota, Texas, Washington, West Virginia and Wyoming.

LS-AC-G-0463-HCP MI 05/25 *Policy Form #: LS-AC-G-0003-P ST 08/14*

Notice of Availability

English: Call the phone number on the back of your member ID card to reach a complimentary interpreter who speaks English or to receive additional support you may need.

Spanish: Llame al número de teléfono que aparece en el reverso de su tarjeta de identificación de miembro para comunicarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

Arabic: اتصل برقم الهاتف الموجود على ظهر بطاقة هوية عضويتك للوصول إلى مترجم مجاني يتحدث باللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

Chinese Mandarin: 拨打您的会员 ID 卡背面的电话号码，即可联系一位会说普通话的免费翻译，或获取您可能需要的其他支持。

Albanian: Telefononi në numrin e telefonit që gjendet në anën e pasme të kartës suaj të anëtarësisë për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shtesë që mund t'ju nevojitet.

German: Rufen Sie die Telefonnummer auf der Rückseite Ihres Mitgliedsausweises an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

Amharic: አማርኛ ከሚናገር ነጻ ተርጓሚ ጋር ለመገናኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት ከአባል መታወቂያ ካርድዎ ጀርባ ያለው ስልክ ቁጥር ላይ ይደውሉ።

Bengali: বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে আপনার মেম্বারশিপ **ID** কার্ডের পিছনে দেওয়া ফোন নম্বরে কল করুন।

French: Appelez le numéro de téléphone figurant au dos de votre carte d'adhérent pour joindre un interprète gratuit qui parle français ou pour bénéficier d'un soutien supplémentaire dont vous pourriez avoir besoin.

Hindi: किसी ऐसे मानार्थ (कंप्लीमेंटरी) दुभाषिए से संपर्क करने के लिए जो हिंदी बोलता हो या ऐसी अतिरिक्त सहायता प्राप्त करने के लिए जिसकी आपको आवश्यकता हो सकती है, आपके सदस्य ID कार्ड के पीछे दिए गए फ़ोन नंबर पर कॉल करें।

Korean: 가입자 ID 카드 뒷면의 전화번호로 전화를 주시면 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으실 수 있습니다.

Polish: Zadzwoń pod numer telefonu znajdujący się z tyłu karty członkowskiej, aby skontaktować się z nieodpłatnym tłumaczem posługującym się językiem polskim lub aby – w razie potrzeby – uzyskać dodatkową pomoc.

Telugu: తెలుగు మాట్లాడే ఉచిత ఇంటర్‌ప్రెటేటర్‌తో కనెక్ట్ కావడానికి లేదా మీకు అవసరం కాగల అదనపు మద్దతును పొందడానికి మీ మెంబర్ ID కార్డు వెనుక ఉండే ఫోన్ నెంబర్‌కు కాల్ చేయండి.

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Discrimination is against the law

Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 1-877-469-2583 or, if you're 65 or older, call 1-888-563-3307, TTY: 711.

Here's how you can file a civil rights complaint

If you believe that Blue Cross Blue Shield of Michigan, Blue Care Network or our vendors have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/.

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