Aon Active Health Exchange™

Make It Yours To Go

make it yours

Table of Contents

Medical 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. 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
Option type	High-deductible option with HSA	PPO	PPO	PPO
Paycheck contributions	$	$$	$$	$$$
		2024 Annual Deductible		
In-network (individual / family)	$4,900 / $9,800	$2,300 / $4,600	$1,000 / $2,000	$800 / $1,600
Out-of-network (individual / family)	$4,900 / $9,800	$4,600 / $9,200	$2,000 / $4,000	$1,600 / $3,200
Traditional or true family?	Traditional	Traditional	Traditional	Traditional
		2024 Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$6,400 / $12,800	$6,700 / $13,400	$5,300 / $10,600	$3,600 / $7,200
Out-of-network (individual / family)	$12,800 / $25,600	$13,400 / $26,800	$10,600 / $21,200	$7,200 / $14,400
Traditional or true family?	Traditional	Traditional	Traditional	Traditional

		2024 In-Network Benefits		
Preventive care	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 $30 for PCP visit and $50 for specialist visit, no 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 $150, then 30% after deductible	You pay $150, then 30% after deductible	You pay $150, then 25% after deductible
Urgent care	You pay 25% after deductible	You pay $50	You pay $50	You pay $40
Inpatient care	You pay 25% after deductible	You pay 30% after deductible	You pay 30% after deductible	You pay 25% after deductible
Outpatient care	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 25% after deductible

Prescription Drug Coverage

	BRONZE	**BRONZE PLUS**	**SILVER**	**GOLD**
Preventive drugs	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 $12	You pay $12	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50	You pay $40
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $80	You pay $70	You pay $60
		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 $30	You pay $30	You pay $25
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $125	You pay $100
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $200	You pay $175	You pay $150

**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 for the Aon Active Health Exchange. 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 recommended by the exchange.

For a more detailed look at these and additional coverages, go to the Exela Health Benefits website at **digital.alight.com/exela**. 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 Exela Health Benefits website at **digital.alight.com/exela**.

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

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 insurance carrier's pharmacy benefit manager.

While your medical 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 and 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
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Blue Cross Blue Shield of Texas	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A
Health Net	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In-network only
Kaiser Permanente	In-network only	In-network only	In-network only	N/A	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

Medical Coverage Level

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II
Option type	High-deductible option with HSA	PPO	PPO	PPO	HMO
Paycheck contributions	$	$$	$$	$$$	$$$
			2024 Annual Deductible		
In-network (individual / family)	$4,900 / $9,800	$2,300 / $4,600	$1,000 / $2,000	$800 / $1,600	N / A
Out-of-network (individual / family)	$4,900 / $9,800	$4,600 / $9,200	$2,000 / $4,000	$1,600 / $3,200	N / A
Traditional or true family?	Traditional	Traditional	Traditional	Traditional	N / A
			2024 Annual Out-of-Pocket Maximum		
In-network (individual / family)	$6,400 / $12,800	$6,700 / $13,400	$5,300 / $10,600	$3,600 / $7,200	$5,400 / $10,800
Out-of-network (individual / family)	$12,800 / $25,600	$13,400 / $26,800	$10,600 / $21,200	$7,200 / $14,400	N / A
Traditional or true family?	Traditional	Traditional	Traditional	Traditional	Traditional
			2024 In-Network Benefits		
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%
Doctor's office visit	You pay 25% after deductible	You pay $30 for PCP visit and $50 for specialist visit, no 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	You pay $25 for PCP visit and $40 for specialist visit

Emergency room	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay $150, then 30% after deductible	You pay $150, then 25% after deductible	You pay $150, then 30% after copay
Urgent care	You pay 25% after deductible	You pay $50	You pay $50	You pay $40	You pay $40
Inpatient care	You pay 25% after deductible	You pay 30% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%
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Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II
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 $12	You pay $12	You pay $10	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50	You pay $40	You pay $40
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $80	You pay $70	You pay $60	You pay $60
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Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $30	You pay $25	You pay $25
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**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.

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Note: For additional comparison, you may find Summaries of Benefits and Coverage on the Exela Health Benefits website at **digital.alight.com/exela**.

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 insurance carrier's pharmacy benefit manager.

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**.

Medical Insurance Carrier Webinars

- Aetna
- BlueCross BlueShield of Texas
- Cigna
- Dean/Prevea360
- Kaiser Permanente
- Priority Health
- UnitedHealthcare
- UPMC Health Plan

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**.

It Depends On Your Medical Coverage Level

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

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, Bronze Plus, Silver, and Gold 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. Also, if you choose coverage under Kaiser Permanente, copays for certain medical benefits may not apply towards the annual out-of-pocket maximum under the Bronze Plus, Silver, and Gold options.

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

When you make a purchase, you decide how you want to pay. Would you rather pay cash now, or use credit and pay later?

It's the same idea with the exchange. You get to decide if you'd rather **pay now or pay later**.

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 Employer Contribution (Credit) From Exela

All eligible Employees will receive a employer contribution (credit) to use toward the cost of coverage.

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

The Coverage Level You Choose

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

The Silver and Gold 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

You can see which insurance carrier offers the lowest paycheck amount for each coverage level. 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

Your eligible dependents include:

- Legal spouse and domestic partner. If spouse or domestic partner is eligible for employer-sponsored medical coverage elsewhere, he or she is not eligible.
- Children up to age 26, whether natural, adopted, stepchildren or those for whom you have legal custody by court decree.
- If you cover your domestic partner, you may also cover your domestic partner's children.

- Your children of any age who are incapable of self-sustaining employment due to a behavioral or physical disability, as long as the incapacity started when the child was eligible for coverage.

When you enroll dependents for the first time, you will be required to provide the necessary documentation to confirm their benefits eligibility. Please refer to the Dependent Verification Document located in the Resource Library of Spring Benefits website **https://exela.springapp.io**.

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 and Bronze Plus 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 coverage level.

Pay Less *Later*

The Silver and Gold 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. Get confident in your choices—before you enroll—by finding answers to some really important questions.

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.

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 Exela Health Benefits website at **digital.alight.com/exela**. 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 insurance carrier's coverage for drugs you and your covered family members need:

- Call the medical **insurance carrier** 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 prescription drug search tool to look up your medication, see how it 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 Exela Health Benefits website at **digital.alight.com/exela**. 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 Exela Health Benefits website at **digital.alight.com/exela**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price for each coverage level, and you'll be able to see all of the prices in one place when you enroll on the Exela Health Benefits website at **digital.alight.com/exela**. (**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:

- See how other people rate their health carriers on the Exela Health Benefits website at **digital.alight.com/exela** anytime.
- 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 Exela Health Benefits website at **digital.alight.com/exela**.)
- 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 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 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 the money you need saved up.

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 and what happens if you already have an HSA or FSA.

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

HSA vs FSA

Wondering how an HSA is different from a Health Care Flexible Spending account (FSA)? Here's how:

	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 coverage level.	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 2024, the annual limits set by the IRS are $4,150 for individual coverage, and $8,300 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 $3,200 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 $640 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 coverage level, you can use an HSA, a Health Care FSA, or both an HSA and Limited Purpose 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, your FSA will be "limited purpose" and can only be used to pay for qualified dental and vision expenses. However, once you meet the medical plan deductible, then it can be used toward qualified medical expenses as well. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Bronze Plus, Silver, or Gold 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 2024, you can save up to $4,150 if you're covering just yourself, or $8,300 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 insurance carrier's pharmacy benefit manager.

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 insurance carrier. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze
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. (If you cover dependents under the Bronze Plus coverage level, the entire family deductible must be met before your insurance will pay benefits for any covered family member.)

Bronze Plus, Silver, or Gold
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. 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 each carrier you're considering.

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 by your insurance carrier—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, insurance carriers can classify higher-cost generics 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 insurance carriers 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. But each insurance carrier determines which drugs it considers "preventive." 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 insurance carriers require approval of certain medications before covering them. This may apply for costly medications that aren't considered medically necessary.

Will I have 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.

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

Start **here** (PDF) to better understand Medicare, your options, impacts to your current coverage, and more. Below are resources where you can find additional information and help:

- 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

Flexible Spending Accounts (FSAs)

Exela offers two tax-advantaged FSAs: the Health Care FSA and Dependent Care FSA. Both FSAs are administered by 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 $3,200 for 2024. 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 $640 from year to year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

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

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 $5,000 (or $2,500 if you are married and filing taxes separately) for 2024. 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.

How to Enroll

Log on to the Exela Health Benefits website at **digital.alight.com/exela** to enroll in your medical, dental, vision, HSA, and FSA benefits for 2024. Please be sure to make any elections and changes to life and disability insurance, new Accident, Hospital and Critical Illness policies through Lincoln Financial, new Group Whole Life insurance with long-term care rider through Allstate insurance, legal, and commuter/parking benefits in the Spring Benefits website **https://exela.springapp.io**.

Logging on to the Exela Health Benefits website for the first time? Register as a new user and follow the prompts to provide requested information and set up your username and password.

Questions?

Once logged on to the Exela Health Benefits website at **digital.alight.com/exela**, look for the "Need Help?" icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. You can also call Exela Benefits Call Center at **1.877.772.7266 (prompt #2)** from 10:00 a.m. to 7:00 p.m. CT, 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 medical insurance carrier's pharmacy benefit manager, who sets the rules for how medications are covered. Don't be caught by surprise! Visit your carrier's website for information about your medications.

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 carrier** 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 carriers 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 medical insurance carrier, 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.

"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."

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

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

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 Exela Health Benefits website at **digital.alight.com/exela** 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

You'll receive a new ID card when you enroll for the first time or change insurance carriers or coverage levels. You'll use your ID card for medical and prescription drug needs.

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 coverage level, 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?

Heads up: 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 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.

How to Get Care

When you get care, it helps to know what you can expect:

Getting Care At The Doctor's Office

Present your medical ID card at your doctor's office. If you're enrolled in the Bronze coverage level, 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 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 Exela Health Benefits website at **digital.alight.com/exela** 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 Exela Health Benefits website at **digital.alight.com/exela** 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.

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 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 Exela Health Benefits website at **digital.alight.com/exela** 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 Exela Health Benefits website at **digital.alight.com/exela** to transfer money from your HSA to your regular bank account.

Set Up Direct Payments

Another option is to have Smart-Choice Accounts make direct payments to your provider from your HSA. Log on to the Exela Health Benefits website at **digital.alight.com/exela** 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=ALICFI/machine-readable-transparency-in-coverage
- **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/nosurprisesact
- **HealthNet:** https://www.centene.com/price-transparency-files.html
- **HCSC:** https://www.bcbstx.com/member/policy-forms/machine-readable-file
- **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, MO, and SD. Availability in some states may be limited.

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

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

Who We Are: At Aetna, we're not just a health insurance company. We're a health company that understands that your health is about more than just coverage and costs.

Learn More

Carrier Name: **Blue Cross Blue Shield**

Areas We Serve: Available nationally

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

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

Customer Service Hours: 24 hours a day/7 days a week/365 days a year, except for major holidays

Phone Number: 1-877-325-2996

Who We Are: Find out why nearly one in three Americans choose a Blue Cross and Blue Shield Plan. Access to a large, national provider network, wellness resources, discount and points programs, and great service are just a few of the features you get when you sign up with Blue Cross and Blue Shield of Texas.

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/aonactivehealth-2024/

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.

Who We Are: Cigna Healthcare is the health benefits provider that advocates for better health through every stage of life. We guide our customers through the health care system, empowering them with the information and insight they need to make the best choices for improving their health and vitality.

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: 1.877.232.9375

Who We Are: With access to more than 4,000 practitioners and close to 200 primary care sites and 28 hospitals, Dean Health Plan connects a strong network of health care providers, innovative hospitals, and comprehensive insurance coverage into one integrated health care system working for you.

Learn More

Carrier Name: **Geisinger Health Plan**

Areas We Serve: Generally available in PA

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

Once you're a member (website): https://www.geisinger.org/member-portal

Customer Service Hours: Monday - Friday: 7:00 a.m. - 7:00 p.m. EST
Saturday: 8:00 a.m. - 2:00 p.m EST

Phone Number: 1.844.390.8332

Who We Are: Choosing a good health insurance plan is more important than ever. With Geisinger Health Plan, we cover the services you need and help you stay healthy by better managing your healthcare needs.

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

Who We Are: At Health Net, we focus on whole-person health care. If you want a low-cost, high-value health plan for yourself and your family, Health Net is the right choice.

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: 1.800.777.9404 (Gold II & Platinum); 1.888.225.7202 (All other 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

Who We Are: Experience the Kaiser Permanente difference. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

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

Who We Are: Experience the Kaiser Permanente difference. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

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

Who We Are: We care about the health and well-being of Ohioans. That's why we offer high-quality health insurance plans with access to the doctors and hospitals you know and trust. We also offer prescription drug coverage, personalized wellness programs and more.

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

Who We Are: Looking for a health plan that fits with your lifestyle? We work hard to create health insurance plans that work for you, your family, your health status and your budget. From cost cutting tools to nationally-recognized customer service, Priority Health delivers a better experience.

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.whyuhc.com/aon9

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

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

Phone Number: 1.888.297.0878

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

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: 7:00 a.m. - 7:00 p.m. EST Saturday: 8:00 a.m. - 3:00 p.m. EST

Phone Number: 1.844.252.0690

Who We Are: High-quality care you and your family deserve: Choose UPMC Health Plan.

Learn More

Get Carrier Ratings

See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available at **digital.alight.com/exela** during enrollment and throughout the year.

Contacts

Once logged on to the Exela Health Benefits website at **digital.alight.com/exela**, look for the “Need Help?” icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. You can also call Exela Benefits Call Center at **1.877.772.7266 (prompt #2)** from 10:00 a.m. to 7:00 p.m. CT, 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 medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Have questions about your claims or coverage? Once your coverage has begun, you can start by contacting your **insurance carrier** directly. They know their coverage rules best and have the final say on all claims and billing questions.

Sometimes you need more help than your insurance carrier can provide. If you have a billing issue, such as your provider charging you more than the amount your Explanation of Benefits (EOB) says you owe, or you believe your plan covers more than what your EOB shows, Advocacy Services is available. Health Pros are experts in handling and resolving your claims and billing issues.

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. Exela doesn't have any influence on the outcome. The insurance carrier—not Exela—is responsible for the cost of claims.

Questions?

Don't worry. You have backups. When you face a billing issue:

1. Start with your insurance carrier.
2. Email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530** if you need help.
3. File an appeal if you're unhappy with the final outcome.

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.

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.

EOB
Also known as an Explanation of Benefits. 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.

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.

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 Exela benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2024 benefits, you can start here:

- **Quick Guide**
- **Enrollment Checklist**
- **Medical**

Make It Yours

Once you’ve done your homework, if you want coverage through Exela, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug, dental, or vision coverage through Exela for you and your family. And, to contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election. Please be sure to elect life and disability insurance, Aflac voluntary benefits, legal, and commuter/parking benefits in Spring **https://exela.springapp.io**.

Enroll now

Questions?

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

Helpful Documents

Enrollment Resources

- 2024 General FAQs
- 2024 Health Benefits FAQs
- 2024 Benefits Guide

Dental Benefits

- Delta Dental PPO Summary
- Delta Dental PPO Orthodontic Benefit
- Delta Dental PPO Getting the Most from Your Plan
- Delta Dental DHMO Summary
- Delta Dental DHMO Orthodontic Benefit
- Delta Dental PPO & DHMO Comparison

Vision Benefits

- EyeMed Vision Summary
- EyeMed Special Offers
- EyeMed FAQs

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** 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/exela**.