Benefits For Your Health and Well-Being

2023 Open Enrollment Guide

Choose Your 2023 Benefits
{November 14th- December 9th

ALLIED

elitestaffing

Contents

Welcome to Open Enrollment!

It's time to choose your benefit options for the 2023 plan year! Open Enrollment will be held from Month X – XX, 202X. During this time, you can re-evaluate your benefit needs and make changes to benefit selections.

This guide contains information about the benefits options available for eligible employees.

Eligibility and Enrollment

Open enrollment runs from Month XX to Month XX, 202X.

This is your annual opportunity to elect new benefits or modify your current benefit elections for you and your eligible family members outside of a qualifying life event (QLE).

Who is eligible to enroll?

Employees: Full-time employees who are regularly scheduled to work at least 30 hours per week are eligible to participate in the Group Health Plan.

Eligible Dependent: You can enroll yourself & your eligible dependents in benefits.
Eligible dependents include your:

- ✓ Legal spouse or domestic partner.
- ✓ Child(ren) up to age 26, regardless of student or marital status, or other coverage options.
- ✓ Unmarried child(ren) of any age who are incapable of supporting themselves due to mental or physical disability and who are totally dependent on you.

When do I enroll?

For current employees, the Open Enrollment period is your time to enroll. This year's Open Enrollment period begins **Month Day** and runs through **Month Day**. The benefits you choose during this open enrollment will become effective **January 1, 2023**.

How do I enroll?

The first step is to review your current benefit elections. Take this opportunity to think about the changes you and your family have experienced in the past year or anticipate in the coming year. Then, review the benefit plans and programs outlined in this guide and determine which plan options will best meet your needs. Submit your elections following the instructions provided by your Employer.

What if I need to make changes during the year?

You can change your benefit elections outside of Open Enrollment only if you have a Qualified Life Event, which include:

1. Birth or adoption of a child
2. Marriage, divorce, or legal separation
3. You or your dependent turning 26 and losing coverage
4. Change in employment status for you or your spouse that results in a gain or loss of benefits.

If you have a Qualified Life Event and want to make benefit changes during the year, you must submit appropriate notification within 30 days of the qualified event.

Health Coverage Terms to Know

When choosing a health plan, you may run across terms and phrases that are unfamiliar to you. Understanding these common health coverage terms can help as you decide on coverage for the coming year.

1. Premium

Your premium, also known as your employee contribution, is the amount you pay for health care coverage, and is deducted from your paycheck.

2. Deductible

Your deductible is what you pay up-front for care and is a set amount for the year. For most services, you will have to pay the full cost until you hit your deductible amount. After that, your health plan kicks in and shares costs for the rest of the year.

3. Copay

A copay is a fixed amount that you pay when you receive care.

How this works with your deductible: Typically, you don't need to meet your deductible for the copay amount to apply, and the money you spend on copays doesn't count toward your deductible.

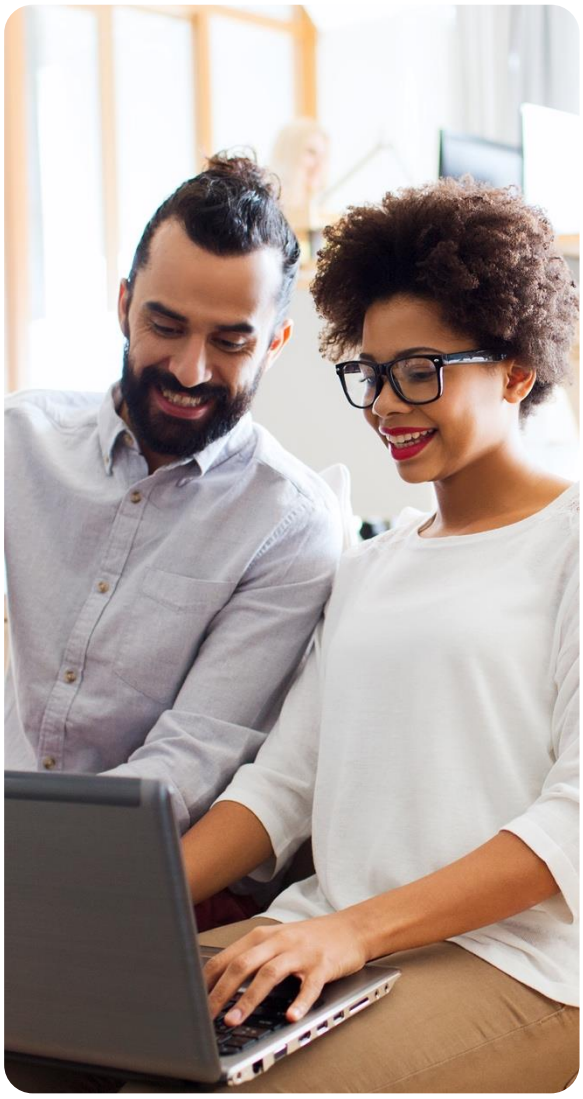
For example: If your plan has a $20 copay for every in-network specialist visit, you will owe $20 when you go in for your visit.

4. Coinsurance

Coinsurance is a varying amount that you pay when you receive care and is calculated as a percentage of the allowed amount for a service.

How this works with your deductible: Typically, coinsurance doesn't kick in until you've met your deductible.

For example: You've met your deductible of $1,000. If your plan has a 10% coinsurance for every in-network specialist visit, and your recent visit is $100, you will owe $10.



5. Out-Of-Pocket Maximum

The out-of-pocket maximum is the most you'll pay for care during your plan year before your health insurance begins to pay 100 percent of any allowed amounts.

It's important to note that this amount does NOT include your premium, balance-billed charges, or healthcare services your plan doesn't cover

Your Health Plan Administrator

Life is unexpected, but your health care coverage shouldn't be.

Allied is committed to helping you and your family make the most of your benefits all year round. With access to on-demand tools and one-on-one customer service support, Allied makes it easy to manage your benefits and stay on track towards a healthier you.

Manage your benefits at-home or on-the-go

Allied's online member portal allows you to manage your benefits at any time from any device. Simply log in at alliedbenefit.com to:

- Access your digital ID card
- Look up claims and deductible progress
- Review your benefits, copays and coinsurance amounts
- Pull up your customized Personal Health Record (PHR)

Expert advice, just a phone call away

When you need help, **Allied's Member Services** team is ready to answer any and all questions, including:

- Help submitting claims, or understanding your medical bills
- Verify your benefits and coverage details directly with your providers
- Find in-network providers
- Navigate your benefits and tools through your online member portal

Call 800-288-2078

Monday-Thursday, 7:30 am to 7:00 pm CT

Friday 8:00 am to 5:00 pm CT

Saturday 9:00 am to 12:00 pm CT

Medical Plan Options

Your Employer offers a choice of medical plans designed to help you and your family maintain good health and financial well-being. Deciding which plan is best for you depends on your specific health care needs, preferences, budget, and lifestyle.

For the 2023 plan year, you have three plan options to choose from:

1. **PPO**
2. **MEC Preventive**
3. **MEC Blue**

When you enroll in any one of the Allied medical plans, you and your family will have:

- **Comprehensive coverage** for major medical services (unless noted otherwise).
- **Free Preventive Care**. Your plan pays 100% for certain in-network preventive care services with no out-of-pocket costs to you. Preventive benefits are determined by national guidelines (incl. USPSTF, HRSA, and the CDC) and may differ from what your doctor recommends. Make sure to check your Summary Plan Description for a complete list of covered services.
- **Prescription drug benefits** through your plan's selected pharmacy partner.
- **24/7 access** to Allied's member website, so you can manage your benefits at any time from any device.
- **Dedicated support.** When you have a question or need assistance, Allied's Customer Service team is ready to help.

PPO Plan

Please note, the following chart presents only the highlights of your medical plan. More detailed information can be found in the Summary Plan Description.

Plan Highlights	In-Network – PHCS	Out-of-Network
Annual Deductible		
Individual	$5,000	$5,000
Family	$12,700	$12,700
Annual Out-of-Pocket Maximum		
Individual	$6,250	$12,500
Family	$12,700	$25,400
Amounts below are what you would pay		
Preventive Care Services	Plan covers 100%	40%, except for routine labs and x-rays which are payable at 100%
Primary Care Doctor Office Visit	20%	40%
Specialist Doctor Office Visit	20%	40%
Chiropractor	20%	40%
Lab Diagnostics and X-Rays	20%	40%
Complex Imaging Services (MRI, PET, and CT scans)	20%	40%
Urgent Care	20%	40%
Emergency Room	20%	Paid same as in-network
Hospitalization	20%	40%
Outpatient Surgery	20%	40%

Prescription Drugs

Rx Copays (30-day supply / 90-day supply)	
Generic	20%
Preferred Brand	20%
Non-Preferred Brand	20%

Network MEC Blue

Medical Plan Summary

The chart below provides a brief cost and coverage overview of this plan. More details can be found in the Summary Plan Description.

Medical Benefits	In-Network Only
Provider Network	MultiPlan Limited Benefit Plan
Deductible	None - $0
Out-of-Pocket Maximum	Unlimited
Preventive Care Services *Includes annual physical, well-woman exams, immunizations, health screenings and tests. Frequency limitations apply*	Plan covers 100%
Telemedicine - Virtual Doctor Office Visit through **Teladoc®**	Unlimited visits, covered at 100%
Primary Care or Specialist Doctor Office Visit	**4 visits** per person per year, covered at 100%
Outpatient/Office Diagnostic Tests, Imaging and Lab Services	**3 visits** per person per year, covered at 100%
Inpatient and Outpatient Hospital Services	**Not Covered**
Emergency Room and Urgent Care Services	**3 visits** per person per year, covered at 100%

Prescription Drug Benefit	CVS Caremark
Up to 30-day supply through participating **CVS Caremark®** network pharmacies	**$5 copay** for generic **$40** copay for preferred brand **Limit 12** prescriptions per person per year

About the Network MEC Care plan:

- **Limited Benefit Plan Design:** The MEC Care is a limited benefit plan and may not cover certain medical services. For example, this plan does not cover hospitalization or surgical benefits. Additionally, certain covered services may have a maximum allowed number of visits per year.
- **In-Network Services Only:** This plan will only cover services from in-network providers through the MultiPlan Limited Benefit Plan network. Out-of-network services will not be covered by the plan.

Network MEC Preventive

Medical Plan Summary

The chart below provides a brief cost and coverage overview of this plan. More details can be found in the Summary Plan Description.

Medical Benefits	In-Network Only
Provider Network	PHCS Preventive Services Only
Deductible	None - $0
Out-of-Pocket Maximum	Unlimited
Preventive Care Services *Includes annual physical, well-woman exams, immunizations, health screenings and tests. Frequency limitations apply*	Plan Covers 100%
Primary Care and Specialist Doctor Office Visit	Not Covered
Diagnostic Imaging or Lab Services	Not Covered
Emergency Room and/or Urgent Care Facilities	Not Covered

Prescription Drug Benefit	CVS Caremark
Prescriptions for preventive care only as required by the Affordable Care Act, through participating **CVS Caremark®** network pharmacies	Covered at 100% Non-preventive medications will not be covered

About the Network MEC Preventive Plan:

- **Preventive Care Services Only:** The MEC Preventive Plan is a minimal essential benefits plan that only covers ACA mandated preventive care services.
- **In-Network Services Only:** This plan will only cover services from in-network providers through the PHCS Preventive Services Only network. Out-of-network services will not be covered by the plan.

CVS Caremark

CVS Caremark is your pharmacy benefit manager and mail service provider.

When you enroll in a medical plan administered by Allied, you automatically receive prescription drug coverage through CVS Caremark. The CVS Caremark pharmacy network has more than 68,000+ retail pharmacies nationwide, including 9,900 CVS pharmacies plus many national and independent retail pharmacies, providing you with convenient access to fill prescriptions throughout the U.S.

Through CVS Caremark, you can:

- Manage your prescriptions, including your family's prescriptions
- Order transfer and refills, and request new prescriptions from your doctors
- Find a pharmacy. Go to Caremark.com and click "Locate Nearby Pharmacy" at the top of the page
- Set-up 90-day prescription delivery by mail for maintenance medications

Ways you can save on your prescriptions:

Ask your doctor or pharmacist about generics versus brand name drugs

Generics are the number one way your doctor or pharmacist can help save you money. By choosing generic medicines you can take more control of your health care costs and start saving. Generic medicine is high quality medicine that costs up to 80 to 85 percent less than its brand-name counterpart. The FDA requires that generic medicines have the same active ingredients, strength and dosage as their brand-name counterparts, which means they have the same quality and performance. And today nearly eight in 10 prescriptions filled in the U.S. are for generic medicine.

Use the CVS Caremark Mail Service or Retail-90 pharmacy for your long-term medications

Medications that you fill on an ongoing basis could cost you less by filling them through the CVS Caremark Mail Service or at a participating Retail-90 pharmacy. Plus, some medications that re filled in a 90day supply have even lower copays or coinsurance compared to a 30-day supply. This includes certain medications for high blood pressure, coronary artery disease, congestive heart failure, asthma/COPD, depression, diabetes, statins for high cholesterol, and in 2021 some osteoporosis medications.

Prescription Drug Coverage Tiers

Your plan may include coverage for a variety of prescription drug tiers. The following provides a break down of each tier.

Rx Tier	Description
Specified Preventive Drugs	Certain generic preventive medications (like birth control) are covered at no cost to you and not subject to annual deductibles provided certain requirements are met. Qualifying preventive drugs required by the Affordable Care Act) 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.
Generic Drugs	Generic drugs have the costs and are considered identical to their brand-name equivalents by the FDA in terms of efficacy and safety,.
Preferred Brand Drugs	Drugs on the brand formulary are designated as preferred based on their cost effectiveness and, in some cases, efficacy. If you or your provider choose a preferred brand-name medication when a generic is available, you'll pay the generic drug copay, plus the difference in cost between the generic and the preferred brand-name drug.
Non-Preferred Brand Drugs	Brand name drugs not on the brand formulary are considered non-preferred and usually the most expensive. Often, there will be generic options for medications prescribed by your doctor. When you fill a prescription, you can ask the pharmacist whether a generic or preferred brand drug of your medication is available. If you or your provider choose a non-preferred brand medication when a generic is available, you'll pay the generic drug copay, plus the difference in cost between the generic and the non-preferred brand drug.
Specialty Drugs	These are high-cost drugs that typically require special handling or administration. Certain specialty medications may be required to be purchased through CVS Specialty pharmacy or Allied's specialty pharmacy program. Unlike your generic and/or brand-name drugs which are filled through a CVS pharmacy, this plan requires you to obtain specialty medications through Allied's Specialty Pharmacy Program.

Find a Health Care Provider

Through your Allied health plan, you have access to the PHCS provider network of doctors, hospitals, and facilities. The PHCS network offers you:

- **Choice –** Broad access to more than 4,800 hospitals, nearly 92,000 ancillary care facilities, and 920,000 healthcare professionals.
- **Savings –** Negotiated discounts that result in significant cost savings for you when you visit in-network providers, helping you to maximize your benefits. A PHCS logo on your health insurance card tells both you and your provider that a PHCS discount applies.
- **Quality –** MultiPlan applies rigorous criteria when credentialing providers for participation in the PHCS Network, so you can be assured you are choosing your healthcare provider from a high-quality network.

How to Find a PHCS Network Provider

By Phone: Call 888-733-9582 Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) and identify yourself as a health plan participant accessing the PHCS Network.

Online: You may also search online at www.multiplan.com:

1. Click on “Find a Provider” at the top of the page.
2. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green ”Select Network” button.
3. When selecting your network, choose “PHCS,” then “I don’t see any of these statements,” and “Front.”
4. Enter one of the search criteria suggested in the search box to begin your search
5. If your browser settings don’t allow your location to be detected, enter a zip code.

Before Your Appointment

It is your responsibility to confirm your providers’ continued participation in the PHCS Network and accessibility under your benefit plan. Please also be sure to follow any preauthorization procedures required by your plan (usually a telephone number on your ID card). In addition, to ensure proper handling of your claim, always present your current benefits ID card upon arrival at your appointment.

If You Need Assistance

If you have issues when scheduling appointments with PHCS Network providers, call **PHCS at 888-733-9582**.

If you have questions about your benefits or claims status, please call **Allied Member Services at 800-288-2078**.

Find a Health Care Provider

Through your Allied health plan, you have access to the Multiplan Network for Limited Benefit Plans. The Multiplan network offers you:

- **Choice –** Broad access to nearly 4,600 hospitals, 98,000 ancillary facilities and 725,000 healthcare professionals nationwide
- **Savings –** Negotiated discounts that result in significant cost savings for you when you visit in-network providers, helping you to maximize your benefits. A Multiplan logo on your health insurance card tells both you and your provider that a Mulriplan discount applies.
- **Quality –** MultiPlan applies rigorous criteria when credentialing providers for participation in the Network, so you can be assured you are choosing your healthcare provider from a high-quality network.

How to Find a PHCS Network Provider

By Phone: Call 800-457-1403 Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) and identify yourself as a health plan participant accessing the Multiplan Network for Limited Benefit Plans.

Online: You may also search online at www.multiplan.com:

1. Click on “Find a Provider” at the top of the page.
2. After acknowledging you have read the disclaimer at the bottom of the screen, click on the green ”Select Network” button.
3. When selecting your network, choose “Multiplan”
4. Enter one of the search criteria suggested in the search box to begin your search.
5. If your browser settings don’t allow your location to be detected, enter a zip code.

Before Your Appointment

It is your responsibility to confirm your providers’ continued participation in the Multiplan Network and accessibility under your benefit plan. Please also be sure to follow any preauthorization procedures required by your plan (usually a telephone number on your ID card). In addition, to ensure proper handling of your claim, always present your current benefits ID card upon arrival at your appointment.

If You Need Assistance

If you have issues when scheduling appointments with Multiplan Network providers, call **Multiplan** at **800-457-1403**. If you have questions about your benefits or claims status, please call **Allied Member Services** at **800-288-2078.**

Allied Member Portal

Once you are enrolled in an Allied health plan, you will have access to your own personalized member portal via AlliedBenefit.com. Allied's online member portal allows you to navigate your benefits and proactively manage your healthcare at any time from any device.

With your Allied Member Portal, you can:

- Access your digital ID card
- Look up claims and deductible progress
- Review your benefits, copays & coinsurance amounts
- Pull up your customized Personal Health Record (PHR)
- Find in-network providers through the PPO directory

Set up your Allied member account at alliedbenefit.com.

1. Go to alliedbenefit.com/Members, click "Register"
2. Enter the required information under "Website Account Request," click "Submit."
3. Look out for two emails from notifications@alliedbenefit.com with instructions on how to authenticate your account. Click the link in the second email to complete the registration.

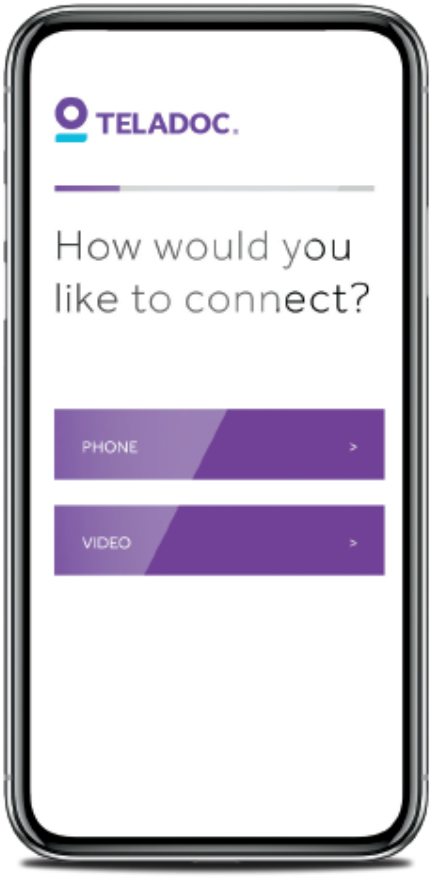
> Log in or register your account at alliedbenefit.com
>
> Group number: A16111

Teladoc® – MEC Plans Only

If you are enrolled in any one of the Allied medical plans, you have access to Teladoc.
Your Teladoc benefit provides you and your covered family members access to virtual care services from anywhere you are.

Talk to a U.S.-licensed doctor for non-emergency conditions 24/7 by phone, video, web or app. Teladoc doctors can:

- Provide a diagnosis, treatment and prescription if needed.
- Treat bronchitis, flu, rashes, sinus infections, sore throats, and more.
- Help you avoid the high cost and long waits of the ER or urgent care.



Talk to a doctor for free

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

*Available to employees enrolled in an Allied medical plan

Preventive Care Services for Adults and Children

Preventive care is an important part of staying healthy, and to avoid potentially serious health conditions by obtaining an early diagnosis and treatment plan. This includes:

- Check-ups (i.e., annual physical, pediatric well-visits, gynecology well-visits)
- Cancer and other health screenings
- Immunizations

Your plan pays 100% of certain preventive care services with no out-of-pocket costs to you. Preventive care is routine health care that includes screenings, checkups and patient counseling to help prevent illnesses, disease or other health problems. There may be some exceptions, so it's important to know what qualifies as preventive care and what questions to ask your doctor to avoid extra costs.

Covered Preventive Services

Preventive care is covered at 100% when 1) it is provided by an in-network doctor, 2) the claim is filed as a preventive visit, and 3) services are identified as preventive care under the Affordable Care Act (ACA). This list is not complete, so make sure you check the full list of services and any limitations in your employer's summary plan description available on your Allied Member Portal at alliedbenefit.com.

MEN

Adult screening tests:

- Abdominal aortic aneurysm
- Blood pressure
- Cholesterol
- Colon cancer
- Depression
- Diabetes
- Lung cancer

Other services:

- Immunizations, including flu shot
- Obesity screening and counseling
- Quitting tobacco
- Sexually transmitted infection (STI) counseling

WOMEN

Adult screening tests:

- Blood pressure
- Breast cancer counseling for genetic testing
- Cervical cancer screening (Pap test and/or HPV)
- Chlamydia and gonorrhea
- Cholesterol
- Colon cancer
- Depression
- Diabetes
- Lung cancer
- Mammogram (breast cancer)
- Osteoporosis

Other services:

- Contraception
- Immunizations, including flu shot
- Intimate partner violence
- Obesity screening and counseling
- Quitting tobacco
- Sexually transmitted infection (STI) counseling

PREGNANT WOMEN

Pregnancy-related screening tests:

- Bacteria in urine
- Gestational diabetes
- Hepatitis B
- Iron deficiency anemia
- Postpartum depression

Pregnancy-related services:

- Breastfeeding support, supplies and counseling
- Folic acid supplementation

INFANTS, CHILDREN, AND TEENS

Routine services and screening tests:

- Developmental and behavioral
- Fluoride dental varnish and oral health check
- Hearing/vision test
- Immunizations, including flu shot
- Newborn and infant screenings
- Well-baby/well-childcare

Other services:

- Depression screening
- Lead exposure test
- Obesity counseling
- Sexually transmitted infection (STI) screening and counseling
- Tobacco and alcohol use counseling

Important Contacts

Allied Member Services (All other PPOs and MECs)	800-288-2078 Monday-Thursday, 7:30 am to 7:00 pm CT Friday 8:00 am to 5:00 pm CT Saturday 9:00 am to 12:00 pm CT alliedbenefit.com/Members
CVS Caremark	877-860-6415 caremark.com
PHCS	888-733-9582
MultiPlan Limited Benefit Plan	800-457-1403
Teladoc	1-800-TELADOC (835-2362) teladoc.com