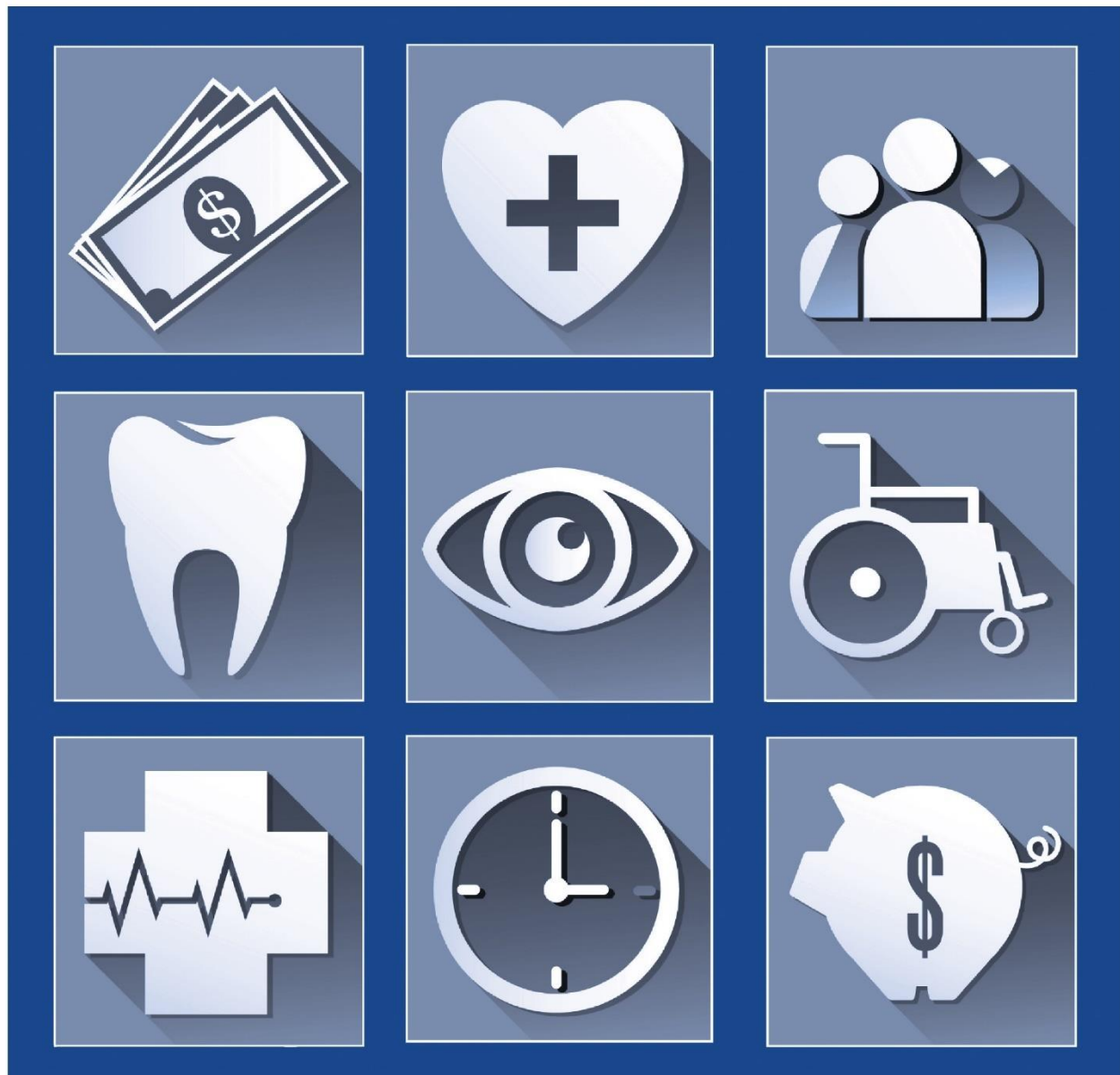




2026 Benefit Guide
Full-Time Associates
(30+ hours per week schedule)



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Important information about Medicare

If you have Medicare or will become eligible for Medicare within the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 32-33 for details.



IMPORTANT CONTACTS

Contact Information

Provider	Benefit	Contact Information	
Blue Cross Blue Shield of Michigan (BCBSM)	Medical and Prescription	Coverage, Claims, Service, Prescription, Order ID cards	(877) 790-2583 www.bcbsm.com
		Finding PPO providers	(800) 810-2583 www.bcbsm.com
Virtual Care through BCBSM Teladoc Health	24/7 Telemedicine for urgent care and/or behavioral health	Registration and contact info	Log in to BCBSM portal or mobile app and access Teladoc Health (855) 838-6628 www.bcbsm.com/virtualcare Payment required at end of visit
National Vision Administrators (NVA)	Vision	Coverage, Claims, Service, Finding NVA providers	(800) 672-7723 www.e-nva.com
Delta Dental of Michigan	Dental	Coverage, Claims, Providers, Finding Delta Dental providers	(800) 524-0149 www.deltadentalmi.com
Prudential	Disability Life Voluntary Benefits	Disability Life Voluntary Benefits	(800) 842-1718 (800) 524-0542 (844) 455-1002 www.prudential.com
Prudential IMG	Travel Assistance Program	Worldwide Emergency Travel Assistance	U.S. (855) 847-2194 Outside US (317) 927-6881 assist@imglobal.com
Flores & Associates	Flexible Spending Accounts (FSA)	Coverage, Claims, Service Participant Portal Resources (flyers, videos, etc.)	(800) 532-3327 https://www.flores247.com/ https://www.flores-associates.com/resources.html
Health Equity	Health Savings Accounts (HSA) (with HD Medical)	Coverage, Claims, Service Education Qualified Medical Expenses	(866) 346-5800 www.HealthEquity.com https://www.healthequity.com/learn/hsa https://learn.healthequity.com/gme/
Ulliance	EAPp	Service and Support	(800) 448-8326 www.LifeAdvisorEAP.com Employer: AAA Life City of Employment: Livonia or Omaha
Voya Financial	401(k) Plan	Service and Support	(800) 584-6001 www.voyaretirementplans.com
QuitWell	Tobacco/Nicotine Cessation Program	To Enroll	(800) 345-2476 (press 1) 8:30am-5:30pm EST OR enroll online: www.CoreHealthyLife.com/HealthCoaching
AAA Life Insurance Company	Benefit Questions	Employee Benefits	HRBenefits@aaalife.com



GENERAL INFORMATION

Introduction

AAA Life Insurance Company recognizes benefits are an important part of your total compensation. Each year at this time, our team carefully reviews our program and explores options to maintain the quality of our benefits to meet the needs of you and your family while balancing costs and employee contributions.

This Benefit Guide summarizes the benefits and options available to you. As a healthcare consumer, it is important to educate yourself about the various plans being offered. In making your elections, consider the benefits, ease of obtaining care, costs, and how well the plan meets the needs of you and your family.

About This Guide

This Benefit Guide contains a general outline of covered benefits and does 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. AAA Life Insurance Company reserves the right to amend, modify, terminate any plan at any time and in any manner.

Associate Eligibility

Associates working a regular schedule of 30 hours or more per week are eligible for our full-time benefit program. Associates must be actively at work on hire date and properly enroll through the Dayforce system for benefits to become effective on date of hire for medical, flexible spending accounts, dental, vision, and life insurance (basic life/AD&D and supplemental life.) Associates are automatically enrolled in LifeAdvisor/EAP services effective on date of hire. Short Term Disability (STD) and Long Term Disability (LTD) insurance is effective first of the month following 30 days from date of hire. Coverage for elected voluntary benefits (critical illness, accident, hospital indemnity) is effective first of the month following 30 days from hire date.

Dependent Eligibility

As an eligible associate, you may enroll certain dependents for coverage under several of our benefit plans. Eligible dependents for Medical, Vision, Dental, and Supplemental Life Insurance include:

- Your legal spouse.
- Your dependent children by birth, marriage, legal adoption or legal guardianship, until the end of the calendar year in which they turn age 26.
- Your child over age 26 who was totally and permanently disabled prior to age 19 due to either a physical or mental disability. They must be 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 the condition before the end of the year in which the dependent turns 26. The disability must be certified by a physician.





GENERAL INFORMATION

Changing Benefits Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. 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 have 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, 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 plan.
- Electing coverage under your state's Marketplace (also known as the "Exchange") during annual enrollment or as a result of a special enrollment.

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 add or drop 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 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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you 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. To request special enrollment or obtain more information, contact Human Resources.

Children's Health Insurance Program Reauthorization Act of 2009 adds the following two special enrollment opportunities:

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this Guide.



GENERAL INFORMATION

Paying For Coverage

To participate in the medical, dental and vision plans, AAA Life Insurance Company asks you to contribute a portion of the cost of coverage through payroll deduction. AAA Life sponsors a Section 125 premium conversion plan, which allows contributions to be taken from your paycheck before federal, state (as allowable) and FICA taxes. In effect, your take home pay will never be reduced by the full amount of the contribution. The amount of savings will vary depending on your individual contribution and income tax bracket. Your Social Security benefit may be reduced due to a decrease in taxable income.

Plan changes made during the Open Enrollment period will take effect on January 1, 2026. Because our Plan is governed by the Internal Revenue Code, the benefits you choose stay in effect until December 31, 2026 unless you have a qualified change in status.

Bi-weekly contributions for the 2026 plan year

Full-Time	Single		Two Person		Family	
Bi-Weekly	Company	Associate	Company	Associate	Company	Associate
*Medical PPO 1500	\$404.72	\$101.54	\$948.81	\$266.22	\$1,150.47	\$368.31
*Medical HD 3400	\$365.51	\$17.31	\$875.50	\$43.27	\$1,058.12	\$90.35
*Medical PPO 3000	\$365.33	\$85.33	\$918.77	\$162.82	\$1,058.25	\$293.73
Vision	\$1.38	\$1.38	\$3.31	\$3.31	\$4.14	\$4.14
Dental	\$6.60	\$8.31	Associate + Spouse		\$23.27	\$32.31
			\$12.38	\$16.15		
			Associate + Child(ren)			
			\$13.75	\$21.69		

*Additional surcharges (working spouse, preventive exam, tobacco user) may be applied to associates enrolled in medical

AAA Life Insurance Company integrates guidelines to encourage positive behaviors. Surcharges are additional employee contributions for your medical plan that may be applicable depending on your situation and/or your covered spouse's involvement and participation.

Medical — Working Spouse Surcharge

If enrolling in medical, an associate must pay an additional cost to cover a working spouse who has the option to elect medical coverage from his or her employer and has declined the coverage. The additional medical premium is \$100 per month (\$46.15 pre-tax deduction on bi-weekly pay period basis). Each employee must complete an attestation on an annual basis or as directed by Human Resources. Employees may avoid the surcharge by having working spouses enroll in their own employer plans.

Medical — Preventive Physical Exam Nonparticipation Surcharges

If enrolling in medical, an associate may pay an additional cost if you, and/or your covered spouse if applicable, do not have a preventive physical exam within published timeframes on an annual basis. If you and/or your covered spouse choose not to have a preventive exam (covered under the medical insurance) and you do not submit the necessary documentation within published timeframes, your medical contribution will increase by \$75 per month (\$34.63 post-deduction on a bi-weekly basis) per non-compliant enrollee. To avoid the surcharge(s), associates must complete and return a participation form signed by a physician for self, and covered spouse if applicable, on an annual basis or as directed by Human Resources. See page 4 for timelines and information.

Medical — Tobacco/Nicotine User Surcharges

If enrolling in medical, an associate will certify tobacco status for self, and covered spouse if applicable, each year during enrollment in the Dayforce system. An associate may pay an additional cost if you (and/or your covered spouse) regularly use tobacco/nicotine and do not participate in an individual telephonic cessation program offered by the company at no cost to you and/or your covered spouse and complete the required sessions in a specified period within the published timeframes on an annual basis. If you and/or your covered spouse choose not to participate within published timeframes, your medical contribution will increase by \$50 per month (\$23.08 post-tax deduction on a bi-weekly basis) per non-compliant participant. See page 4 for timelines and information.



GENERAL INFORMATION

Wellness Initiatives: AAA Life Insurance encourages associates to take an active role in their health and in staying well.

Preventive Physical Wellness Requirement or Surcharges

Preventive healthcare focuses on taking proactive measures to prevent the onset or progression of diseases and conditions. Rather than waiting for symptoms to appear or for a health issue to worsen, preventive healthcare aims to identify and address potential health risks early on. The great news is that age-appropriate preventive care services are covered at no cost to you and your covered family members enrolled in a AAA Life medical plan.

2026 Plan Year

To help you stay healthy, if enrolling in a medical plan, please be sure both you, and your covered spouse if applicable, complete Preventive Physical exam(s) with your physician(s) and complete the submission requirements. See below for key details and timeframes:

- **Preventive Exam Acceptable Dates:** [October 1, 2025 through June 15, 2026](#)
- **Documentation Submission Deadline Date:** [June 15, 2026](#)
- **Documentation Submission Process:** [Human Resources will share process details in targeted communication](#)

If you and/or your covered spouse choose not to have a preventive exam (covered under the medical insurance) and do not submit the necessary documentation signed by your physician by June, your medical contribution will increase by \$75 per month per non-compliant enrollee starting in July and continuing through the last pay period in December.

- **Surcharge amount:** [\\$75 per month](#) (\$34.63 bi-weekly post-tax deduction) per non-participating enrollee and spouse
- **Surcharge effective date:** [First pay cycle in July](#) (pay period beginning July 6, 2026 for pay date July 23, 2026)

Tobacco/Nicotine User Surcharges or Tobacco/Nicotine Cessation Program

Continuous tobacco/nicotine use can lead to cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Choosing to live tobacco and nicotine-free can help you stay healthier, reduce doctor visits, and minimize time away from work. AAA Life Insurance Company is committed to supporting your health and well-being by offering associates and covered spouses if applicable, a no-cost Tobacco/Nicotine Use cessation program.

2026 Plan Year (November 2025 enrollment)

If enrolling in a medical plan, an associate will certify tobacco status for self, and covered spouse if applicable, during enrollment in the Dayforce system. If you and/or your spouse are enrolled in a medical plan and currently use tobacco or nicotine, a monthly surcharge of \$50 per individual will apply in April through the last pay period in 2026.

However, if you (and/or your covered spouse) certify as a tobacco user and enroll in and complete the QuitWell telephonic smoking cessation program offered at no cost to you and/or your spouse, you can avoid the surcharge effective in April. See below for key details and timeframes:

- **QuitWell Program enrollment window:** [December 1 to December 15 2025](#)
- **QuitWell Program completion deadline date** (5 of 5 sessions): [March 20, 2026](#)
- **Surcharge amount:** [\\$50 per month](#) (\$23.08 bi-weekly post-tax deduction) per non-participating tobacco user
- **Surcharge effective date:** [First pay cycle in April](#) (pay period beginning April 6, 2026 for pay date April 23, 2026)

New Hire Enrollment

If enrolling on a medical plan and certify that you, and/or your covered spouse if applicable, are tobacco users, you each must enroll in the QuitWell program within *first day of first month following hire date and complete 5 out of 5 sessions within 95 days or the monthly surcharge of \$50 per individual will apply* the first pay cycle following the program end date (if participating) or first pay cycle following 95 days after medical plan enrollment effective date through the end of year.

QuitWell Tobacco/Nicotine Cessation Program provides telephone support, education materials, and opportunities to speak with a health coach about how to kick the habit.

- **To Enroll:** [Call QuitWell at \(800\) 345-2476 and press 1](#) or [Online: www.CoreHealthyLife.com/HealthCoaching](#)



MEDICAL INSURANCE

Choice of Medical Plans

You have a choice between three fully insured plans through Blue Cross Blue Shield of Michigan (BCBSM). Each plan provides coverage for service and uses a PPO network of providers.

Highlights In-Network Services	PPO 1500 Simply Blue	HD 3400 Simply Blue PPO HDHP	PPO 3000 Simply Blue
Office Visit Specialist Visit	\$30 copay \$30 copay	20% after deductible	\$40 copay \$60 copay
Emergency Room Urgent Care	\$150 \$40	20% after deductible	\$250 \$60
Chiropractic Care	12 visits per year	12 visits per year	12 visits per year
Annual Deductible			
Single	\$1,500	\$3,400	\$3,000
Two Person/Family	\$3,000	\$6,800	\$6,000
Coinsurance After Deductible	20%	20%	20%
Annual Coinsurance Maximum			
Single	\$2,500	N/A	\$2,500
Two Person/Family	\$5,000		\$5,000
Annual Out-of-Pocket Maximum			
Single	\$6,350	\$6,900	\$8,150
Two Person/Family	\$12,700	\$13,800	\$16,300
Prescription Drug (30 days)	\$10/\$40/\$80/ 15%(\$150)/25%\$300	\$10/\$40/\$80	\$10/\$40/\$80/ 15%(\$150)/25%\$300

Simply Blue PPO Medical Plans

- All medical options are preferred provider organization (PPO) plans with In-network and out-of-network benefits.
- An office visit copayment applies to the exam.* Deductibles and coinsurance apply to any visit services; services include diagnostic (including complex), surgery and therapeutic. (*Cost share may not apply if preventive or immunization services are provided during the office visit.)
- Preventive Care services are covered at 100% in network.
- Emergency room copay is not waived for accidental injury; copay is waived for admission.
- Covers physical, speech and occupational therapy to 30 visits per calendar year.
- Chiropractic—12 visit limit.
- Deductible and coinsurance applies to outpatient mental health and substance abuse visits.
- Out of network services paid as out-of-network, even if referred by a PPO provider.

HD Plan: Simply Blue PPO High-Deductible Health Plan (HDHP) and Health Savings Account (HSA)

- You must satisfy the deductible before the plan begins paying for covered services. This means the cost for office visits and prescription drugs apply towards the deductible requirement. The only exception is preventive care, which is covered at 100% in network, with no deductible or coinsurance required.
- If you enroll in the HDHP, you may be eligible to contribute to a Health Savings Account (HSA). You may use the money in an HSA to pay for current or future qualified medical expenses. More information on the HDHP and HSA is provided later in this Guide.



MEDICAL INSURANCE

In-Network and Out-of-Network Providers

- You don't need to choose a Primary Care Physician with a PPO—you can see any provider you want to see, even a specialist.
- You can see non-PPO providers, but your benefits will be reduced and you'll pay more out-of-pocket.

Non-Participating Providers

If you visit a non-PPO provider, it is important to know whether the provider is Participating or Non-participating. It will be in your financial interest to receive care from a BCBSM Participating provider. Participating providers have a signed agreement with BCBSM and accept payment in full for covered services after out-of-network deductibles, coinsurance, or copays. A Participating provider must accept BCBSM's approved amount—they can't balance bill you for more than your deductible and coinsurance. (Balance billing is when a provider bills you for the balancing remaining on the bill that your plan does not cover.) A non-participating provider can balance bill you whatever amount s/he thinks is fair – there's no limit to what you can be charged. Any charges related to balance billing do not go towards meeting the annual out-of-pocket maximum.

Coverage at non-participating hospitals (those who do not participate with BCBSM) is limited to care needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital care or care received at non-participating mental health or substance abuse facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

Medical Plan Features Definitions

Outlined below are definitions of select medical plan features. For more information, the Uniform Glossary of Health Coverage and Medical Terms (prepared by the federal government) is included in the last section of this Guide and available separately on LifeNet.

Office Visit Copays are generally a fixed amount (for example, \$30) you pay for a covered health care service usually when you receive the service. The amount can vary by the type of service. For the PPO Plan, fixed dollar copays generally apply to office visits, specialty visits, medical online visits, chiropractic, visits and urgent care visits.

Annual Deductibles are the amounts you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay.

Coinsurance is your share of the costs of a covered health care service, calculated as a percentage (for example, you pay 20% and plan pays 80%) of the allowed amount for the service. Generally, you meet your deductible first and then pay your coinsurance share.

Annual Coinsurance Maximums is the highest amount you will pay in a calendar year for your coinsurance payment. It 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.

For example, consider an individual who had a covered service costing \$11,000. The first \$1,000 would go to meeting the annual deductible. The next \$10,000 would be subject to the 20% coinsurance (\$2,000). The \$2,000 would go toward meeting the Annual Coinsurance Maximum. Any other service subject to coinsurance for the remainder of the calendar year would be paid at 100% for the remaining calendar year.

Annual Out-of-Pocket Maximums is the most you could pay during a calendar year for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. Applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable.



MEDICAL INSURANCE

Medical Plan Differences

The “PPO” plans are similar the “HD” (High Deductible Health Plan or HDHP) but there are important differences. See below for a comparison of some key features for each plan.

In-Network	PPO Plans PPO 1500 and PPO 3000	HDHP Plan HD 3400
Deductible Calculations	One member never has to satisfy more than the single deductible. Any deductible met in the fourth quarter carries over, or is credited towards the following calendar year. ACA-mandated preventive care, is covered at 100% in network, with no deductible copay or coinsurance required.	If you are enrolled as a two person contract or as a family contract, and only one family member is incurring claims, that member will need to satisfy the entire family deductible of \$3,400 in-network, (\$6,800) for the plan to pay. ACA-mandated preventive care, is covered at 100% in network, with no deductible copay or coinsurance required.
Copays	You have copays for physician office visits, emergency room treatment, urgent care visits and prescriptions. The copays will accumulate towards your out-of-pocket maximum.	After your annual deductible is satisfied, covered medical services (in-network) are paid at 80% and prescriptions are covered with a copay.
Annual Coinsurance Maximums	In a calendar year, after you have paid your 20% coinsurance on covered services to the annual maximums of \$2,500 individual or \$5,000 family, then you have met your coinsurance obligation for the year and the plan pays 100% of the approved amount (for covered services subject to the 20% coinsurance)	N/A
Annual Out-of-Pocket Maximums	Once your out-of-pocket maximum is met, the plan pays 100% of the approved amount for covered services, including office visit copays and prescription drug copays.	Once your out-of-pocket maximum is met, the plan pays 100% of the approved amount for covered services, including office visits and prescription drug copays.
Out-of-Pocket Expenses	These expenses may be paid with pre-tax dollars from a Health Care FSA. A Health Care FSA is a ‘use it or lose it’ account. Any amounts left in the account at the end of the plan year are forfeited. In 2026, you can contribute up to \$3,400 annually to your Health Care FSA.	These expenses may be paid with pre-tax dollars from a Health Savings Account. <i>HSA balances roll over year-to-year and can follow you into retirement.</i> You can fund your HSA with pre-tax contributions. The maximum contribution for 2026 is \$4,400 for single coverage and \$8,750 for family coverage. If you drop your health care coverage, change health care plans or leave the company, your HSA goes with you—it is always your account.
Prescription Coverage	You have a copay for all covered prescriptions. The copays are different for each drug tier including generic, formulary, non-formulary and specialty drugs.	The full cost of prescriptions applies to your annual medical plan deductible. Once the deductible is satisfied, you have a copay for prescriptions depending on drug tier.
Other Health Care Coverage	You and your eligible dependents may be covered by our PPO plans and have other health care coverage, such as another PPO plan or Medicare.	You may not contribute to a Health Savings Account if you are covered under another medical plan that is not a high deductible health plan (including a spouse’s health plan or FSA; Medicare; Tricare; or received VA benefits for non-service related conditions or certain Indian Health benefits in the past 3 months).



MEDICAL INSURANCE

Prescription Drugs

Prescription drug coverage is included with our medical plans. The amount you pay for each prescription depends on the drug tier.

For the HD Plan (Simply Blue HDHP) your prescription drug costs (other than for preventive medications) will apply towards the annual deductible and then a copay will apply after the deductible is met. For both plans, the prescription drug copays accumulate towards the annual out-of-pocket maximum.

Prescription Drug Coverage Overview	PPO Plans PPO 1500 and PPO 3000	HDHP Plan HD 3400
	30-day supply (if available)	30-day supply (if available)
Tier 1: Generic 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. Has lowest copay making them the most cost-effective option for the treatment.	\$10 copay	You pay Deductible first, then \$10 copay
Tier 2: Preferred Brand Name Includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them.	\$40 copay	\$40 copay
Tier 3: Non-Preferred Brand-name 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.	\$80 copay	\$80 copay
Tier 4: Preferred Specialty Drugs Includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than non-preferred specialty drugs.	15% of approved amount, but no more than \$150	N/A
Tier 5: Non-Preferred Specialty Drugs Includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.	25% of approved amount, but no more than \$300	N/A

Prior Authorization and Step Therapy

Prior authorization is required for certain prescription drugs before they are dispensed. Your doctor should contact BCBSM directly for approval of any drug that is on the prior authorization or step therapy list.

Step therapy is part of the prior authorization process required for some drugs. BCBSM will not approve payment unless the patient has followed specific medication therapy first.



MEDICAL INSURANCE

Prescription Drugs

Generics Save You Money

Generic utilization is mandatory. If you choose to fill your prescription with a brand-name medication when a generic is available, you must pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug, plus your applicable copay.

Convenient 90 day supply at certain retail pharmacies

Retail coverage of prescription drugs includes 84 to 90 day supplies subject to a copay that is double the amount that would apply for a 30-day refill. Prescriptions for 35 to 83 day supply are not covered via retail. All retail 90-day supplies of medication must be obtained from a “90-Day Retail Network” provider. You can find a list of participating pharmacies at bcbsm/pharmacy.

Mail Order Program

To save money, you may have prescriptions filled through the mail order program for certain maintenance medications. The mail order program allows you to obtain a 31-90 day supply for two copays versus three at retail. Your prescription is delivered to your door. Optum Rx is the vendor for Mail Order Prescription services.

Specialty Drugs

Specialty prescription drugs are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. A list of specialty drugs is available at bcbsm.com/specialtydrug. Specialty drugs are obtained through an exclusive specialty pharmacy program through Walgreens Specialty Pharmacy.

- Walgreens Specialty Pharmacy will handle mail order prescriptions for specialty drugs. Contact Walgreens Specialty Pharmacy at www.WalgreensSpecialtyRx.com or 1-866-515-1355 with questions.
- You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location (call ahead to be sure.) Find a Walgreens location at walgreens.com/storelocator/find.jsp. If you go to a non-Walgreens Specialty Pharmacy provider, you may be responsible for 100% of the cost of the specialty drug.
- **Covered specialty drugs are only available in a 30-day supply whether the drugs are obtained from a 90-Day Retail Network provider or mail-order provider.**
- BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be adjusted accordingly.

Select Controlled Substance Drugs

BCBSM will limit the 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.

High-Cost Prescription Drug Discount Program

A Blue Cross Blue Shield high-cost drug discount program helps you find and take advantage of manufacturer copayment assistance programs that may lower your out-of-pocket costs for expensive medications. PillarRx (1-517-583-3944) contacts eligible members (currently PPO Community Blue plan only at this time) directly by mail and phone to enroll in the program. Only the amounts you pay for the prescription will apply to your annual out-of-pocket maximum. Adjustments may be required to accurately reflect your true out-of-pocket cost.

VISION INSURANCE

Vision benefits are fully insured through National Vision Administrators (NVA).

You will receive maximum benefits when you receive care from an In-Network NVA provider. To find a provider in your area, please visit the contacts page for telephone and website address information.

You may receive care from a non-NVA provider, but you will have higher out-of-pocket costs. Also, you will have to pay the entire bill when you receive out-of-network services and then submit your claim to NVA for reimbursement.

If you choose extra options, you will be responsible for paying the provider for the additional cost of those options. However, NVA providers offer preferred pricing on many cosmetic options, such as lens coating, tinting, and other services.

A detailed benefit summary is available at the back of this Guide.

Vision Highlights	NVA (In-Network)
	<i>Benefits available every calendar year</i>
Exam	\$5 copay
Lenses (Single, bifocal, trifocal)	\$10 copay
Frame	Up to \$130 allowance 20% discount on balance
Contact Lenses (elective-prescribed) <i>In lieu of Lenses</i>	Up to \$130 Retail Conventional: 15% discount on balance Disposable: 10% discount on balance
Contacts (medically necessary) <i>In lieu of Lenses</i>	<i>NVA Pre-approval required</i> No copay, paid in full
Refer to Certificate of Insurance for complete coverage details.	





DENTAL INSURANCE

Dental benefits are fully insured through Delta Dental of Michigan.

You will receive maximum benefits when you receive care from a Delta Dental PPO or Premier provider. Participating dentists with Delta Dental PPO have agreed to accept lower fees as full payment for covered services. Delta Dental Premier dentists agree to accept Delta Dental's fee determination as full payment for covered services. To find a provider in your area, please visit the contacts page for telephone and website address information.

You may receive care from a non-Delta provider, but you will have higher out-of-pocket costs. Also, you may also have to pay the entire bill when you receive out-of-network services and then submit your claim to Delta for reimbursement.

A detailed benefit summary is available at the back of this Guide.

Delta Dental PPO Dentist	- No balance billing on covered services - Most significant network discounts with more than 200,000 office locations nationwide - Dentists file claims for member
Delta Dental Premier Dentist	- No balance billing on covered services - Significant network discounts with the more than 340,000 office locations nationwide - Dentists file claims for member
Non-Participating Dentist	- May be balance billed - No discounts - May need to file own claims for reimbursement

<i>December 1 through December 31 Benefit Year</i>	PPO	Premier
Annual Deductible (<i>applies to Type B, and C services only</i>)	\$50 Individual/ \$150 Family	\$50 Individual/ \$150 Family
Type A – Diagnostic and Preventive - Diagnostic and Preventive Services – exams, cleanings, fluoride (once per calendar year through age 13), and space maintainers - Sealants – to prevent decay of permanent teeth - Brush biopsy – to detect oral cancer - Radiographs – bitewing X-rays	100%	100%
Type B – Basic - Other Radiographs – all other X-rays - Minor Restorative Services – fillings and crown repair - Endodontic – root canals - Periodontal – gum disease treatment - Oral Surgery Services - extractions	80%	50%
Type C – Major - Major Restorative Services – crowns - Prosthetic Services – bridges, implants, dentures	60%	50%
Annual Plan Maximum (Types A, B, C) per person per benefit year	\$1,500	\$1,500
Type D – Orthodontia Braces (no age limit) - \$1,250 Lifetime Maximum	50%	50%
Lifetime Orthodontia Benefit Maximum Per Person	\$1,250	\$1,250

Refer to Certificate of Insurance for complete coverage details.

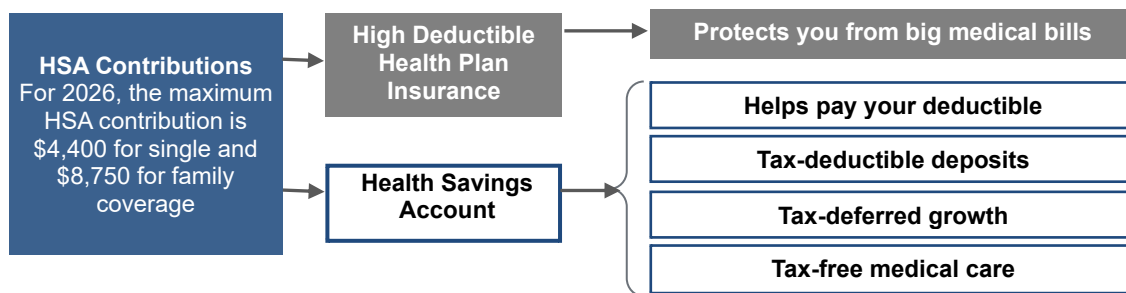


TAX FAVORED ACCOUNTS

Health Savings Accounts (HSA)

When you elect the HD Plan, you also have the opportunity to enroll in a Health Savings Account (HSA). An HSA is a special bank account that provides a tax-free way to pay for current or future health care expenses. You choose whether to use your HSA now or to save it for health care expenses after you retire.

The HSA provides a *triple tax advantage*: money goes in tax-free, grows tax-free and is tax-free when used to pay for eligible medical expenses. If you don't use all the money in the HSA during the benefit year, it rolls over to the next year. You can also take the money in the HSA if you leave the company or retire. Once money is in the account, it's yours to keep or use toward eligible healthcare expenses. Here is a quick snapshot of how HSA works with the insured health plan.



BCBSM HSA Administrator is Health Equity

If you elect the High Deductible Plan and you meet the HSA eligibility requirements, you may set up a Health Savings Account with Health Equity, the BCBSM partner vendor. Your HSA contributions may be conveniently payroll deducted on a pre-tax basis. The funds will be transmitted from AAA Life to Health Equity and deposited into your HSA. You may also make individual post-tax deductions directly to Health Equity. The combined pre and post-tax contribution may not exceed the annual limit.

Associates who enroll with Health Equity will receive an introductory letter mailed to their home. It will include a Personal Identification Number (PIN) for accessing account activity on the Health Equity website and instructions for making investment elections. You will also receive your convenient debit card with instructions on how to activate the card. The Health Equity website is also conveniently linked to the BCBSM member website, making it easier to access the account information.

Reimbursements

You do not need to submit receipts to substantiate the expenses. Instead, you simply request a distribution (much like a bank withdrawal) or use the debit card to pay for medical expenses. As long as there are sufficient funds in the Account, Health Equity will send a reimbursement or process the payment on the debit card. It is your responsibility to understand the parameters and keep good records of expenses to ensure that the distributions have been made for qualified medical expenses.

Using Your Own Financial Institution as HSA Administrator

You may choose to set up an HSA through your own financial institution. However, you will need to deposit funds directly into your HSA rather than through payroll deduction. Since the contributions will be post-tax, they are reported as an above-the-line deduction on your annual tax return. The HSA financial institution will provide an IRS form 8889 annually for tax preparation purposes.



TAX FAVORED ACCOUNTS

HSA Eligibility

In order to contribute to an HSA:

- You must be enrolled in a qualified High Deductible Health Plan like the HD Plan.
- You are not allowed to be enrolled in any other health coverage plan, including Medicare (i.e., no secondary coverage permitted under spouse's employer's plan). There are very few exceptions, described in IRS Publication 969.
- You cannot participate in a general purpose (full purpose) Health Care Flexible Spending Account if you contribute to an HSA. Also, your spouse cannot have a general purpose health care pre-tax spending account.
- You may not be claimed as a dependent on someone else's tax return.
- You cannot be receiving Veterans Administration (VA) benefits for non-service related conditions or certain Indian Health Benefits currently and within the past three months.

HSA Advantages

- Your payroll contributions go into your HSA before taxes are withdrawn from your paycheck.
- Withdrawals for qualified expenses are tax-free.
- You can use your funds for future qualified health care expenses. See the complete list of qualified health care expenses in IRS Publication 502. Visit [IRS.gov](https://www.irs.gov) and enter "Publication 502" in the search box.
- The interest and earnings in an HSA grow tax-free.
- An HSA is "portable" so it stays with you if you change employers or leave the work force.
- The account holder controls all decisions over how the money is invested.

Important HSA Rules

- For 2026, the maximum amount you can contribute to an HSA is \$4,400 for single coverage and \$8,750 for two person or family coverage.
- If you are age 55 or older, you can contribute an additional \$1,000 per year.
- You may change your HSA pre-tax contribution amounts anytime during the year.

Prorated HSA Contributions for Midyear Enrollments and Changes

If you do not have HSA-compatible health coverage for an entire calendar year, generally you must prorate your HSA contributions to avoid tax penalties.

If you join the plan midyear, you may be able to take advantage of the *last month rule* and contribute the entire maximum for the year.

Under the *last month rule*, if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year.

You are treated as having the same HDHP coverage for the entire year as you had on the first day of that last month. However, there is a testing period. If contributions were made to your HSA based on you being an eligible individual for the entire year under the last month rule, you must remain an eligible individual during the testing period.

For the last month rule, the testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month. For example, December 1, 2024 through December 31, 2025.

For more information:

- See IRS Publication 969 under "Contributions to an HSA".
- Review the prorated HSA contribution amounts listed on the *Limitation Chart and Worksheet* in the Instructions for IRS Form 8889, Health Savings Accounts (HSAs).
- Consult a qualified tax advisor. There may be exceptions to HSA federal and state tax advantages depending on your State of residence.

More HSA Information

Visit LifeNET for a library of resource information about High Deductible Health Plans and HSAs.

Limited Purpose FSA

Associates who are enrolled in the HD Plan and make contributions to the HSA are not eligible to participate in the general Health FSA. However, you can maximize the benefits of an HSA by participating in a Limited Purpose FSA for reimbursement of eligible dental and vision care expenses, and for medical expenses incurred after the plan deductible is met.



TAX FAVORED ACCOUNTS

Flexible Spending Accounts (FSA)

Flexible Spending Accounts allow you to pay for health care and day care expenses with tax-free dollars. They help you stretch your money and reduce your federal, state, and Social Security taxes. How much you save depends on how much you pay in income tax. FSAs are administered by Flores & Associates.

Annual Amount You Contribute to a Health Care FSA or DCRA	Annual Tax Savings in a 15% Tax Bracket	Annual Tax Savings In a 25% Tax Bracket
\$500	\$113	\$163
\$1,000	\$227	\$327
\$3,000	\$680	\$980
\$4,000	\$906	\$1,306
\$5,000	\$1,133	\$1,633

Savings include 7.65% for FICA. Actual savings will vary based on how many dependents you claim and other factors.

FSA Administration

We offer a Health Care Flexible Spending Account (FSA), a Limited Purpose FSA and a Dependent Care Reimbursement Account (DCRA). You decide before the start of each plan how much to contribute to each account. Your contributions are withheld in equal amounts from your paychecks throughout the year. The money goes into an account(s) set up in your name.

Eligibility

- You don't have to enroll in our health plan in order to participate in the Health Care FSA or DCRA.
- Associates who contribute to the HSA may contribute to the Limited Purpose FSA and the DCRA.

No double dipping

- You cannot claim tax credits or deductions for expenses for which you are reimbursed through the Health Care FSA and/or DCRA. Be sure to carefully evaluate which tax savings approach is best suited for your situation.

No transfers between accounts

- Your accounts are maintained separately and are mutually exclusive. You cannot use the balance in one FSA to pay for expenses eligible for reimbursement under the other.

Fund Availability

- Under the DCRA, you can only be reimbursed for the amount currently funded in your account via your payroll deductions.
- By contrast, medical expenses are reimbursed from your Health Care FSA based upon your annual election, not your actual account balance at the time of service. The full amount will be available on January 1.

Use it or lose it

- If you have not incurred enough expenses by the end of the plan year to use up the money remaining in your account, IRS rules require that you forfeit that remaining money.
- Run-out is a period after the end of the plan year in which participants can submit expenses incurred during the prior plan year. Participants have until March 31 to submit claims incurred for the prior calendar year.



TAX FAVORED ACCOUNTS

Flexible Spending Accounts (FSA)

Health Care FSA

The Health Care FSA (HFSA) helps you pay for medical, dental, and vision bills that aren't covered by insurance. For example, you may be reimbursed for items like:

- Plan deductibles and coinsurance.
- Office visit and prescription drug copays.
- Vision exams and materials.
- Other expenses that the medical, vision or dental plans do not cover.

For a complete list of the expenses eligible for reimbursement, visit the IRS website and view Publication 502.

You may set aside a minimum of \$100 to a maximum of \$3,400 annually in the Health Care FSA. The full amount will be available January 1, 2026.

For the Health Care Reimbursement Account, generally you must incur qualified expenses during the period of January 1 – December 31 or the money in your account will be forfeited.

Limited Purpose FSA

Associates enrolled in the HD Plan, are not eligible to participate in the general Health FSA, and that is why our Limited Purpose FSA is such a great benefit.

You can maximize the benefits of an HSA by participating in a Limited Purpose FSA for reimbursement of eligible dental and vision care expenses. You may elect to contribute any dollar amount from a minimum of \$100 to a maximum of \$3,400 for the 2026 plan year.

What's limited in the Limited Purpose FSA?

Only claims for certain eligible dental and vision care expenses, and medical expenses incurred after the plan deductible is met are allowed under this account.

General medical expenses are not eligible for reimbursement through the Limited Purpose FSA, because they may be submitted to the HSA.

The Limited Purpose FSA is similar to a traditional Health Care FSA. Associates decide how much money to contribute, and that amount is deducted tax-free from their paychecks. Just like the HFSA, any money remaining in the account at the end of the plan year is forfeited.

Dependent Care Reimbursement Account (DCRA)

A DCRA lets you pay eligible dependent care expenses with pre-tax dollars. Most child and elder care and companion services are eligible expenses too. Your dependents must be:

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

In 2026, the maximum you can put into the DCRA is \$7,500. But if both you and your spouse work, the IRS limits your maximum contribution to a DCRA.

- If you file separate income tax returns, the annual contribution amount is limited to \$3,750 each for you and your spouse.
- If you file a joint tax return and your spouse also contributes to a DCRA, your family's combined limit is \$7,500.
- If your spouse is disabled or a 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.

Usually the DCRA will save 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, posted on the IRS website.

If you contribute to a Dependent Care Reimbursement Account, 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 pay and who you paid for day care.

Reimbursements

Flores & Associates offers multiple ways to submit claims to request reimbursement, including a mobile app or web portal. A debit card is included with the Health Care and Limited Purpose FSAs and you will be requirement to submit claims substantiation if needed.



DISABILITY ACCOUNTS

Short Term Disability

AAA Life Insurance Company provides you with Short Term Disability (STD) insurance through Prudential at no cost to you. STD replaces a portion of your income if you are disabled and cannot work due to a non-work-related illness or injury.

The STD plan provides 60% of your weekly earnings up to a \$3,500 weekly maximum. In Dayforce, associates may elect to pay tax now on the company-paid premium for the STD so that any future benefit received is non-taxable. The tax on the premium is relatively small in comparison to the taxes you would pay if you became disabled and received benefits. You have the option of not paying the tax on the premium, but then any benefit received will be subject to tax.

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Complete coverage information is in the certificate of insurance.

Overview	Short Term Disability
Monthly Benefit	60% of earnings to a weekly maximum of \$3,500
Definition of Earnings	Includes your base pay and commissions. Earnings do not include income received from overtime pay, bonuses or other extra compensation, or income received from sources other than the Employer. Earnings will be calculated based on the shorter of the 12 month period just prior to the date of disability, or the period of employment. Commission will be averaged over the period of employment if it is less than 12 months.
Elimination Period	STD benefits for approved claims begin on the first day following a non-occupational injury and the eighth day following a non-occupational illness.
Benefit Duration	Benefits are payable for up to 13 weeks from the first day of disability, as long as you remain disabled under the contract.

Depending on the State where you reside, you may be eligible for a State disability or paid leave program and any benefits may be coordinated with company-provided STD and LTD programs.

These sections regarding STD, LTD, Basic Life/AD&D, and Supplemental Life/AD&D contain a general outline of covered benefits and do not include all the benefits, limitations, and exclusions of the benefit programs. If there is any discrepancy between this document and the group contract issued by The Prudential Company of America (Prudential), the terms of the group contract will govern. See the official benefit plan documents for a full list of exclusions. The Booklet-Certificate contains all the details, including any policy exclusions, limitations, and restrictions which may apply. If there is any discrepancy between this document and the Booklet-Certificate/Group Contract, the Group Contract will govern.



DISABILITY ACCOUNTS

Long Term Disability

AAA Life Insurance Company provides you with Long Term Disability (LTD) insurance through Prudential at no cost to you. LTD replaces a portion of your income in the event you are disabled due to illness or injury beyond a period of 90 days (coinciding with the end of the maximum 13 week short disability benefit.)

The LTD plan provides 60% of your earnings up to a \$17,500 monthly maximum. In Dayforce, associates may elect to pay tax now on the company-paid premium for the LTD, so that any future benefit received is non-taxable. The tax on the premium is relatively small in comparison to the taxes you would pay if you became disabled and received benefits. You have the option of not paying the tax on the premium, but then any benefit received will be subject to tax.

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Complete coverage information is in the certificate of insurance.

Overview	Long Term Disability
Monthly Benefit	60% of earnings to a monthly maximum of \$17,500
Definition of Earnings	Includes your base pay and commissions. Earnings do not include income received from overtime pay, bonuses or other extra compensation, or income received from sources other than the Employer. Earnings will be calculated based on the shorter of the 12 month period just prior to the date of disability, or the period of employment. Commission will be averaged over the period of employment if it is less than 12 months.
Elimination Period	If you are disabled according to the contract, benefits are payable after the 90th day of disability (coinciding with the end of the maximum 13 week short disability benefit.)
Benefit Duration	Benefits may continue until you reach your Social Security Normal Retirement Age, as long as you remain disabled under the contract, depending on a person's age at disability. Employees age 62 and older should review the booklet regarding limitations on the duration of Long Term Disability payments. Benefits are limited for mental illness conditions (and substance abuse conditions that fall under mental illness.)
Definition of Disability	You are prevented from performing one or more of the Essential Duties of: 1) Your Occupation during the Elimination Period; 2) Your Occupation, for the 24 month(s) following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings; and 3) after that, Any Occupation.
Pre-existing Conditions	A pre-existing limitation applies. A pre-existing condition is a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to your effective date of insurance, or the date of a change in insurer. A condition shall no longer be considered pre-existing after you have been insured under the policy for a period of 12 months. Coverage under AAA Life's plan with our prior insurer counts towards the twelve months of coverage. Please see the booklet or additional benefits, limitations and exclusions.

These sections regarding STD, LTD, Basic Life/AD&D, and Supplemental Life/AD&D contain a general outline of covered benefits and do not include all the benefits, limitations, and exclusions of the benefit programs. If there is any discrepancy between this document and the group contract issued by The Prudential Company of America (Prudential), the terms of the group contract will govern. See the official benefit plan documents for a full list of exclusions. The Booklet-Certificate contains all the details, including any policy exclusions, limitations, and restrictions which may apply. If there is any discrepancy between this document and the Booklet-Certificate/Group Contract, the Group Contract will govern.



LIFE AND AD&D INSURANCE

Life insurance and Accidental Death and Dismemberment (AD&D) insurance provides financial protection to you and your family in the event of death or serious accident. Basic Life and AD&D is insured through Prudential at no cost to you.

Basic Life Insurance

The plan provides a Basic Term Life Insurance benefit of three times your annual earnings up to a maximum of \$750,000. Life and AD&D benefits reduce by 35% at age 70, and 50% at age 75.

The effective date of any initial, increased or additional insurance will be delayed for an associate who is not actively at work until the associate returns to an actively at work status. Complete coverage information is in the certificate of insurance.

AD&D Insurance

The plan also includes an Accidental Death and Dismemberment (AD&D) benefit. If your death is determined to be an accident, the (AD&D) portion of the policy will pay an additional benefit to your beneficiary. The benefit is equal to your Basic Life amount. If you lose a limb or sight in one or both eyes, you may qualify for a percentage of the life benefit under the dismemberment portion of the plan.

The effective date of any initial, increased or additional insurance will be delayed for an associate who is not actively at work until the associate returns to an actively at work status. Complete coverage information is in the certificate of insurance.

Life Insurance Beneficiary Designation

It is important to complete a beneficiary designation on Dayforce and keep it current.

Overview	Basic Life/AD&D Insurance
Benefit Amount	3 times annual earnings to a maximum of \$750,000
Definition of Earnings	Includes your base pay and commissions. Earnings do not include income received from overtime pay, bonuses or other extra compensation, or income received from sources other than the Employer. Earnings will be calculated based on the shorter of the 12 month period just prior to the date of disability, or the period of employment. Commission will be averaged over the period of employment if it is less than 12 months.
Benefit Reductions	Life and AD&D benefits reduce by 35% at age 70, and 50% at age 75

These sections regarding STD, LTD, Basic Life/AD&D, and Supplemental Life/AD&D contain a general outline of covered benefits and do not include all the benefits, limitations, and exclusions of the benefit programs. If there is any discrepancy between this document and the group contract issued by The Prudential Company of America (Prudential), the terms of the group contract will govern. See the official benefit plan documents for a full list of exclusions. The Booklet-Certificate contains all the details, including any policy exclusions, limitations, and restrictions which may apply. If there is any discrepancy between this document and the Booklet-Certificate/Group Contract, the Group Contract will govern.



LIFE AND AD&D INSURANCE

Supplemental Life and AD&D Insurance

Optional supplemental term life insurance options are available through Prudential for you to purchase at your own cost as long as you are enrolled in Basic Life and AD&D insurance. This convenient program allows you to pay your premiums through a post-tax payroll deduction.

If you elect to enroll in the Supplemental Life plan after 31 days from eligibility, then you are considered to be a Late Entrant and must complete Evidence of Insurability. If a physical is required, it will be at your cost. Once approval is received from Prudential, premiums will be deducted from payroll for the appropriate amount. If you elect to increase coverage by one level which results in coverage exceeding the guarantee issue, an evidence of insurability form must be completed. Once approval is received from Prudential payroll deductions will begin for the appropriate amount.

See below for a brief overview. Additional information is available on LifeNET. Complete coverage information is in the certificate of insurance booklet.

Overview	Supplemental Options
Associate Supplemental Life and AD&D Insurance - At your initial eligibility, you may elect up to the lesser of 3x annual earnings or \$250,000 without Evidence of Insurability (EOI). - The maximum amount of coverage you may purchase is the lesser of 3x annual earnings or \$500,000. - If you buy coverage at your initial eligibility date, you may increase your coverage in the future. At open enrollment, you may increase your coverage amount by one level without EOI. However, an initial request for a coverage amount above \$250,000 will be subject to EOI. - If you initially waive Supplemental Life coverage and elect to enroll in the Supplemental Life plan after 31 days from your initial eligibility, then you are considered to be a Late Entrant and must complete EOI. Prudential may approve or deny your request for coverage based on the EOI. - Rates are age-banded and customized to you on Dayforce. - Benefits are reduced based on age - The effective date of any initial, increased or additional insurance will be delayed for an associate who is not actively at work until the associate returns to an actively at work status.	Associates with Basic life and AD&D may elect additional Supplemental Life and AD&D Insurance: Self —Three Options: 1x annual earnings or 2x annual earnings or 3x annual earnings
Dependent Supplemental Life Insurance - Spouse coverage cannot exceed 100% of the coverage amount for yourself. - If you elect to enroll in the Spouse Supplemental Life plan after 31 days from your initial eligibility, you must complete Evidence of Insurability. Prudential may approve or deny your request for coverage if the medical evidence is not acceptable. If you are currently enrolled in Spouse life for \$10k, you may increase coverage to \$20k without EOI.. - Rates are available on Dayforce.	Associates must elect Supplemental Life Insurance in order to elect dependent coverage Spouse –Two Options \$10,000 or \$20,000 *Child(ren) –Two Options \$5,000 or \$10,000 *Children live birth to age 14 days are eligible for \$1,000 of coverage.

These sections regarding STD, LTD, Basic Life/AD&D, and Supplemental Life/AD&D contain a general outline of covered benefits and do not include all the benefits, limitations, and exclusions of the benefit programs. If there is any discrepancy between this document and the group contract issued by The Prudential Company of America (Prudential), the terms of the group contract will govern. See the official benefit plan documents for a full list of exclusions. The Booklet-Certificate contains all the details, including any policy exclusions, limitations, and restrictions which may apply. If there is any discrepancy between this document and the Booklet-Certificate/Group Contract, the Group Contract will govern.



VOLUNTARY BENEFITS

Optional Critical Illness, Accident, Hospital Indemnity Insurance

You may purchase voluntary worksite benefits through Prudential. These benefits can protect your finances from uncertainty of the future and give you peace of mind in the case of life's unexpected emergencies. These plans pay benefits directly to you. If elected, these policies are 100% employee paid through post-tax payroll deductions. All benefits paid are tax-free.

Prudential policies outline complete definitions of covered conditions. Some exclusions may apply. See Prudential information and policy documents for a complete list of exclusions and policy provisions.

These options are completely portable if you go on leave, terminate employment or retire. If interested, you make direct arrangements to pay Prudential to continue the coverage.

These plans do not impact your eligibility to contribute to a Health Savings Account.

Options

- ***Critical Illness Insurance - may pay money directly to you when diagnosed with serious illnesses**

Pays a lump-sum amount directly to you when you are diagnosed with a covered condition. Helps with the unexpected costs of a serious illness that your health insurance may not cover.

For more information, see Prudential materials on LifeNet. A Prudential flyer is also available in the Benefit Summaries section of this Guide.

Prudential Critical Illness Insurance Video Link: www.prudential.com/ci-wasntjust

- ***Accident Insurance - may pay a set benefit amount based on covered accidental injuries and treatment**

Pays a set amount for various treatments and services if you get injured accidentally on/off the job. Payments are made directly to you to use however you wish.

For more information, see Prudential materials on LifeNet. A Prudential flyer is also available in the Benefit Summaries section of this Guide.

Prudential Accident Insurance Video Link: www.prudential.com/ai-wasntjust

- ***Hospital Indemnity Insurance- may pay benefits that help you with the costs of a covered hospitalization**

Pays a lump-sum amount directly to you when you're diagnosed with a covered condition. Helps with the unexpected costs of a serious illness that your health insurance may not cover.

For more information, see Prudential materials on LifeNet. A Prudential flyer is also available in the Benefit Summaries section of this Guide.

Prudential Hospital Indemnity Insurance Video Link: www.prudential.com/hi-wasntjust

*There may be limitations or exclusions for existing conditions diagnosed prior to the effective date of coverage.

This section regarding Group Accident, Group Critical Illness and Group Hospital Indemnity Insurance contains a general outline of covered benefits and do include all the benefits, limitations, and exclusions of the benefit program. If there is a discrepancy between this document and the group contract issued by The Prudential Company of America (Prudential), the terms of the group contract will govern. The Booklet-Certificate contains all the details, including any policy exclusions, limitations, and restrictions which may apply. If there is any discrepancy between this document and the Booklet-Certificate/Group Contract, the Group Contract will govern. Contract provisions may vary by state.



EMPLOYEE SUPPORT

Paid Parental Bonding Leave

AAA Life Insurance offers paid parental bonding leave to full-time benefit-eligible associates with 6 months of service.

The Paid Parental Bonding Leave program provides continuous leave of up to 6 weeks of job-protected parental leave at full regular pay for new parents to bond with a new child(ren) within 12 months of birth or placement of a child through surrogacy, adoption, or foster care.

Paid Parental Bonding Leave is to be used after all available Short-Term disability coverage has been exhausted and concurrent with FMLA. Associates have an elimination period of 7-calendar days prior to be eligible to receiving the Paid Parental Bonding leave benefits. If an associate had a 7-calendar day elimination period for Short-Term disability it will be applied towards the Paid Parental Bonding leave.

Paid Parental Bonding Leave is a fully funded leave by the Company and/or our third-party provider for up to 6 weeks (minus the elimination period) and is subject to normal payroll taxes and deductions including elected benefit premiums.

For more information, contact Human Resources.

Emergency Travel Assistance Program

You and your family have access to worldwide emergency travel assistance provided by International Medical Group i(IMG) in partnership with Prudential. This service offers you and your dependents medical, and travel assistance services, 24 hours a day, 365 days a year, worldwide.

IMG has extensive experience handling complex and remote medical transport situations, as well as providing support for travel concerns when they arise. The team of international, multilingual specialists are accustomed to working across time zones and with different languages and currencies.

See the brochure and wallet card on LifeNET for information on how to access services.

- Emergency Medical Transport Services (traveling outside of US)
- Medical Assistance Services
- Travel Assistance Services
- Security Assistance Services





EMPLOYEE SUPPORT

Life Advisor/Employee Assistance Program (EAP)

AAA Life Insurance Company offers a confidential employee assistance program (EAP) through Ulliance at no cost to you with automatic enrollment.

Ulliance
www.LifeAdvisorEAP.com
800-448-8326

EAP Services

Ulliance Life Advisor EAP offers total well-being services to employee and spouse and dependents. Visit the website or contact a Life Advisor Consultant to explore the many no-cost and confidential services.

Counseling

- **Short Term Solution Focused Counseling.** Connect with a Life Advisor Counselor for short term, solution focused support for work-life issues such as stress, major life transitions, relationship issues, substance use, grief/loss and overwhelming emotions.
- **Convenient and Your Way.** Meet face to face, on the phone or by video for your sessions with a licensed counselor. Confidential and at no cost to you, our counselors can be found close to work or home, at your convenience.

Coaching

- **Goals for Self Improvement.** Self Improvement is the key to success. Work life goals that focus on education, career advancement, communication skills or a financial / savings goal, keep us grounded and moving forward.
- **Inspiration and Motivation.** See the goal on the horizon but need a plan to get there? Life Advisor Coaching services will help you make that happen. Meet telephonically with a counselor who will coach you in constructing a plan of action, support and motivate you to achieve your goals in no time.

Crisis Support (24 hours per day / 7 days per week)

- You never know what life might throw your way. That's why Life Advisor Consultants are available 24 / 7 to get you through those tough times. The benefit covers not only you, but your spouse / partner and dependents.
- Need some emotional support? Call anytime to speak to a counselor immediately for the support and guidance that you need during an emotional crisis.

Well-being Resources

Access the Life Advisor Well-being Resource Center to gain access to your well-being benefit and a variety of emotional, physical, financial, career, and community resources to support all areas of your life. Access articles, videos, webinars, assessments, challenges, health trackers, journals, health tips, discount programs and more.

- **Legal and Financial Referrals.** Need some legal advice or help creating a budget? Call for a free 30-minute initial consultation with an attorney or certified financial planner. There are discounts available for ongoing services.
- **Childs & Eldercare Referrals.** Family is the most important thing in life. Access resources to care for your kids and parents.



401(k) PLAN

What does retirement look like for you? Whatever your vision for retirement is, it's important to plan ahead so you have the income you'll need in the future.

AAA Life Insurance Company Pension & 401(k) Plan Highlights

- Please review the *Voya Financial Enrollment Guide* on LifeNet for important information about the plan and enrollment.
- Auto Enroll: Once you have satisfied eligibility requirements, unless you opt out, you will be automatically enrolled in the Plan with a minimum contribution determined by the Plan.
- You may contribute using convenient payroll deductions up to the maximum IRS limits each year
 - \$23,500 for 2025
 - (\$24,500 projected for 2026)
- Are you aged 50 or older? You may make an additional "catch-up" contributions up to the maximum IRS limits
 - \$7,500 for 2025
 - (\$8,000 projected for 2026)
- Company Match effective January 1, 2024: 100% on contributions up to 5%.
- You can change the amount of your contributions or stop your payroll contributions at any time through your Voya account.
- You can decide how to invest your 401(k) or engage a service to manage your plan.

This section describes highlights of your employer's retirement plan. It represents a general overview of the information printed in your employer's Summary Plan Description (SPD). Your retirement program is more fully described in the formal provisions of your employer's plan document. If there is a conflict between these plan highlights and your SPD, the language provided in the plan document will govern. Your employer reserves the right to amend, modify or terminate any plan at any time and in any manner.

Plan Contact Card

Keep in touch with your account:

AAA Life Insurance Company
Plan Number: 775075

For automated phone access – 1-800-584-6001

For Internet access – www.voyaretirementplans.com

For a Customer Service Associate – 1-800-584-6001

M – F, 8 a.m. – 9 p.m., ET



You can also access your Plan account using your mobile device. The Voya Retirement Plan Account mobile app can be downloaded from your preferred mobile app store. Search using the keywords: **Voya Retire.**



NOTES

[illegible]



IMPORTANT NOTICES

Health and Welfare Benefits Notices AAA Life Insurance Company

For Plan Year: January 1, 2026 to December 31, 2026

Enclosed Notices:

- Summary of Material Modifications
- Disclosure About the Benefit Enrollment Communications
- Midyear Election Changes to Pre-Tax Benefits
- HIPAA Special Enrollment Rights Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' And Mothers' Health Protection Act (NMHPA) Notice
- HIPAA Notice of Availability of Notice of Privacy Practices
- Medicaid and the Children's Health Insurance Program (CHIP)
- Your Prescription Drug Coverage and Medicare

Should you have any questions regarding the content of the notices, please contact Human Resources.

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.



IMPORTANT NOTICES

Summary of Material Modification

The information in this document and in the benefit guide applies to the AAA Life Insurance Company Flexible Benefits 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).

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the Benefit Guide, newsletters, PowerPoint presentations, 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. AAA Life Insurance Company 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.

Midyear Election Changes to Pre-Tax Benefits

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.



IMPORTANT NOTICES

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in AAA Life Insurance Company 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 or any longer period that applies under the plan] 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.

Women's Health Cancer Rights Act (WHCRA) Notice

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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator [Blue Cross Blue Shield of Michigan at (877) 790-2583] for more information.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

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

HIPAA Notice of Availability of Notice of Privacy Practices

The AAA Life Insurance Company Group Health Plan (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 Human Resources.



IMPORTANT NOTICES

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 17, 2025. 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.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584



IMPORTANT NOTICES

IOWA – Medicaid and CHIP (Hawki)		KANSAS – Medicaid	
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562		Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	
KENTUCKY – Medicaid		LOUISIANA – Medicaid	
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@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/la hipp 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: HSHIPPPProgram@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	



IMPORTANT NOTICES

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 Rlte 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, 2025, or for more information on special enrollment rights, contact either:

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

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



IMPORTANT NOTICES

Medicare Part D Creditable Coverage Notice

Important Notice from AAA Life Insurance Company 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 AAA Life Insurance Company 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 AAA Life Insurance Company has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Michigan 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 AAA Life Insurance Company coverage as an active employee, please note that your AAA Life Insurance Company 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 AAA Life Insurance Company coverage as a former employee.

You may also choose to drop your AAA Life Insurance Company coverage. If you do decide to join a Medicare drug plan and drop your current AAA Life Insurance Company 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 AAA Life Insurance Company 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.



IMPORTANT NOTICES

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

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

Contact the employer 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 AAA Life Insurance Company 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).

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

Date:	November 2025
Name of Entity/Sender:	AAA Life Insurance Company
Contact--Position/Office	Human Resources
Address:	17900 North Laurel Park Drive, Livonia, MI 48152
Phone Number:	800-624-1662



APPENDIX

AAA Life Insurance Company

Carrier Summaries/Information

For Plan Year: January 1, 2026 to December 31, 2026

- Medical: Blue Cross Blue Shield Summaries
 - “PPO” 1500
 - “HD” High Deductible Health Plan 3400
 - “PPO” 3000
- Vision: NVA Vision Summary
- Dental: Delta Dental Summary of Dental Plan Benefits
- Flexible Spending Account (FSAs) Administrator: Flores & Associates Information
- Voluntary Benefits: Prudential Summaries
 - Critical Illness Insurance
 - Accident Insurance
 - Hospital Indemnity Insurance

This Benefit Guide and carrier information and summaries e contain a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the benefit programs. If there are any discrepancies between the materials 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.



**Blue Cross
Blue Shield
of Michigan**

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

AAA LIFE INSURANCE

A1TAJ7

0070186080002

Simply BlueSM PPO LG

Effective Date: On or after January 2026

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 approval by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at bcbam.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.

ADM PLANYR JAN;INFS LG;PDRX LG;S10408015%25%3K;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN\$2.5KL;SB-ECM-ON \$5K L;SB-MTC \$30 LG;SB-OV \$30 LG;SB-UC \$40 LG;SBD-ON 3K/6K LG;SBDIN1.5K/3K LG;SBOPMIN 6350 LG;SBOPMON12.7K LG

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	\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year	\$3,000 for one member, \$6,000 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 • \$30 copay for virtual primary care visits • \$30 copay for medical online visits • \$30 copay for chiropractic and osteopathic manipulative therapy • \$150 copay for emergency room visits • \$40 copay for urgent care visits	• \$150 copay for emergency room visits
Coinsurance amounts (percent copays)	• 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
Note: Coinsurance amounts apply once the deductible has been met.		
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but <u>does not</u> 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.
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	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 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	

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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-woman 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-woman 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
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

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Benefits	In-network	Out-of-network
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 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 (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 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.	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.	\$30 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	\$30 copay for each office consultation 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.	80% after out-of-network deductible

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Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	\$40 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	\$150 copay per visit (copay waived if admitted)	\$150 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
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
Note: For facility services See "Hospital Care"		

Hospital care

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

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Benefits	In-network	Out-of-network
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 Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care	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)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a participating home health care 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
Voluntary sterilization of male reproductive organs	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Elective Abortion Services	80% after in-network deductible	60% after out-of-network deductible
Note: Abortions are not covered if rendered in a location where abortions are not legal.		

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

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Benefits	In-network	Out-of-network
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
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 health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
Note: Facility services are covered in participating facilities only.		
Unlimited days		
Residential psychiatric treatment facility:	80% after in-network deductible	60% after out-of-network deductible
- covered mental health services must be performed in a residential psychiatric treatment facility - treatment requires prior authorization - subject to medical criteria		
Outpatient mental health care:	80% after in-network deductible	80% after in-network deductible
Facility and clinic		
Note: Facility services are covered in participating facilities only.		
Online visits - for services equivalent to a medical online visit	\$30 copay per online visit	60% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered.		
Physician's office	80% after in-network deductible	60% after out-of-network deductible
Note: For services equivalent to a medical office visit. See "Physician Office Services".		
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)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization	\$30 copay for each office visit	60% after out-of-network deductible
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).		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		

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Benefits	In-network	Out-of-network
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: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	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. Limited to a combined 12-visit maximum per member per calendar year	60% after out-of-network deductible
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 30-visit maximum per member per calendar year
Durable medical equipment Note: Reference the Find A Doctor tool at bcdsm.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 bcdsm.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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AAA LIFE INSURANCE

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Preferred Rx Program LG

Effective Date: On or after January 2026

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 provider*	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 \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay 15% of the approved amount, but no more than \$150. 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 25% of the approved amount, but no more than \$300. 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 providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	In-network mail order provider*	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

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Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
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	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
Note: Needles and syringes have no copay/coinsurance.				
Select diabetic supplies and devices (test strips, lancets and glucometers)	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
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .				

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

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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 than 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. • Generic and preferred specialty drug tier - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • Nonpreferred specialty drug tier - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
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 bcbm.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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Simply BlueSM HSA PPO with Rx Embedded Cost-Sharing LG

Effective Date: On or after January 2026

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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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: Two or more members must meet the family deductible. If the one-member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.	\$3,400 for one member or \$6,800 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)	\$6,800 for one member or \$13,600 for the family (when two or more members are covered under your contract) 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.	20% of approved amount for most covered services	40% 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	\$6,900 for one member, \$13,800 for the family (when two or more members are covered under your contract) each calendar year	\$13,800 for one member, \$27,600 for the family (when two or more members are covered under your contract) 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

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Benefits	In-network	Out-of-network
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)	60% 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
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 routine colonoscopy per member per calendar year		

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Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	80% after in-network deductible for each office visit (in person or virtual) 80% after in-network deductible for each virtual primary care visit for members 18 years of age or older, by a BCBSM-selected vendor	60% after out-of-network deductible
Note: Virtual Primary Care visits by a non-BCBSM selected vendor are not covered.		
Online visits - by physician or BCBSM selected vendor must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
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.		
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care

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

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Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
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 90 days per member per calendar year	
Hospice care	80% after in-network deductible	80% 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)	
Home health care: - must be medically necessary - must be provided by a participating home health care 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	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Elective Abortion Services	80% after in-network deductible	60% after out-of-network deductible
Note: Abortions are not covered if rendered in a location where abortions are not legal.		

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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)	80% after in-network deductible	80% 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)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
Note: Facility services are covered in participating facilities only.	Unlimited days	
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 health care: Facility and clinic	80% after in-network deductible	80% after in-network deductible
Note: Facility services are covered in participating facilities only.		
Online visits	80% after in-network deductible	60% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered		
Physician's office	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)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization	80% after in-network deductible	60% after out-of-network deductible
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).		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	

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Benefits	In-network	Out-of-network
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)	80% after in-network deductible	60% after out-of-network deductible
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: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	60% after out-of-network deductible
Limited to a combined 12-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 30-visit maximum per member per calendar year		
Durable medical equipment	80% after in-network deductible	60% after out-of-network deductible
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.		
Prosthetic and orthotic appliances	80% after in-network deductible	60% after out-of-network deductible
Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.		
Private duty nursing care	80% after in-network deductible	60% 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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Effective Date: On or after January 2026

Benefits-at-a-glance

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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

Benefits		90-day retail network pharmacy	In-network mail order provider*	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 \$10 copay	After deductible is met, You pay \$10 copay	After deductible is met, You pay \$10 copay	After deductible is met, You pay \$10 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 93-day period	No coverage	After deductible is met, You pay \$20 copay	No coverage	No coverage

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Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	84 to 90-day period	After deductible is met, You pay \$20 copay	After deductible is met, You pay \$20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	After deductible is met, You pay \$40 copay	After deductible is met, You pay \$40 copay	After deductible is met, You pay \$40 copay	After deductible is met, You pay \$40 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, You pay \$80 copay	After deductible is met, You pay \$80 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, You pay \$80 copay	After deductible is met, You pay \$80 copay	After deductible is met, You pay \$80 copay	After deductible is met, You pay \$80 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, You pay \$160 copay	After deductible is met, You pay \$160 copay	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 \$10 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 \$40 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 \$80 copay 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 providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	In-network mail order provider*	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

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Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
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
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 .	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 providers, including Internet providers.

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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 than 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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AAA LIFE INSURANCE

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Simply BlueSM PPO LG

Effective Date: On or after January 2026

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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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	\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year	\$6,000 for one member, \$12,000 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	\$40 copay for office visits and office consultations with a primary care physician \$40 copay for virtual primary care visits \$60 copay for office visits and office consultations with a specialist \$40 copay for medical online visits \$40 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)	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
Note: Coinsurance amounts apply once the deductible has been met.		
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but <u>does not</u> 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.

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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-woman 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-woman 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 • 8 visits, 13 months through 23 months • 8 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.	\$40 copay for each office visit with a primary care physician (in person or virtual) \$40 copay for each virtual primary care visit for members 18 years of age or older, by a BCBSM selected vendor \$80 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.	\$40 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

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	\$40 copay for each office consultation with a primary care physician \$80 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	\$80 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	80% after in-network deductible	60% after out-of-network deductible
Note: For facility services See "Hospital Care"		

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
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 health care: • must be medically necessary • must be provided by a participating home health care 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

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

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	80% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Cornea and skin transplants	80% after in-network deductible	80% 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 health care and inpatient substance use disorder treatment	80% after in-network deductible	80% after out-of-network deductible
Note: Facility services are covered in participating facilities only. Unlimited days		
Residential psychiatric treatment facility:	80% after in-network deductible	80% after out-of-network deductible
- covered mental health services must be performed in a residential psychiatric treatment facility - treatment requires prior authorization - subject to medical criteria		
Outpatient mental health care:	80% after in-network deductible	80% after in-network deductible
Facility and clinic		
Note: Facility services are covered in participating facilities only.		
Online visits - for services equivalent to a medical online visit	\$40 copay per online visit	80% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered.		
Physician's office	80% after in-network deductible	80% after out-of-network deductible
Note: For services equivalent to a medical office visit. See "Physician Office Services".		
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	80% 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	\$40 copay for each office visit	60% after out-of-network deductible
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).		Note: Services rendered by an approved licensed behavior analyst (LSA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited	60% after out-of-network deductible
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)	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
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: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 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. Limited to a combined 12-visit maximum per member per calendar year	60% after out-of-network deductible
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 30-visit maximum per member per calendar year

ADM PLAN/YR JAN;NFS LG;PDRX LG;\$10408015%;25%3K;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-INS2.5KL;SB-ECM-ON \$5K L;SB-MTC \$40 LG;SBD-IN \$3000-LG;SBD-ON \$6000-LG;SBOPM IN \$8150;SBOPM ON \$16300;SBTCP40600250L

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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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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

ADM PLANYR JAN;INFS LG;PDRX LG;S10408015%25%3K;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-INS2 5KL;SB-ECM-CN \$5K L;SB-MTC \$40 LG;SBD-IN \$3000-LG;SBD-CN \$6000-LG;SBOPM IN \$8150;SBOPM ON \$16300;SBTCP406000250L

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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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AAA LIFE INSURANCE

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Preferred Rx Program LG

Effective Date: On or after January 2026

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

ADM PLAN YR JAN; INF'S LG; PDW LG; \$10438015%25%3K; SB BH OV LG; SB LG; SB- EA-1 LG; SB- ECM- INS2 5KL; SB- ECM- ON \$5K L; SB- MTC \$40 LG; SBD- IN \$3000- LG; SBD- ON \$6000- LG; SBO PM IN \$8150; SBO PM ON \$16300; SB7CP406003250L

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Benefits		90-day retail network pharmacy	In-network mail order provider*	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 \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay 15% of the approved amount, but no more than \$150 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 25% of the approved amount, but no more than \$300 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 providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	In-network mail order provider*	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

ADM PLAN/YR JAN;NFS LG;PDRX LG;\$104088/15%/25%3K;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN\$2.5K;SB-ECM-ON \$5K L;SB-MTC \$40 LG;SBD-IN \$3000-LG;SBD-ON \$6000-LG;SBOPM IN \$8150;SBOPM ON \$16300;SBTCP406060250L

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Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
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	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
Note: Needles and syringes have no copay/coinsurance.				
Select diabetic supplies and devices (test strips, lancets and glucometers)	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
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .				

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

ADM PLAN/YR JAN/INP LG;FORX LG;\$16488015%25%3K;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN\$2.5KL;SB-ECM-ON \$5K L;SB-MTC \$40 LG;SBD-IN \$3000-LG;SBD-ON \$6000-LG;SBOPM IN \$8150;SBOPM ON \$16300;SBTCP406000250L

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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 than 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. • Generic and preferred specialty drug tier - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • Nonpreferred specialty drug tier - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
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 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.

ADM PLANYR JAN;NPS LG;PDRX LG;S10408015%25%3K;SB BH0V LG;SB LG;SB-EA-1 LG;SB-ECM-IN52.5KL;SB-ECM-ON \$5K L;SB-MTC \$40 LG;SBD-IN \$3000-LG;SBD-ON \$6000-LG;SBOPM IN \$3150;SBOPM ON \$16300;SBTCF406090250L

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National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	Covered 100% After \$5 copay	Reimbursed Amount Up to \$35
Lenses Once Every Calendar Year - Single Vision - Bifocal - Trifocal - Lenticular - Polycarbonate (under age 19)	Standard Glass or Plastic Covered 100% After \$10 copay	- Up to \$45 - Up to \$55 - Up to \$80 - Up to \$110 - Up to \$10
Frame Once Every Calendar Year	Retail Allowance Up to \$130 (20% discount off balance)*	Up to \$45
Contact Lenses Once Every Calendar Year Elective Contact Lenses	In lieu of Lenses Up to \$130 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	In lieu of Lenses Up to \$105
Medically Necessary***	Covered 100%	Up to \$210

*Does not apply to Wal-Mart / Sam's Club or Lenscrafters locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers.

***Pre-approval from NVA required.

⊕Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

• \$10 Solid Tint	\$50 Progressive Lenses Standard
• \$12 Fashion / Gradient Tint	\$85 Transitions Single Vision Standard
• \$10 Standard Scratch-Resistant Coating	\$70 Transitions Multi-Focal Standard
• \$12 Ultraviolet Coating	\$25 Polycarbonate (Single Vision) 19 & over
• \$40 Standard Anti-Reflective	\$30 Polycarbonate (Multi-Focal) 19 & over
• \$20 Glass Photogrey (Single Vision)	\$30 Blended Bifocal (Segment)
• \$30 Glass Photogrey (Multi-Focal)	\$55 High Index
• \$75 Polarized	\$100 Progressive Lenses Premium

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

AAA Life Insurance Company

Effective 01/01/2022

Group Number #51761000001

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every calendar year.

At the start of the program, if authorized by your employer you may receive identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, you must indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 51761000001 or the group number on the identification card and enter in your search parameters. It's that easy!

Get a Better View

VC-108052014



Page 1

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
 -Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
 -View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen The National LASIK Network to serve their members. This network was developed by LCA Vision in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®

Discounts: In addition to your funded benefit you are eligible to access the EyeEssential® Plan discount (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	Participating Provider	Lens Options
Eye Examination:	Member Cost: Retail Less \$10	\$12 Solid Tint/ Gradient Tint \$50 Standard Progressive Lenses \$75 Polarized Lenses \$85 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard \$15 Standard Scratch Coating \$12 UV Coating \$35 Polycarbonate \$45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	\$35.00	
Bifocal	\$55.00	
Trifocal or Lenticular	\$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	Member Cost:	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

The proposed vision insurance program is insured through Fidelity Security Life Insurance Company (FSL) Kansas City, MO. Fidelity Security Life Insurance Company brings over 45 years of underwriting experience in the insurance industry since 1969.

Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com.

Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.

Exclusions: The following benefits are not payable under this Policy for services or materials connected with or charges arising from (unless otherwise indicated in the Proposed Schedule of Benefits): Aniseikonic Lenses; Subnormal visual aids; Orthoptics, vision training, and any associated supplemental testing; Broken, lost or stolen lenses, contact lenses, or frames will not be replaced except in the next Benefit Frequency when Vision Materials would next become available; Services or materials provide as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Services rendered after the date an insured Person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan; Medical and/or surgical treatment of the eye, eyes or supporting structures; Two pair of glasses in lieu of bifocals; Plano (non-prescription) lenses; non-prescription sunglasses

Limitations: Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider, such fees or materials are not covered under the Policy. For Contact Lenses, any remaining balance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

National Vision Administrators, L.L.C. • PO Box 2187 • Clifton, NJ 07015
 Web: www.e-nva.com • Toll-Free: 1.800.672.7723
 NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

Policy Nos. VC-108, VC-109, VC-110; Form NOS. M-9142, M-9143, M-9144.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.



**Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0001-0001, 0003, 0099
AAA Life Insurance**

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 Plan Pays	Delta Dental Premier* Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency 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%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	50%	50%
Endodontic Services - root canals	80%	50%	50%
Periodontic Services - to treat gum disease	80%	50%	50%
Oral Surgery Services - extractions and dental surgery	80%	50%	50%
Other Basic Services - misc. services	80%	50%	50%
Relines and Repairs - to prosthetic appliances	80%	50%	50%
Major Services			
Major Restorative Services - crowns	60%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	60%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

* 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 or Delta Dental approves 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 for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- 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.

KR#27356735

- 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 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 - \$1,500 per Member total per Benefit Year on all services except orthodontic services. \$1,250 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 monthly fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible - \$50 Deductible per Member total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period - Enrollees who are eligible for Benefits are covered on the first day of employment. Employees on non-FMLA leave of absence will continue their coverage for 60 days; after 60 days, if they do not return to work, they will be offered COBRA.

Eligible People - All employees working at least 20 hours per week who choose the dental plan (0001), all eligible retirees include employees who were hired prior to September 1, 2001 subject to the following: 1) If retired prior to March 1, 2007 - have at least ten years of service, are at least fifty-five (55) years old and hired prior to September 2001, or have at least five years of service, are at least sixty-five (65) years old at the time of retirement and hired prior to September 1, 2001; 2) If retiring on or after March 1, 2007 - have at least ten years of service, are at least fifty-five (55) years old at the time of retirement and hired prior to September 1, 2001. A retiree shall become a Participant as of the retirement date. A surviving spouse of a Participant retiree shall become a Participant as of the day following the Participant retiree's death (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099).

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 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.

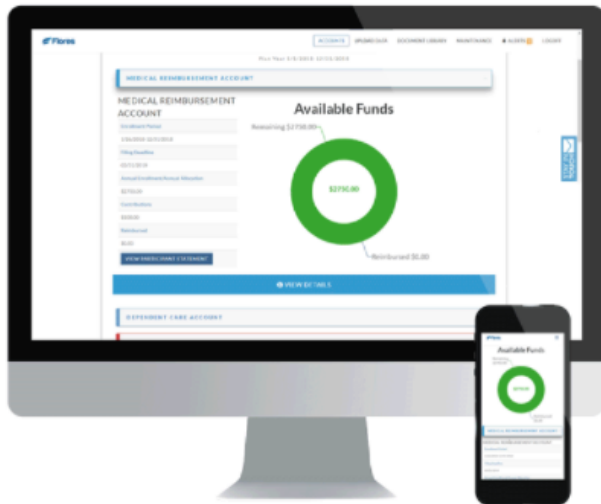
Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)
<https://www.DeltaDentalMI.com>
Contract Start Date: January 1, 2023
Document Creation Date: December 8, 2022

KR#66359878

Flores & Associates Flexible Spending Accounts Administrator
Health Care FSAs (General and Limited Purpose)
Dependent Care FSA
Partnership Effective January 1, 2022



Talk with a live representative: 1-800-532-3327 M-F 8:30am-5pm EST



FOR PARTICIPANTS

- ✓ Dedicated account manager
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**IRS ANNOUNCES PERSONAL
PROTECTIVE EQUIPMENT
PURCHASES RELATED TO COVID-
19 PANDEMIC ARE CONSIDERED
ELIGIBLE MEDICAL EXPENSES
UNDER SECTION § 213(D)**

MARCH 26, 2021

[READ MORE](#)

Resource Library

Welcome to the Flores Resource Library
Explore the tools and resources below to learn more about your Flores benefits.



<https://www.flores-associates.com/resources.html>



Flores Mobile



IVR/SMS



Flores Benefits Card



Documents



Videos



FAQs



Calculators



Eligibility Checker

Videos

Please select a category to learn more about how you can take advantage of your account features and manage your account.



<https://www.flores-associates.com/videos.html>



General



Health Care
Flexible Spending Accounts
(HCFA)



Limited Health Care
Flexible Spending Accounts
(LFSA)



Dependent Care
Flexible Spending Accounts
(DCFSA)

Five Ways to Check Your
Flores Balance



How to Log In to the
Flores247 Web Portal



How to Reset Your Password
for Flores247 Web Portal



What is a Health Care FSA



How to Enroll in Text Alerts

How to Add an Authorized User



Consider critical illness insurance—even if you have a good medical plan

Many people aren't financially prepared for the unexpected costs of a serious illness. **Even a good medical plan can leave you with out-of-pocket expenses.¹** You may have to pay deductibles, co-pays, and everyday expenses, while making up for salary from time off from work.

Critical illness insurance can help provide a financial cushion so you can stay on track financially and focus on your recovery.

➔ Answers to frequently asked questions

I have a good medical plan, so why do I need critical illness insurance?

Critical illness insurance works to complement your medical coverage—paying in addition to what your medical plan may or may not cover.

It pays a lump sum amount directly to you to use however you choose, like for out-of-pocket* medical costs such as deductibles, co-pays, or non-covered services. You can even use it to pay for everyday living expenses, like babysitters and take-out food, making recovery easier and helping you safeguard your savings.

What types of conditions are covered?

Critical illness insurance, issued by **The Prudential Insurance Company of America (Prudential)**, pays you for a variety of medical conditions including, but not limited to:

- Alzheimer's Disease
- Cancer—invasive or in situ
- Coma
- Coronary Artery Disease (severe)
- Heart Attack
- Major Organ failure
- Paralysis
- Renal (Kidney) failure
- Stroke
- Infectious disease benefit (includes Covid-19)
- More than 15 childhood conditions

Every **40 seconds** someone has a stroke in the U.S.[†]



Monthly employee coverage* may **cost less than the allowance** for a 10-year old.**



Enroll from
November 12 to
November 27, 2024



Prudential Voluntary Benefits

Effective January 1, 2025

Critical Illness Insurance (page 2 of 2)

How much would it cost?

Critical illness insurance may cost less than you think. It's designed to be an affordable way to complement your current medical plan.

Do I have to answer medical questions to get this coverage?

No. You're guaranteed coverage regardless of your health when you enroll during your annual open enrollment period or if you experience a qualifying event. You just need to be actively at work on the day your coverage starts.

Is my family eligible to enroll for this coverage?

Yes. You can choose coverage for yourself as well as eligible family members.

What additional benefits are included in the plan?

Transportation benefit: Our transportation benefit pays a covered person's round-trip travel between his/her primary residence and a medical facility.

Lodging benefit: The lodging benefit provides \$100 per day if a companion is accompanying a covered person while hospitalized.

Are filing claims really that simple?

Our claims process is as easy as 1, 2, 3:

1. Log in to: www.prudential.com/mybenefits First-time users: Click "Register Now."



Scan the QR code using your mobile device camera or a QR app.

2. Select "My claims" from the left side menu and click on the option to "File a claim/Report an absence."
3. Give us permission to get information from your doctor, so you don't have to.

We'll notify you when a claim decision is reached and send payments directly to you. We'll also auto-pay a critical illness claim due to an eligible disability or absence claim.

How can I find out more information?

Contact your benefits administrator for more information.

[†]Benefits can be used for medical and non-medical purposes.

[‡]Centers for Disease Control and Prevention. Stroke Facts. <https://hcup-us.ahrq.gov/reports/statbriefs/sb261-Most-Expensive-Hospital-Conditions-2017.jsp>, accessed June 14, 2022.

[§]Premium is based on Prudential's standard plan designs. Actual costs may vary by group plan design.

^{**}Scholastic Parents, "Allowance, Age by Age." <https://www.inc.com/sarah-jackson/best-tv-streaming-services.html>

Product may not be available in all states at this time.

THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

This coverage is not health insurance coverage (often referred to as "Major Medical Coverage").

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services. IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Group Critical Illness Insurance coverage is a limited benefit policy issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ. Prudential's Critical Illness Insurance is not a substitute for medical coverage that provides benefits for medical treatment, including hospital, surgical, and medical expenses, and it does not provide reimbursement for such expenses. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. A more detailed description of the benefits, limitations, and exclusions applicable are contained in the Outline of Coverage provided at time of enrollment. Please contact Prudential for more information. Contract provisions may vary by state. Contract Series: 114774.

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Consider accident insurance— even if you have a good medical plan

Accidents happen. And many people are not financially prepared for the unexpected out-of-pocket costs that come with them. Accident insurance can help provide a financial cushion so you can stay on track financially and focus on your recovery.

→ Answers to frequently asked questions

I have a good medical plan, so why do I need accident insurance?

An accident plan works to complement your medical coverage—paying in addition to what your health plan may or may not cover. It pays a lump sum amount directly to you to use however you choose, like for out-of-pocket* medical costs such as deductibles, co-pays, or non-covered services. You can even use it to help pay for everyday living expenses, like babysitters and take-out food, making recovery a little easier and helping you to safeguard your savings.

What types of services are covered?

Accident insurance, issued by **The Prudential Insurance Company of America (Prudential)**, pays you for a variety of injuries and medical services including, but not limited to:

Injuries, like:

- Fractures
- Burns—2nd and 3rd Degree
- Concussion
- Laceration
- Broken Tooth

Medical services, like:

- Ambulance (Ground, Air or Water)
- Emergency Room Visit
- X-ray
- Medical Appliances (like crutches)
- Physical Therapy

40 million

ER visits are related to
injuries **from accidents**¹



Enroll from
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November 27, 2024

Prudential Voluntary Benefits

Effective January 1, 2025

Accident Insurance (page 1 of 2)

How much would it cost?

Accident Insurance may be more economical than you think. It's designed to be an affordable way to complement your current medical plan.

How are benefits paid?

We send payments directly to you, not your doctor, hospital, or any other health care provider. There's no coordination with any other coverage, so the amount you receive is in addition to other benefits you may have.

How does the plan pay benefits for fractures?

Prudential will bundle benefits for fracture claims. This means we'll pay your fracture claim and automatically bundle additional benefits including emergency room, physical therapy, X-rays, and doctor follow-up.

Do I have to answer medical questions to get this coverage?

No. You're guaranteed coverage regardless of your health when you enroll during your annual open enrollment period or if you experience a qualifying event. You just need to be actively at work on the day your coverage starts.

Is my family eligible to enroll for this coverage?

Yes. You can choose coverage for yourself as well as eligible family members.

What additional benefits are included in the plan?

The following additional benefits are included in your plan:

Transportation benefit: This benefit pays you for travel expenses associated with a covered person's round-trip travel between his/her primary residence and a hospital or medical facility.

Lodging benefit: You can receive \$100 per day if a companion is accompanying a covered person while hospitalized.

Is it simple to file a claim?

Our claims process is as easy as 1, 2, 3:

1. Log in to: www.prudential.com/mybenefits. First-time users: Click "Register Now."



Scan the QR code using your mobile device camera or a QR app.

2. Select "My claims" from the left side menu and click on the option to "File a supplemental health claim."
3. Give us permission to get information from your doctor, so you don't have to.

We'll notify you when a claim decision is reached and send payments directly to you.

How can I find out more information?

Contact your benefits administrator for more information.

¹Benefits can be used for medical and non-medical purposes.

[†]CDC, 2021 <https://www.cdc.gov/nchs/fastats/emergency-department.htm>

Product options may not be available in all states at this time.

THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

This coverage is not health insurance coverage (often referred to as "Major Medical Coverage").

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services. IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Group Accident Insurance coverage is a limited benefit policy issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ. Prudential's Accident Insurance is not a substitute for medical coverage that provides benefits for medical treatment, including hospital, surgical, and medical expenses, and it does not provide reimbursement for such expenses. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. Please contact Prudential for more information. Contract provisions may vary by state. Contract Series: 83500.

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Prudential Voluntary Benefits

Effective January 1, 2025

Hospital Indemnity Insurance (page 1 of 3)



IMPORTANT:

This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) online or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



Consider hospital indemnity insurance—even if you have a good medical plan

Many people are not financially prepared for an unexpected hospital stay, the average 3-day hospital stay is around \$30,000. Hospital indemnity insurance can help provide a financial cushion so you can stay on track financially and focus on your recovery.*

→ Answers to frequently asked questions

I have a good medical plan, so why do I need hospital indemnity insurance?

A hospital indemnity plan works to complement your medical coverage—paying in addition to what your health plan may or may not cover.

It pays a lump sum amount directly to you to use however you choose, like for out-of-pocket[†] medical costs such as deductibles, co-pays, or non-covered services. You can even use it to help pay for everyday living expenses, like babysitters and take-out food, making recovery a little easier and helping you to safeguard your savings.

55%

of U.S. households struggle to pay their medical bills in a given year.[§]



What types of services are covered?

Hospital indemnity insurance issued by **The Prudential Insurance Company of America (Prudential)**, pays you for a variety of medical services including, but not limited to:

Hospital services:

- Hospital Admissions
- Daily In-Hospital Stays
- Intensive Care Unit Admission
- Daily Hospital Intensive Care Unit Stays

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1059959-00006-00



Prudential Voluntary Benefits

Effective January 1, 2025

Hospital Indemnity Insurance (page 3 of 3)

How much would it cost?

Hospital indemnity insurance may cost less than you think. It's designed to be an affordable way to complement your medical plan.

Do I have to answer medical questions to get this coverage?

No. You're guaranteed coverage regardless of your health when you enroll during your annual open enrollment period or if you experience a qualifying event. You just need to be actively at work on the day your coverage starts.

Is my family eligible to enroll for this coverage?

Yes. You can choose coverage for yourself as well as eligible family members.

Are there additional benefits included in the plan?

Our transportation benefit pays a covered person's round-trip travel between their primary residence and a medical facility.

Is filing claims really that simple?

Our claims process is as easy as 1, 2, 3:

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3. Give us permission to get information from your doctor, so you don't have to.

We'll notify you when a claim decision is reached and send payments directly to you.

How can I find out more information?

Contact your benefits administrator for more information.

¹Healthcare.gov, Why health insurance is important, accessed March 2024. (<https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/>)

²Benefits can be used for medical and non-medical purposes.

³Mike Winters, "Over half of Americans have medical debt, even those with health insurance—here's why," CNBC.com, March 11, 2022 (<https://www.cnbc.com/2022/03/11/why-55percent-of-americans-have-medical-debt-even-with-health-insurance.html>) Product options may not be available in all states at this time.

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