Make It Yours **To Go**

make it yours

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Eligibility

It's up to you to understand who you can cover under your medical, dental, vision, and other benefits. Be sure to review the information carefully **before** you enroll in coverage. You are eligible for benefits if you are a full-time employee who works 30 or more hours a week.

Your **eligible** dependents include:

- Your legally married spouse;
- Your or your spouse's child or children who are under age 26, including natural children, a child for whom legal guardianship has been awarded to the covered employee or the employee's spouse, a stepchild, a child of a domestic partner, or adopted child; keep in mind, dependent children can be covered up to the end of the month of their 26th birthday;
- Unmarried children age 26 or over who are or become disabled and dependent on you; or
- A domestic partner (same or opposite gender):
    - Must not be currently married to, or a domestic partner of, another person under either statutory or common law;
    - Must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
    - Must share joint responsibilities for common welfare and financial obligations;
    - Must be at least 18 years old;
    - Must share the same permanent residence for a 12-month period prior to enrolling in coverage;
    - Must be mentally competent to enter into a contract; or
    - Must be financially interdependent.

Dependent Verification

If you add a dependent to your coverage, you will need to provide documentation confirming the eligibility of the dependents you cover in your employer's medical/prescription, dental, and vision plans. You may be asked to provide a copy of your marriage certificate, child's birth certificate, prior year federal tax return, or other types of documents that verify you dependents meet your employer's eligibility requirements.

If you are required to submit documentation, you will see a notification on the My Benefit Plans Website to verify your dependents. You will also receive a letter in the mail from the Alight Solutions Dependent Verification Center with instructions and a list of acceptable documents. If you do not respond by the deadline provided to you, your dependent(s) will be removed from coverage. **Learn more**.

Medical Coverage Level

Which Coverage Level Is Best?

When you choose your coverage level, you get to pick the one with the coverage and features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you **do your homework** before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different **insurance carriers** at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO that offers limited benefits for out-of-network care**
			2026 Annual Deductible		
In-network (individual / family)	$4,900 / $9,800	$2,500 / $5,000	$1,700 / $3,400	$1,000 / $2,000	$250 / $500
Out-of-network (individual / family)	$4,900 / $9,800	$2,500 / $5,000	$1,700 / $3,400	$2,000 / $4,000	$5,000 / $10,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional
			2026 Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$6,400 / $12,800	$4,500 / $9,000	$4,250 / $8,500	$4,250 / $8,500	$2,300 / $4,600
Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000	$8,500 / $17,000	$8,500 / $17,000	$11,500 / $23,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional

2026 In-Network Benefits

Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $30 for PCP visit and $50 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay $150, then 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $50	You pay $25
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 15% after deductible

Note: For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the coverage is an HMO option that covers in-network care only.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
	30-Day Retail Supply				
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $50
	90-Day Mail Order Supply				
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $75

Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $125

**Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

California Residents: Your options will be different, depending on the insurance carrier you choose. See **what's different**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **digital.alight.com/mybenefitplans** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. **Employees who enroll under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. All other carriers will manage their own prescription drug coverage.**

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how your family's medications will be covered. **Get the details**.

Questions?

Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

California Medical Coverage Level

Live In California?

Your options will be different, depending on the insurance carrier you choose.

For starters, each **insurance carrier** in California can elect to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold II option offers **only** in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Highmark Blue Cross Blue Shield	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Health Net	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In-network only	In- and out-of-network
Kaiser Permanente	In-network only	In-network only	In-network only	In-network only	In-network only	In-network only
United Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Medical Coverage Level

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	High-deductible option with HSA	PPO	HMO	PPO that offers limited benefits for out-of-network care**
2026 Annual Deductible						
In-network (individual / family)	$4,900 / $9,800	$2,500 / $5,000†	$1,700 / $3,400†	$1,000 / $2,000	N / A	$250 / $500
Out-of-network (individual / family)	$4,900 / $9,800	$2,500 / $5,000†	$1,700 / $3,400†	$2,000 / $4,000	N / A	$5,000 / $10,000
Traditional or true family?	Traditional	True family	True family	Traditional	N / A	Traditional
2026 Annual Out-of-Pocket Maximum						
In-network (individual / family)	$6,400 / $12,800	$4,500 / $9,000†	$4,250 / $8,500†	$4,250 / $8,500	$5,400 / $10,800	$2,300 / $4,600
Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000†	$8,500 / $17,000†	$8,500 / $17,000	N / A	$11,500 / $23,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional	Traditional
2026 In-Network Benefits						
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%, no deductible

Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $30 for PCP visit and $50 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay $150, then 30% after copay	You pay $150, then 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay $50	You pay $40	You pay $25
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 30%	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 30%	If not an office visit, you pay 15% after deductible

Note: For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the coverage is an HMO option that covers in-network care only.

†Under Health Net and Kaiser Permanente, there are minor differences (including possible lower family deductibles and a **traditional** annual deductible and out-of-pocket maximum) under the Bronze Plus and Silver coverage levels.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
			30-Day Retail Supply			
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $8

Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $50

90-Day Mail Order Supply

Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **digital.alight.com/mybenefitplans** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. **Employees who enroll under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. All other carriers will manage their own prescription drug coverage.**

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how you and your family's medications will be covered. **Get the details**.

Questions?

Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the **insurance carrier**. Insurance carrier member sites and apps have resources that can help you look up the cost of care.

It Depends On Your Medical Coverage Level

Bronze, Gold, and Platinum have a traditional deductible. Once a covered family member meets the individual deductible, your insurance will begin paying benefits for only that family member.

Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus and Silver have a "true family deductible". This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in the Bronze Plus and Silver coverage levels when you have family coverage. So even if only one person in your family has a lot of expenses, the full family deductible must be met before insurance will begin to pay its portion of benefits.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage. Also, copays for certain medical benefits may not apply towards the annual deductible.

Do You Use Out-of-Network Providers?

Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, do **not** cover out-of-network benefits at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

It Depends On Your Medical Coverage Level

Bronze, Gold, and Platinum have a traditional out-of-pocket-maximum. Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

It doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus and Silver have a "true family out-of-pocket-maximum". This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in the Bronze Plus and Silver coverage levels when you have family coverage.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?
Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, do not cover out-of-network benefits at all.

Medical Price

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care.

How much you'll pay for medical coverage depends on:

The Amount Of Your Credit From Your Employer

All eligible employees will receive a credit to use toward the cost of coverage.

If you enroll in a Bronze, Bronze Plus, and Silver coverage level and don't use the full credit, the unused dollars will be deposited into your HSA, if you are eligible. If you are an AZ-Genesis employee, you are eligible to have unused dollars deposited into your paycheck.

You'll see the credit amount from your employer and your price options for coverage when you **enroll**.

The Coverage Level You Choose

The Bronze, Bronze Plus, and Silver coverage levels cost less per paycheck, but you will pay a higher deductible before your coverage kicks in.

The Gold and Platinum coverage levels cost more per paycheck, but you'll probably pay less out of pocket for services throughout the year.

Learn more about coverage levels.

The Insurance Carrier You Choose

Since each coverage level is covered the same across carriers, it's easy to see which insurance carrier offers the lowest cost for the same coverage. For example, if you know you want a Silver option, you can look to see how much each insurance carrier would charge you for it. **Learn more about insurance carriers.**

Important: Choose an insurance carrier whose network includes providers critical to your care. If you see an out-of-network provider, your medical insurance carrier could pay a much lower benefit —leaving you to pay the rest.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best value on your total health care costs.

Would you rather pay **less** now and **more** when you need care? Or pay **more** now and **less** when you need care?

Pay Less *Now*

The Bronze, Bronze Plus, and Silver coverage levels cost less per paycheck, but your deductible is higher. That means you'll pay more out of your pocket when you need care.

Make sure you know **how the deductible works**. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an **HSA** when you enroll in a Bronze, Bronze Plus, or Silver coverage level.

Pay Less *Later*

The Gold and Platinum coverage levels cost more per paycheck, but your deductible is lower. If you don't expect to have a lot of health care needs, you could be spending money for benefits you don't use.

How to Get the Right Medical Option

Now that you understand the basics, it's time to put it all together. There are several resources to help you get confident before you enroll—including the Help Me Choose tool, an integrated guidance tool that can help you look up providers, prescription drugs, and more.

Get ready now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount. And certain options in some states won't cover out-of-network services at all.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Do **not** rely on your provider's office to know the carriers' network(s). To search for providers:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. You can access this information by entering your provider information in the Help Me Choose tool or clicking **Find Doctors** when you're selecting your medical plan. For the best results:
    - Search for your provider by name—not medical practice.
    - Check only the office location(s) you are willing to visit.
    - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider networks on the carrier preview sites before making a decision.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a covered family member regularly takes medication, make sure you're comfortable with the pharmacy benefit manager's coverage for drugs you and your covered family members need:

- Call OptumRx (if you're considering coverage under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare) or the medical **insurance carrier** (for all other carriers) before you enroll. Get a list of **prescription drug questions** to ask.
- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.
- When it's time to enroll, you can use the Help Me Choose tool to look up how your medication will be classified (Tier 1, Tier 2, Tier 3) and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage.

What to Do
If you need help deciding, there are tools to help you:

- Get an overview of your medical **coverage levels**.
- See which coverage level could be **best for you** with the Help Me Choose tool. By answering a few questions about your preferences when you enroll, you can see which option could be a good fit for you and your family.
- Compare your options side by side when you enroll on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. Just check the boxes next to medical options you want to review and click **Compare**. You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price and provider network, and you'll be able to see all of the prices in one place when you enroll on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. (**Note:** The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- Use Help Me Choose—an interactive decision-making tool that allows you to compare your options based on your preferences, doctors, and prescriptions.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking **Compare**. That makes it easy to see which carrier is offering you the most value. (You may also find Summaries of Benefits and Coverage for comparison on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.)

- Browse the carrier **preview sites** to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? **Find out how.**

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze, Bronze Plus, or Silver coverage level. If you also have coverage under a second medical plan, it must also be a high-deductible option for you to use an HSA.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to **decide how much to save**.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze, Bronze Plus, or Silver coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee. With a high deductible, you might worry about how you're going to afford the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy. You could already have saved the money you need.

An HSA allows you to set aside tax-free money to pay for qualified health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on qualified health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on your qualified medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

Wondering what the difference is between an HSA and a Health Care Flexible Spending Account (FSA)? **Find out.**

Questions?

Get answers to your questions, including eligibility rules, how to contribute, and more.

If you enroll in a Bronze, Bronze Plus, or Silver coverage level, learn how the HSA works in the **HSA User's Guide** (PDF).

HSA vs FSA

See how an HSA is different from a Health Care Flexible Spending Account (FSA) and a Limited Purpose Health Care FSA below.

	HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
When to Use	You can use the HSA to pay for eligible medical, dental, and vision expenses under the Bronze, Bronze Plus, or Silver coverage levels.	You can use the Health Care FSA to pay for eligible medical, dental, and vision expenses under any coverage level.
Contributions	You can contribute to your account before taxes. For 2026, the annual limits set by the IRS are $4,400 for individual coverage, and $8,750 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	You can contribute to your account before taxes, up to the $3,300 annual limit.
Fund Availability	You can use up to the total amount you have contributed to your HSA.	The total amount of your annual election is available at the beginning of the plan year.
Rollovers	Unused dollars roll over from year to year. The funds are always yours to keep, even if you leave the company or retire.	You can roll over up to $660 from year to year.
Earning Interest	The money in your HSA earns interest.	The money in your FSA does **not** earn interest.
Debit Cards	Yes, a debit card is available.	Yes, a debit card is available.
Investment Option	You can open an investment account when your balance reaches $1,000.	You cannot invest your FSA balance.

Which Account Should I Use

If you enroll in the Bronze, Bronze Plus, or Silver coverage level, you can use an HSA, both an HSA and a Limited Purpose Health Care FSA or if Medicare eligible, a Health Care FSA. If you contribute to an:

- HSA **or** Health Care FSA, you can use your account to pay for qualified medical, dental, and vision expenses.
- HSA **and** Limited Purpose Health Care FSA, in order to contribute to an HSA, your FSA will be "limited purpose" and can only be used to pay for qualified dental and vision expenses. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Gold or Platinum coverage level, you can use the Health Care FSA to pay for qualified medical, dental, and vision expenses.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2026, you can save up to $4,400 if you're covering just yourself, or $8,750 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Prescription Drugs

Your prescription drug coverage will be provided through your pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Employees who enroll under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. All other carriers will manage their own prescription drug coverage.

That means your prescription drug coverage depends on the medical coverage level you choose **and** your medical **insurance carrier.**

Your Coverage Level Matters

You pay nothing for preventive drugs, as determined by your pharmacy benefit manager. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze, Bronze Plus, or Silver
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

Gold or Platinum
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your specific prescription coverage is based on the medical coverage level you select. **Get the details**.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—**before** choosing an insurance carrier.

Get a list of **prescription drug questions** to ask.

Prescription Drug Questions

Your prescription drug coverage will be provided through your **insurance carrier's** pharmacy benefit manager, which could be a separate prescription drug company. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So **you need to do your homework** to find out how your medications will be covered—**before** you choose an insurance carrier.

What To Ask

Here's a list of questions to ask OptumRx (if you're considering coverage under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare) or the medical **insurance carrier** (if you're considering coverage under other carriers).

Tip: You can also print out the **Prescription Drug Transition Worksheet** (PDF) and use it to take notes.

Is my drug on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, higher-cost generics can be classified as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information by using the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical pharmacy benefit managers will require you to pay the copay or coinsurance of a higher tier—**plus** the cost difference between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in-network. You can view a list of drugs considered to be "preventive" when you enroll. If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many medications require approval before they are covered. This may apply for costly medications that have lower-cost alternatives or aren't considered medically necessary.

What is a step therapy program?
If this applies to one of your medications, you'll need to try using the most cost-effective version first—usually the generic. A more expensive version will be covered only if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Are weight loss drugs covered?
Medications prescribed for the sole purpose of weight loss are not covered. Note: When using **digital.alight.com/mybenefitplans** prescription drug tool or looking at a carrier's formulary, you may still see the medications listed because they may be prescribed for other health conditions.

We'll Help You Through The Transition

After you enroll, check out things to know **before your benefits start**.

Medicare Basics

Medicare is a federal medical insurance program, which includes Original Medicare. Original Medicare is a low-cost government insurance program that guarantees access to health insurance for Americans age 65 and older and younger people with certain medical disabilities. It pays for many health care expenses, but not all.

How It Works

Medicare covers its share of an approved amount and you pay the rest through deductibles and coinsurance. Original Medicare is made up of two parts:

- **Part A is hospital insurance.** It covers inpatient hospital care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.
- **Part B is medical insurance.** It covers things like clinical research, ambulance services, durable medical equipment, mental health services, limited outpatient prescription drugs, and more.

You are automatically eligible for Medicare Parts A and B when you become Medicare-eligible. If you are receiving Social Security benefits, you may be enrolled in Medicare automatically.

If you have to sign up to get coverage, you can enroll starting three months before the month you turn age 65. The deadline to enroll is three months after the month you turn age 65. (Note: You can wait to enroll in Part B; however, you may have to pay a late enrollment penalty. In general, you can wait to enroll in Medicare Part B without facing a late enrollment penalty until your active employment ends or the date your coverage under your employer's plan ends, whichever occurs first. Consult your Medicare advisor for more details.)

Part D is optional prescription drug coverage. You can enroll in Part D if you want coverage to help pay for your prescription drug costs.

How Medicare Works With Company Coverage

If you are actively employed, your company's health plan will be your primary medical coverage, and, if you choose to enroll in Medicare, Medicare will be your secondary coverage. Please note, once you are enrolled in any part of Medicare (Parts A or B), you can no longer make contributions to an HSA, even if you are also covered by an HSA-eligible medical plan.

If you are retired and have coverage through your previous employer, Medicare will be your primary medical coverage, and your company's health plan will be your secondary coverage.

As you prepare to transition to Medicare, you will want to understand if your dependents under age 65 will be eligible for coverage under your company's health plan.

How Medicare Works With COBRA

If you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. COBRA coverage pays secondary to Medicare Parts A and B. Therefore, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did not actually enroll in Medicare.

If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later.

If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

To Learn More

Below are resources where you can find additional information and help:

- Visit **Alight Retiree Health Solutions** or call **1.833.791.0780**
- Visit the **Social Security website** or call **1.800.772.1213** (TTY **1.800.325.0778**) between 8:00 a.m. and 7:00 p.m. Monday through Friday
- Review the **Medicare & You** handbook from the Centers for Medicare & Medicaid Services

Accident Insurance

Accidents can slam your wallet too.

Even with medical coverage, your costs related to an accident can be hefty. Depending on the injury, you may be faced with copays, deductibles, hospital charges, transportation fees, and lodging expenses.

Accident insurance pays a benefit in the event you or a family member covered under this plan is in an accident. Accident insurance is not a replacement for medical coverage.

You can learn more about this coverage **here**.

For additional details on accident insurance, visit the **Helpful Documents** page.

Things To Consider

When deciding whether to enroll in accident insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Your and Your Family's Needs
Does your family lead an active lifestyle? Have you or an eligible family member suffered financial loss resulting from an accident? If you answered "yes" to either question, having accident insurance could give you peace of mind.

Other Coverage
Consider how accident insurance could fit in with other coverage for which you might enroll.

Critical Illness Insurance

When illness strikes, you can strike back. If you experience a serious health condition in the future, critical illness coverage can help lighten the load.

Even with medical insurance, a serious health condition could cost you. Critical illness insurance can provide you with extra cash when you need it most—if you or a family member once covered under this plan is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage renal disease).

You can learn more about this coverage **here**. Critical illness coverage has limitations and exclusions.

For additional details on critical illness insurance, visit the **Helpful Documents** page.

Choose Your Coverage Level

If you decide you want critical illness coverage, you may choose $10,000, $20,000, $30,000, or $40,000 of coverage.

Things To Consider

When deciding whether to enroll in critical illness insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover, age, tobacco status, and the level of coverage you elect. You'll be able to see the cost per paycheck for all your options when you enroll through the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Your and Your Family's Needs
Does a serious health condition run in your family? Would you need financial help to offset the cost of a serious health situation? If you answered "yes" to either question, having critical illness insurance could give you peace of mind.

Hospital Indemnity Insurance

Even with medical insurance, hospital stays can be costly. You may have copays, deductibles, and other incidental hospital charges that add up. That's why you can buy extra insurance through hospital indemnity coverage.

Hospital indemnity insurance pays you a single lump-sum benefit in the event you or a family member covered under this plan is hospitalized. The benefit is based on the type of hospital stay.

You can learn more about this coverage **here**.

For additional details on hospital indemnity insurance, visit the **Helpful Documents** page.

Things To Consider

When deciding whether to enroll in hospital indemnity insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Your and Your Family's Needs
Does a serious health condition run in your family? Are you or an eligible family member frequently hospitalized? If you answered "yes" to either question, having hospital indemnity insurance could give you peace of mind.

Dental Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays). Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Dental Coverage Level Options

	BRONZE	SILVER	GOLD	PLATINUM[2]
		Annual Deductible and Plan Limits		
Annual deductible (individual / family)	$100 / $300	$100 / $300	$50 / $150	None
Annual maximum (excludes orthodontia)	$1,000 per person	$1,500 per person	$2,500 per person	None
Orthodontia lifetime maximum[1]	Not covered	$1,500 per child	$2,000 per person	Varies by insurance carrier
		In-Network Benefits		
Preventive care	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible	Varies by insurance carrier; generally covered 100%
Minor restorative care (e.g., root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	Varies by insurance carrier
Major restorative care (e.g., crowns, implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible	Varies by insurance carrier

Orthodontia	Not covered	You pay 50%, no deductible; children up to age 19 only	You pay 50%, no deductible; for children and adults	Varies by insurance carrier

[1]If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.

[2]Not available in some limited areas. Only the coverage levels for which you are eligible will show as options when you enroll.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Considering Platinum? It may cost less than some of the other options, but you **must** designate a primary care dentist who participates in the insurance carrier's Platinum network (where available by carrier) and get care from your primary care dentist. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll. If you don't designate a primary care dentist when you enroll, one may be assigned to you. To change your primary care dentist, you will need to contact the insurance carrier directly. If you enroll in a Platinum option and don't use a network dentist, you'll pay for the full cost of services.

Considering Delta Dental? With most carriers, knowing that your dentist is in the network is a simple way to get the best deal when you need care. If you're considering Delta Dental, you need to take it one step further.

- If you choose a Bronze, Silver, or Gold option, there are actually two Delta Dental networks —PPO and Premier. Although the benefits are the same for both, you may have to pay more if your dentist is only a part of the Premier network. You can save more by seeing a Delta Dental dentist who participates in both the PPO and Premier networks, or by using any in-network dentist if you choose another insurance carrier.
- If you choose a Platinum option, the Delta Dental network goes by the name of "DeltaCare." So you need to make sure your dentist is in the DeltaCare network—not just the Delta Dental network. You can also get the same deal by using any in-network dentist if you choose another insurance carrier.

You can check if your provider is part of either network on **digital.alight.com/mybenefitplans** or through **Your Carrier Connection**.

Dental Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

Just like your medical coverage, your dental coverage costs will depend on a few factors:

The Coverage Level You Choose

Bronze
The Bronze coverage level generally costs less per paycheck. That's because some services aren't covered and because it has the lowest benefit maximum.

Silver
The Silver coverage level is moderately priced since most services are covered. However, the benefit maximum is lower.

Gold
The Gold coverage level costs more per paycheck since most services are covered. The benefit maximum is also higher.

Platinum
The Platinum coverage level generally costs less. It provides comprehensive coverage for in-network care only.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Vision Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care. Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Vision Coverage Level Options

	BRONZE	SILVER	GOLD
In-Network Benefits			
Routine vision exam (once per plan year)	Covered 100%	You pay $10	Covered 100%
Frames (once per plan year)	Discount may apply	$150 allowance[1]	$200 allowance[1]
Lenses (once per plan year; premium lenses may cost more)			
Single vision	Discount may apply	You pay $20	You pay $10
Bifocal	Discount may apply	You pay $20	You pay $10
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[2]	Discount may apply	You pay $20	You pay $10
Lenticular	Discount may apply	You pay $20	You pay $10
Lens Enhancements			

UV treatment	Discount may apply	Varies by carrier	Varies by carrier
Tint (solid and gradient)	Discount may apply	Varies by carrier	Varies by carrier
Standard plastic scratch-resistant coating	Discount may apply	Varies by carrier	Varies by carrier
Standard anti-reflective coating	Discount may apply	Varies by carrier	Varies by carrier
Standard polycarbonate (adults)	Discount may apply	Varies by carrier	Varies by carrier
Standard polycarbonate (children)	Discount may apply	You pay nothing	You pay nothing
Other add-ons	Discount may apply	Discount only	Discount only
Contact Lenses			
Medically necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$150 allowance[1]	$200 allowance[1]
Fit and evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery			
Elective	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1]Allowance can be used for frames or elective contact lenses, but not both.

[2]Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Vision Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

Just like your medical coverage, your vision coverage costs will depend on a few factors:

The Coverage Level You Choose

The Bronze option will generally be less expensive per paycheck. That's because it covers only exams with some in-network discounts available. The Silver and Gold options will cost more per paycheck and provide coverage for exams as well as frames and lenses.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Flexible Spending Accounts (FSAs)

Your employer offers two tax-advantaged FSAs: the Health Care FSA and Dependent Care FSA. Both FSAs are administered by Alight Smart-Choice Accounts.

Health Care FSA

A Health Care FSA allows you to set aside dollars from your pay on a pre-tax basis to reimburse yourself for qualified medical, dental, and vision expenses.

The Health Care FSA contribution limit is $3,300 for 2026. Once you enroll and set your annual contribution, you cannot change that amount during the year (except in the case of certain qualified life events).

With the Health Care FSA, you can roll over up to $660 from year to year. Any funds above that amount are forfeited, so it is essential that you carefully estimate the amount to contribute each year.

Wondering what the difference is between a Health Savings Account (HSA) and Health Care FSA? **Find out.**

Limited Purpose Health Care FSA

If you enroll in the Bronze, Bronze Plus, or Silver coverage level, you can use an HSA, both an HSA and a Limited Purpose Health Care FSA or if Medicare eligible, a Health Care FSA. If you contribute to an:

- HSA **or** Health Care FSA, you can use your account to pay for qualified medical, dental, and vision expenses.
- HSA **and** Health Care FSA, your Health Care FSA will be “limited purpose” and can only be used to pay for qualified dental and vision expenses. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Gold or Platinum coverage level, you can use the Health Care FSA to pay for qualified medical, dental, and vision expenses.

Dependent Care FSA

A Dependent Care FSA may be used to reimburse yourself for qualified child and dependent care expenses. You may use this account without being enrolled in medical coverage.

The Dependent Care FSA contribution limit is $7,500 (or $3,750 if you are married and filing taxes separately) for 2026. Once you set your annual contribution when you enroll, you cannot change that amount during the year (except in the case of certain qualified life events).

And, with the Dependent Care FSA, you lose any unused money at the end of the year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

Things To Consider

When deciding whether to enroll in FSAs, be sure to consider the following:

Tax savings
Do you have moderate to high health care or dependent care expenses? If so, an FSA could help reduce how much you pay in taxes.

Your expected expenses
Carefully estimate your anticipated eligible expenses for the coming year. You should only set aside FSA dollars you know you will be able to use on eligible expenses.

Life Insurance

Protect your loved ones. Choose the amount of life insurance coverage that's right for you and your family.

Life insurance protects your family financially in the event of a death. Your employer automatically provides basic life insurance and Accidental Death and Dismemberment (AD&D) for you free of charge.* And, if you decide your family needs more life insurance protection, you can buy additional coverage for yourself and dependents.

Life insurance is administered by MetLife.

* Federal tax law requires you to pay taxes on the cost of basic life insurance coverage over $50,000. This is called "imputed income" and will be added to your gross taxable income. It will be included on your paychecks and on your Form W-2 each year. The amount of imputed income is based on your age and coverage amount.

Choose Your Beneficiaries

Your family depends on you for all kinds of things—including your pay. Make sure to choose the people and/or estate that should receive your life insurance benefit if you die. It is important that you make your beneficiary elections on the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

First, gather the Social Security numbers and birth dates for each beneficiary. Then, when you're enrolling in life insurance, you'll be prompted to designate your beneficiaries.

You can change beneficiaries at any time. If you die and have no beneficiaries on file, the benefit may—or may not—eventually reach the individual(s) you would prefer. The result could be a significant delay in payment during an already challenging time for your loved ones.

Things To Consider

When deciding whether to enroll in supplemental and dependent life insurance coverage, be sure to consider the following:

Cost per Paycheck
The cost of supplemental and dependent life insurance coverage could be based on age, level of coverage, and whether the covered person uses tobacco. You'll be able to see the cost per paycheck for your options when you enroll through the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

Your Family's Needs
Remember that life insurance is intended to help protect your family financially if a covered family member dies. Would you have enough money to pay funeral expenses? Would you need to replace an income?

Every situation is different, so consider your family situation carefully.

EOI Requirements
In order to buy certain levels of supplemental and spouse /domestic partner life insurance, you'll need to prove that you and your spouse /domestic partner are in good physical health. This is called providing evidence of insurability (EOI).

If EOI is required, you will get instructions on how to access the form as you complete your enrollment online. Please fill out the form and submit it promptly. Full coverage won't take effect until the carrier approves your coverage.

If you don't submit the EOI form or it doesn't get approved, your coverage (and paycheck contributions) will reflect the highest level of coverage that doesn't require EOI.

Disability

Could you pay your bills if an illness or injury prevented you from working? Disability benefits can help.

Disability benefits are administered by MetLife.

Short-Term Disability (STD)

STD benefits replace a portion of your income if you're unable to work due to pregnancy, illness, or non-work-related injury. Your personalized options will be available during enrollment on the My Benefit Plans Website.

Long-Term Disability (LTD)

LTD benefits pick up where your STD benefits end—providing you with a portion of your income for as long as you remain eligible. Your personalized options will be available during enrollment on the My Benefit Plans Website.

Things To Consider

When deciding whether to enroll in supplemental disability coverage, be sure to consider the following:

Cost per Paycheck
The cost of disability coverage is based on the level of coverage you elect. You'll be able to see the cost per paycheck when you enroll.

Other Income Sources
If you were unable to work, would other sources of income be available to you, such as sick pay, salary continuance, a short-term state disability plan, or Social Security? If so, consider whether you would have enough money to pay your ongoing expenses for a period of time.

Taxes
Disability benefits may be taxable as ordinary income. That means federal and state income taxes will be deducted from disability benefit checks. When choosing a disability coverage level, be aware that taxes may affect the dollar amount of your benefit.

Identity Theft Protection

Victims of identity theft spend countless hours trying to sort out the damage.

Identity theft protection could help you catch fraud in its early stages through 24/7 monitoring of your personal and financial information. It can also help you act quickly to limit damage if your personal or financial information is stolen.

For more information, you can visit **https://www.gendigital.com/us/en/partner/employee-benefits/premier-plan**.

Identity theft protection is a voluntary benefit administered by LifeLock by Norton. The plan covers all eligible family members. And you can drop coverage at any time during the year.

For additional details on identity theft protection, visit the **Helpful Documents** page.

Things To Consider

When deciding whether to enroll in identity theft protection, be sure to consider the following:

Cost per Paycheck
You'll be able to see the cost per paycheck when you enroll.

Your Risk Factors
While everyone has risk, some people are at greater risk than others. Have you used credit cards on unsecure websites? Do you make online purchases regularly? If you answered "yes" to either question, having identity theft protection could give you peace of mind.

Pet Insurance

Pet insurance allows you to focus on your pet's health—not how to pay for it.

Pet insurance can help pay veterinary expenses for a sick or injured dog or cat. It covers a wide range of services with no annual or lifetime limits. There is not a network of providers—you can use any licensed veterinarian. Go **here** for a complete list of covered services.

You can add or drop coverage at any time during the year. You can learn more and enroll through the My Benefit Plans Website at **digital.alight.com/mybenefitplans**.

MetLife Pet Insurance

MetLife Exotic Pet Benefit

Paying For Coverage

You'll pay your premiums by credit or debit card.

Things To Consider

When deciding whether to enroll in pet insurance, be sure to consider the following:

Cost
Your cost of coverage is based on the type of pet, breed, and age. Coverage is provided by pet. So if you have more than one, you can get a personalized quote for each.

Your Pet's Needs
Does your pet need regular veterinary care? Are you paying a lot of money out of your pocket for veterinary care? If you answered "yes" to either question, having pet insurance could give you peace of mind.

Flexibility
Since you can add or drop coverage at any time, it's easy to make a change if the need arises.

Other Benefits

Virtual Care

Through your medical insurance carrier, you'll have access to virtual care (also called telemedicine or telehealth) to speak to board-certified providers via email, phone, tablet, or computer. Virtual care services connect you with doctors for preventive care, behavioral health, dermatology, and urgent care.

For more information about the virtual care services offered by each insurance carrier, visit the **carrier preview sites**. For more tips and what to expect when you schedule a virtual care visit, check out **The Inside Scoop**.

Employee Assistance Program

The Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife life insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life.

- **MetLife LifeWorks Flyer**

Looking for more information?

If you'd like information about your 401(k) plan or have questions about other benefits, refer to your Plan Summary.

How to Enroll

Log on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans** to enroll in your benefits for 2026.

Logging on for the first time? From the My Benefit Plans Website, register as a new user and follow the prompts to provide requested information and set up your username and password.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success **after you enroll**.

In the weeks following your enrollment, you could be asked to complete a short, confidential survey about your enrollment experience. The survey will be sent from an Aon email address. Please take a few minutes to share your thoughts and help us improve your experience.

Questions?

Once logged on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the My Benefit Plans Website. You can also call the My Benefit Plans Center at **1.855.750.2920** from 10:00 a.m. to 10:00 p.m. ET Monday through Friday.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do **now** to use your benefits successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

Your prescription drug coverage is provided through your pharmacy benefit manager, who sets the rules for how medications are covered. The pharmacy benefit manager could be a separate prescription drug company. Employees who enrolled under Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. All other carriers will manage their own prescription drug coverage.

Check the Formulary

A **formulary** is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. **Check with your pharmacy benefit manager** to make sure your drug is listed on the formulary **before** you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they **typically** cost less. And, because brand name drugs can be expensive, some pharmacy benefit managers don't cover them **at all** if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new pharmacy benefit manager, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized—print the **Prescription Drug Transition Worksheet** (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your **new** medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, **call customer service** at your **new** medical insurance carrier as soon as possible to ask for help with "transition of care." You may be eligible to submit a Transition of Care form to your carrier in order to continue to receive services.

- **Aetna**
- **Cigna**

- Highmark
- UnitedHealthcare

Give your new insurance carrier information about your treatment and the providers you use today.

Will you have a new dental plan? Will you or your child(ren) continue receiving ongoing orthodontic treatment? **Call customer service** at your **new** dental insurance carrier as soon as possible to ask for help with "transition of care."

Track your to-dos and get organized! Print the **Transition of Care Worksheet** (PDF).

Avoid Unexpected Out-Of-Network Costs

It's very important to know whether your doctor participates in your medical insurance carrier's network.

You Could Pay a Lot More for Out-of-Network Care

Insurance carrier member sites and apps have resources that can help you look up the cost of care. But your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 45% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 45% of $2,000 and 100% of the remaining $3,000, for a total of $3,900.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 45% of $3,000 and 100% of the remaining $2,000, for a total of $3,350.

Take These Steps to Protect Yourself

If you *didn't* check your doctor's status before you enrolled or you want to look up a different doctor, do it *now*—before making an appointment with that doctor.

You can check the provider directory through the My Benefit Plans Website at **digital.alight.com/mybenefitplans** or your **insurance carrier's website**.

Important! Do not rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you're keeping the same insurance carrier, the provider network could be different. **Always** check the provider directories on the carrier preview sites before making a decision.

If your doctor is out-of-network and you still want to see them, check the cost with your doctor *before* you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you'll be responsible. That way you'll be prepared for any potentially significant costs.

When To Expect New Cards

If you enroll in medical coverage with Aetna, Highmark Blue Cross Blue Shield, Cigna, or UnitedHealthcare, you will have a medical ID card and separate prescription drug ID card from OptumRx. If you enroll in medical coverage with another insurance carrier, you will have one ID for both medical and prescription drugs.

Once your eligibility information is received by the carrier, you'll be able to create an account on the carrier's website to download a digital ID card. You can use these digital cards while waiting for your physical cards to arrive. Log in to your carrier's website and look for an option to print your member ID card.

Note: Many dental insurance carriers also issue ID cards. If you receive one, simply present it when you get dental care during the new plan year.

For questions about ID cards, **contact the insurance carrier**. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze, Bronze Plus, or Silver coverage levels, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing debit card. New money added to your account will be accessible through your current debit card.

HSA vs. FSA: Which One Should You Use?

If you enrolled in an HSA **and** a Health Care Flexible Spending Account (FSA), you will use the same debit card for **both** accounts. And Alight Smart-Choice Accounts will automatically follow IRS guidelines on how to use each account. So when you use the debit card to pay for medical, dental, or vision expenses, the expense will automatically be deducted from the correct account.

Want To Print?

Print these worksheets and get a step-by-step guide to what to do and what to ask as you get ready to use your new coverage.

Prescription Drug Transition Worksheet (PDF)
Transition of Care Worksheet (PDF)

How to Get Care

When you get care, it helps to know what you can expect. Remember, insurance carrier member sites and apps have resources that can help you look up the cost of care before you go.

Getting Care At The Doctor's Office

Present your medical ID card at your doctor's office. If you're enrolled in the Bronze, Bronze Plus, or Silver coverage levels, you can wait to pay until your insurance carrier processes the claim and you get your doctor's bill.

When it's time to pay, you can **pay with your HSA**, FSA, or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical or prescription drug ID card each time you drop off a prescription. If payment is due, you pay out of pocket (or you can **pay with your HSA** or FSA if you have one).

Know When You'll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you'll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You'll Pay Less With In-Network Providers

You can check the provider directory on the My Benefit Plans Website at **digital.alight.com/mybenefitplans** or refer to your **insurance carrier's website**.

If a doctor is out-of-network and you still want to see them, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you'll be prepared for potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying for Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay **a lot** less when you see in-network providers. You can check the provider directory on the My Benefit Plans Website or refer to your **insurance carrier's website**.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you. You will receive a copy of your ID card after enrollment. You can also visit your carrier's website to print or download a copy.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is **not** a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket or you can **pay with your HSA** or FSA for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze, Bronze Plus, or Silver coverage level. When it's time for you to pay for care or prescription drugs, your HSA gives you options:

Use Your HSA Debit Card

Just use it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card for eligible expenses, and that you have enough money in your HSA to cover it.

Log on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans** to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans** to transfer money from your HSA to your regular bank account.

Set Up Direct Payments

Another option is to have Alight Smart-Choice Accounts make direct payments to your provider from your HSA.

Log on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans** to set up direct payments.

Eligible Expenses

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Always remember to save your receipts when you make payments from your HSA, in case you need to provide proof of your eligible expenses to the IRS.

Questions?

Learn more in the **HSA User's Guide** (PDF).

Transparency in Coverage

Your employer is subject to the Affordable Care Act's requirements to make certain information available to the public. These links lead to the machine-readable files that are published in response to the federal Transparency in Coverage Rule and include negotiated service rates and out-of-network allowed amounts between health plans and health care providers. The machine-readable files are formatted to allow researchers, regulators, and application developers to more easily access and analyze data.

- **Aetna:** https://health1.aetna.com/app/public/#/one/insurerCode=AETNACVS_I&brandCode=ALICSI/machine-readable-transparency-in-coverage?reportingEntityType=Third Party Administrator_113990696&lock=true
- **Cigna:** https://www.cigna.com/legal/compliance/machine-readable-files
- **Dean/Prevea360:**
    - https://www.Deancare.com/transparencyincoverage
    - https://www.Prevea360.com/transparencyincoverage
- **Geisinger:** https://www.geisinger.org/health-plan/no-surprises-act
- **HealthNet:** https://www.centene.com/price-transparency-files.html
- **Highmark:** https://mrfdata.hmhs.com
- **Kaiser:** https://healthy.kaiserpermanente.org/front-door/machine-readable
- **Med Mutual of OH:** https://medmutual.healthsparq.com/healthsparq/public/#/one/insurerCode=MMO_I&brandCode=MMO&productCode=MRF/machine-readable-transparency-in-coverage
- **Priority Health:** www.priorityhealth.com/landing/transparency
- **United Healthcare:** https://transparency-in-coverage.uhc.com
- **UPMC:** https://www.upmchealthplan.com/transparency-in-coverage/mrf/

Your Carrier Connection

Check out your health care insurance carrier choices—and see all the unique features and services they have to offer. Discover what each provides, see the doctors included in their network, and then decide for yourself.

Medical

Carrier Name: **Aetna**

Areas We Serve: Offered in all states except AK, ID, MT, WY, and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/si

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Pharmacy Contact (OptumRx): 1.855.524.0381

Learn More

Carrier Name: **Cigna**

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-aso2025/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna Support is available 24/7/365

Phone Number: 1.855.694.9638 , For Cigna company names and product disclosures, visit Cigna.com/product-disclosure.

Pharmacy Contact (OptumRx): 1.855.524.0381

Learn More

Carrier Name: **Dean/Prevea360**

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours: Mon - Thurs: 7:30 a.m. - 5:00 p.m. CST
Friday: 8:00 a.m. - 4:30 p.m. CST

Phone Number: 1-877-357-3164

Learn More

Carrier Name: **Health Net**

Areas We Serve: Available in CA

Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PST

Phone Number: 1.888.926.1692

Learn More

Carrier Name: **Highmark Blue Shield**

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.choosehmk.com/AonSFBS

Once you're a member (website): https://www.highmarkblueshield.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. EST

Phone Number: 1.844.637.5488

Pharmacy Contact (OptumRx): 1.855.524.0381

Learn More

Carrier Name: **Kaiser Permanente**

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours: Monday - Friday: 8:00 a.m. - 5:00 p.m. PST

Phone Number: 1.855.407.0900

Learn More

Carrier Name: **Kaiser Permanente**

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours:
CA: 24/7 except major holidays
CO: Mon - Fri: 8:00 a.m. - 6:00 p.m. MST
GA: Mon - Fri: 7:00 a.m. - 7:00 p.m. EST
DC, MD, VA: Mon - Fri: 7:30 a.m. - 9:00 p.m. EST
OR and WA (Vancouver/Longview area): Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number:
1.877.580.6125 , CA Post-enrollment: 1.800.464.4000
CO Post-enrollment: 1.800.632.9700 (Gold II & Platinum); 1.855.364.3184 (All other metallics)
GA Post-enrollment: 1-888-865-5813 (Gold II & Platinum); 1-855-364-3185 (All other metallics)
DC, MD, VA Post-enrollment: 1.888.225.7202 (All metallics)
Southwest WA Post-enrollment: 1.800.813.2000 (Kaiser & Platinum); 1.866.616.0047 (All other metallics)

Pre-enrollment Phone Number: 1.877.580.6125

Learn More

Carrier Name: **Medical Mutual**

Areas We Serve: Generally available in OH

Before you're a member (preview site): http://www.medmutual.com/aon

Once you're a member (website): https://member.medmutual.com

Customer Service Hours: Monday- Thursday: 7:30 a.m. - 7:30 p.m. EST
Friday: 7:30 a.m. - 6:00 p.m. EST
Saturday: 9:00 a.m. - 1:00 p.m. EST

Phone Number: 1.800.541.2770

Pre-enrollment Phone Number: 1.800.677.8028

Learn More

Carrier Name: **Priority Health**

Areas We Serve: Available in the lower peninsula of MI

Before you're a member (preview site): https://www.priorityhealth.com/aon

Once you're a member (website): https://member.priorityhealth.com/

Customer Service Hours: Monday -Thursday 7:30 a.m. -7:00 p.m. EST
Friday 9:00 a.m. - 5:00 p.m. EST
Saturday 8:30 a.m. - noon EST

Phone Number: 1.833.207.3211

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon12

Once you're a member (website): http://myuhc.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. all time zones

Phone Number: 1.888.297.0878

Pharmacy Contact (OptumRx): 1.855.524.0381

Learn More

Carrier Name: **UPMC Health Plan**

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours: Monday-Friday: 8:00 a.m. - 6:00 p.m. EST.

Phone Number: 1.844.252.0690

Learn More

Dental

Carrier Name: **Aetna**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/si

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm EST

Phone Number: 1.855.496.6289

Learn More

Carrier Name: **Cigna**

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-aso2025/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna Support is available 24/7/365

Phone Number: 1.855.694.9638

Learn More

Carrier Name: **Delta Dental (Bronze, Silver, and Gold)**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.deltadental.com/us/en/aon/california.html

Once you're a member (website): http://www.deltadentalins.com

Customer Service Hours: Mon - Fri: 8:00 a.m. - 8:00 p.m. EST

Phone Number: 1.800.471.7614

Pre-enrollment Phone Number: 1.800.503.4162

Learn More

Carrier Name: **Delta Dental (Platinum)**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.deltadental.com/us/en/aon/california.html

Once you're a member (website): http://www.deltadentalins.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 9:00 p.m. EST

Phone Number: 1.800.471.8073

Pre-enrollment Phone Number: 1.800.546.9751

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-benefit-experience

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Friday: 8:00 a.m. - 11:00 p.m. EST

Phone Number: 1.888.309.5526

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon11

Once you're a member (website): https://www.myuhc.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. local time zone

Phone Number: 1.888.571.5218

Learn More

Vision

Carrier Name: EyeMed

Areas We Serve: Available nationally

Before you're a member (preview site): https://eyemed.com/en-us/benx-aon

Once you're a member (website): https://member.eyemedvisioncare.com/member/en

Customer Service Hours: Monday - Friday: 7:30 a.m. - 11:00 p.m. EST
Saturday: 8:00 a.m. - 11:00 p.m. EST

Phone Number: 1.844.739.9837

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-benefit-experience

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday-Saturday 9:00am-8:00pm EST

Phone Number: 1.888.309.5526

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon11

Once you're a member (website): https://www.myuhcvision.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. local time zone

Phone Number: 1.888.571.5218

Learn More

Carrier Name: **VSP Vision Care**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.vsp.com/aon

Once you're a member (website): https://www.vsp.com/login

Customer Service Hours: Monday – Saturday: 6AM-5PM PT
Sunday: Closed (IVR available 24/7)

Phone Number: 1.877.478.7559

Learn More

Contacts

Once logged on to the My Benefit Plans Website at **digital.alight.com/mybenefitplans**, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the My Benefit Plans Website. You can also call the My Benefit Plans Center at **1.855.750.2920** from 10:00 a.m. to 10:00 p.m. ET Monday through Friday.

Health Pros are also available to assist with tough issues like claims and billing disputes.

Questions About Coverage?
Start by contacting the **insurance carrier** directly. They know their coverage rules best.

If you enrolled in a Bronze, Bronze Plus, or Silver medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Medical bills can be confusing. That's why your employer offers expert support to help you understand and resolve medical claims or billing issues. Your Health Pro can review your health care bills to ensure you are charged correctly according to your plan benefits. If there is an error, they will partner with your care provider and health plan on your behalf.

If you aren't satisfied with the resolution, you can file an appeal through your **insurance carrier**, who will be able to direct you through that process.

Not sure where to start? Once your coverage has begun, contact your **insurance carrier**. Your insurance carrier is most knowledgeable about coverage rules and has the final decision on all claims and billing questions.

Need Help? Your Health Pro Is Waiting.

Reach out to your Health Pro and they will guide you through the required steps and important deadlines. Your Health Pro can also manage the back-and-forth between your health insurance and doctor, as needed.

Your Health Pro can help:

- Interpret explanation of benefits (EOB) statements.
- Identify and correct claims or billing errors.
- Navigate the health plan appeals process.
- Manage correspondence with your health plan or providers.

If you've contacted your carrier and were unable to resolve your issue, email or call your Health Pro for help.

Email: **AlightHealthPro@alight.com**

Call: **1.866.300.6530**

Get Answers

Have a question? Start with the **Frequently Asked Questions** (PDF).

Wondering what something means? Check out the **Glossary**.

Want to talk with someone? Here's who to **contact**.

Glossary

Wondering what a term means? Find it here.

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Copay
A flat-dollar amount you pay for certain covered services.

Coverage Level
A benefit level that determines how services are covered.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. **How the deductible works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual deductible. They only count toward your out-of-network deductible.

Explanation of Benefits (EOB)
An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
A list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and effective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for qualified health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. **How the out-of-pocket maximum works**

depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual out-of-pocket maximum. They only count toward your out-of-network out-of-pocket maximum.

Payroll Contribution
The amount deducted from your paycheck on a pre-tax basis to cover your share of health care benefit costs.

Pharmacy Benefit Manager
The insurance carrier or third-party administrator who manages your retail and mail-order prescription drug benefit.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a specific area for a specific service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member. Expenses for all other family members will continue to count toward their individual deductible *and* the family deductible. Once any individual family member or combination of family members meet the family deductible, the plan will begin paying coinsurance for all covered members.

Traditional Out-of-Pocket Maximum
Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Expenses for all other family members will continue to count toward their individual out-of-pocket maximum *and* the family out-of-pocket maximum. Once any individual family member or combination of family members meet the family out-of-pocket maximum, the plan will begin paying the full cost of covered charges.

True Family Deductible
The entire family deductible must be met before your insurance will pay benefits for any covered family member.

True Family Out-of-Pocket Maximum
The entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

Newly Eligible for Benefits?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in your employer benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2026 benefits, you can start here:

- **Quick Guide**
- **Enrollment Checklist**
- **Medical**
- **Dental**
- **Vision**

Need To Enroll For 2025 *And* 2026 Benefits?

If you’re enrolling in benefits for the rest of 2025 and all of 2026, you should know what to expect for both years. While most things don’t change from year to year, some things could be different.

For your 2025 benefits, you can start here:

- **2025 Benefits Guide (PDF)**
- **What's Changing (PDF)** (see what’s different from 2025 to 2026)

Make It Yours

Once you’ve done your homework, if you want coverage through your employer, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug, dental, or vision coverage through your employer for you and your family.

Enroll now

Questions?

Check out the **Frequently Asked Questions** (PDF) for more details.

Helpful Documents

Please use the following to assist you during enrollment and beyond.

- **What's the Aon Benefit Experience?** (Video)

Accident insurance

- **Accident Insurance Brochure** (PDF)
- **How to File a Claim** (PDF)
- **Wellness Flyer** (PDF)

Critical illness insurance

- **Critical Illness Brochure** (PDF)
- **How to File a Claim** (PDF)
- **Wellness Flyer** (PDF)

Hospital indemnity insurance

- **Hospital Indemnity Brochure** (PDF)
- **How to File a Claim** (PDF)
- **Wellness Flyer** (PDF)

Identity theft protection

- **LifeLock Brochure** (PDF)
- **LifeLock Flyer** (PDF)
- **Onboarding and FAQs** (PDF)
- **Product Guide** (PDF)
- **Member Support and Contact Sheet** (PDF)

COBRA Coverage Options

If you leave the company or lose coverage due to a status change, your COBRA enrollment notice has details regarding your options.

If you choose not to enroll by your COBRA enrollment deadline, you will not be able to enroll in COBRA coverage in the future. Also, once enrolled, you can make changes to your elections only during enrollment or following a qualified change in status.

You will receive additional information—including prices—once you lose access to health benefits through the company.

Your COBRA Coverage Options

You can start by reviewing your **medical**, **dental**, and **vision** coverage level options.

You'll also want to review your **insurance carrier** options.

How To Enroll

To enroll in COBRA coverage when eligible, follow the instructions on the COBRA enrollment notice mailed to you and enroll at **digital.alight.com/mybenefitplans**.