Employee Benefit Guide 2021

Agents

alorica

Get to Know Your Benefits

You're awesome. Frankly, it's one of the reasons we hired you. And with that in mind, we are proud to offer a benefits program that says thank you for your hard work and dedication to Alorica. These programs provide flexibility for the diverse and changing needs of our employees, and are designed to help you stay healthy and productive throughout the year.

The following brochure highlights the Medical, Dental, Vision, Life/AD&D, Disability and other Voluntary insurance benefits available to you in 2021.

You work hard to make lives better—we're happy to return the favor. Now let's get to it.

2021 BENEFIT HIGHLIGHTS

2020 is coming to a close—and it was a year we won't soon forget! But now it's time to look ahead and explore all that 2021 has to offer.

Agent Hourly (Year One) Benefit Plan Options:

Limited Medical Benefits
- The American Worker MEC Value

Dental Benefits
- Cigna Dental HMO
- Cigna Dental PPO

Vision Benefits
- UHC Vision

Employee Assistance Program

Disability Benefits
- Prudential Short Term Disability
- Prudential Long Term Disability

Life and AD&D Benefits
- Prudential Life and AD&D

Additional Voluntary Benefits
- Chubb LifeTime Benefit Term Insurance
- Aflac Critical Illness Insurance
- Aflac Accident Insurance
- Liberty Mutual Auto, Home, Property & Renters Insurance
- Pet Assure Discount Program
- Commuter Benefits

What's Inside

Agent Hourly 30 (After Year One) Benefit Plan Options (pages 21-27):

In addition to the Benefit Plan Options listed above the following plan options below are available only to employees that meet the ACA minimum 30 hours paid requirement:

HPI Health Choice PPO | HPI Health Select HSA | Flexible Spending Accounts | Health Savings Account

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see pages 32-33 for more details.

DISCLAIMER The information in this brochure is a general outline of the benefits offered under the Alorica benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents on AloricaBenefitsUS.com, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.

Benefits Eligibility

Employee Eligibility

Agent Hourly Benefit Plans:
In order to get these sweet, sweet benefits, you must be a regular hourly employee of Alorica. If elected, eligible employee coverage will begin the first of the month following 30 days of employment for the following benefit plans.

- The American Worker MEC Plan
- Prudential Term Life/AD&D, LTD & STD
- Chubb LifeTime Benefit Term
- Employee Assistance Program (EAP)
- Cigna Dental HMO or PPO
- Aflac Accident, Hospital Indemnity and Critical Illness
- Liberty Mutual Auto, Home, Property, & Renters Insurance
- UHC Vision
- Commuter Benefits
- Pet Assure

Agent Hourly 30 (After Year One) Benefit Plans:
The Affordable Care Act (ACA) requires Alorica to track employee's average hours paid during a prescribed measurement period to determine eligibility for additional benefit plans. If we determine that you have met the ACA average 30-hour requirement, you will be eligible for additional plan options described on pages 21-27 of this Benefit Guide. For additional details on our prescribed measurement method, please refer to page 28.

If you have any questions, please contact the Employee Benefit Resource Center at 1-877-801-7928.

Dependent Eligibility

Your eligible dependents may participate in the plans as well. Supporting documentation may (unless we hear otherwise) be required.

An eligible dependent includes:

- Your legal spouse or registered domestic partner (RDP)
- Your dependent children up to age 26, regardless of student status (for medical/dental/vision/accident/critical illness/term life/LifeTime Benefit Term)
- Dependent children include stepchildren, legally adopted children and children for whom you or your spouse/RDP has been appointed legal guardian

If you do not enroll yourself or your dependents when initially eligible or during Open Enrollment, you will not be able to enroll until the next Open Enrollment period unless you experience a qualifying change in family status as defined by the IRS. See "RULES FOR BENEFIT CHANGES DURING THE YEAR" section on page 6 for more information. Coverage for dependents added due to a qualifying event, with the exception of a newborn, will become effective the first of the month following the date of the qualifying event.

Spousal Surcharge *(applies to Agent Hourly 30 HPI plans only)*

Alorica sponsors affordable health insurance for its employees and pays a significant portion of the costs. Covering spouses adds to those costs. If your spouse/domestic partner is working and eligible for group health insurance through his or her current employer (or former employer through non-Medicare group retiree benefits), then you will be subject to a spousal surcharge of $46.15 per paycheck if you choose to enroll your spouse in Alorica's major medical benefits plans. You will be required to certify your spouse's access to other group health insurance during the online enrollment process at AloricaBenefitsUS.com.

When You Can Enroll

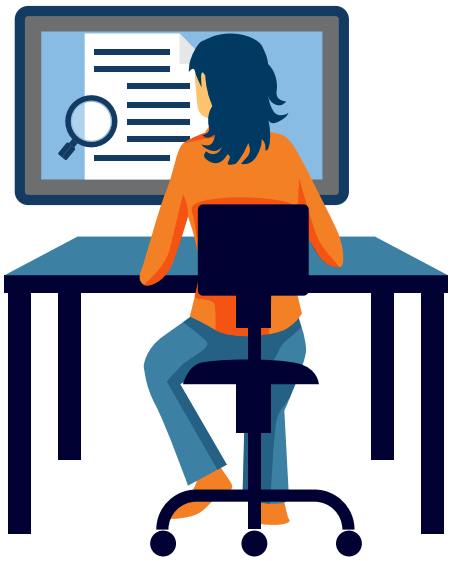
- Alorica's benefit plan year is January 1st to December 31st.
- Employees have until their benefits effective date to enroll or during Open Enrollment.
- Your enrollment choices or declination of coverage will remain in place for the calendar year and the next time you have a chance to enroll or change them will be during the next Open Enrollment period.

HOW TO ENROLL

Enroll online at AloricaBenefitsUS.com
(directions on next page)

How to Enroll

To enroll online in the Alorica benefit plans, log in to AloricaBenefitsUS.com:



Steps to Enroll:

1) Select *"New User" if this is your first time to login**

2) Enter your *Alorica Employee ID* and your *Date of Birth*

3) Enter your *home zip code*

4) The *"Create Your Own Log On Information"* page will launch where you can enter a *new User ID, password and password hint*

5) You will be asked to select and answer five security questions

6) You will then have the option to select "Remember Me on this Computer"

7) Click on the *"Enroll in Your Benefits" box* and begin your enrollment

8) Review and make updates to your Personal Information

9) Make your benefit choices by selecting the 'View/Change' button next to each benefit plan

10) Verify your covered dependents

11) Be sure to *Save your elections and select "Complete Enrollment" on the Benefit Summary page*

*If you're already enrolled or been on the site previously, enter your ***existing user ID and password***

Review/Update Beneficiaries and Designations

To view your benefit plans, log in to AloricaBenefitsUS.com:

1) Enter your log-in credentials *(refer to How to Enroll for creating new user credentials)*

2) Select the *"Your Profile"* drop-down menu in the upper right-hand corner of the Home Page

3) Click on *"Life Insurance Beneficiaries"* from the menu options

4) Select *Add* beneficiaries to add a new beneficiary

5) Complete all applicable demographic fields, read and check the acknowledgement statement, then click *Save*

6) Select *Choose Beneficiaries* to edit an existing beneficiary

7) Update beneficiary type and/or percentages, and select Done

Trouble Enrolling Online? Have a Benefit Question?

Employee Benefit Resource Center: 1-877-801-7928
Monday-Friday from 8am to 8pm Central Time

About UPoint® Mobile HR

The new UPoint Mobile HR app is all about convenience—making it easy for you to get benefits information when and where you need it. For example, Google Maps integration in the provider search tool can help you find a nearby, in-network provider while you're on the go.

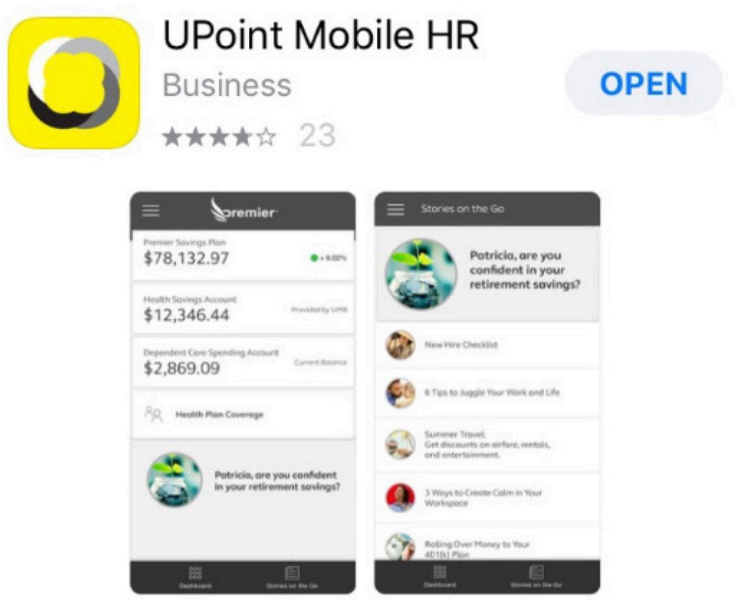
The app features:

- **A personalized dashboard that shows:**
  - How to enroll in health benefits as a New Hire or during regular Annual Enrollment, with a quick tap from the dashboard
  - Which medical, dental and vision plan options you are enrolled in, and which family members are covered
  - A tool to save health plan ID cards within the app
  - How much money is available in your flexible spending accounts and/or health savings account (HSA)
- **Need Help – to access frequently asked questions**
- **Stories on the Go – brief articles and videos on health and financial wellness topics**

And when you need even more information, the full, mobile-friendly web site is always available!

How to get it

You can download the app from the Apple or Google Play app store. Search for Alorica and during setup, log on with your AloricaBenefitsUS.com username and password—and then you're ready to go!



Rules For Benefit Changes During The Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualifying life event or qualify for a "special enrollment". If you qualify for a benefit change outside of an enrollment period, you will be required to contact the Employee Benefit Resource Center. For all qualifying life events, with the exception of a newborn, coverage will become effective the first of the month following the date of the qualifying life event.

Qualifying Life Event Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment and death.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse/RDP, or your dependent child.
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse/RDP, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in place of residence or worksite**, that affects the accessibility of network providers.
- **Change in your health coverage or your spouse/RDP coverage** attributable to your spouse/RDP employment.
- **Change in an individual's eligibility for Medicare or Medicaid.**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment if:

  1) Employee or dependent loses eligibility for Medicaid or CHIP or 2) Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- Any change you make must be consistent with the change in status, AND
- You must make the change within 30 days of the date the event occurs (unless otherwise noted above).

With questions regarding qualifying life events, please contact the Employee Benefit Resource Center at 1-877-801-7928.

Affordable Care Act (ACA) Insurance Requirements

Agent Hourly 30 Benefits Eligibility

Alorica will track your average hours paid during a "Prescribed Measurement Period" to determine your eligibility for our Health & Welfare benefit plans, as required by ACA. As a new hire, your initial Prescribed Measurement Period consists of an initial measurement period of 11 months, plus a two-month administrative period. When your "Prescribed Measurement Period" ends, your "Benefits Effective Date" will begin.

If Alorica has determined that you have met the 30 hours average requirement (the "Hourly Average Test") as of your earliest Benefits Effective Date or some subsequent date, you will be eligible to participate in our "Agent Hourly 30" benefit plans. In addition to the Agent Hourly benefit plans available to you, Agent Hourly 30 employees will also be eligible for the HPI medical plans.

Please call the Employee Benefit Resource Center at 1-877-801-7928 to determine your earliest Benefits Effective Date—based upon your hire date.

If you do NOT meet the minimum hours paid requirement as defined by the ACA, you will not be eligible to enroll in these additional plan options and should look into other individual plan options, such as the Marketplace, for more comprehensive medical plan options.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Open Enrollment for health insurance coverage though the Marketplace begins November 1, 2020 for coverage starting as early as January 1, 2021.

Am I Eligible for Premium Savings through the Marketplace?

You may be eligible for premium savings through the Marketplace if you meet certain income requirements and are not offered qualified coverage through your employer (Agent Hourly employees). Therefore, depending on your income you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing.

How Can I Get More Information About the Health Insurance Marketplace?

Health*Compare* experts can help you for free. Call them at **(800) 318-2596**.

Limited Medical Benefit Plan

MEC Value Plan

The American Worker Plan *(formerly known as Century Healthcare)* is a limited medical plan that covers preventive services and provides additional indemnity benefits. ***Benefits provided are supplemental and are not intended to cover all medical expenses.*** This plan pays a fixed dollar amount per day regardless of the amount that the provider charges. The plan typically has no copays, deductibles or coinsurance (except for Rx). If you choose a preferred (in-network) provider, then you may pay less, because the provider may accept payment for the negotiated charge.

The American Worker MEC Value (Agent Hourly 30) Deduction Per Paycheck:

Employee Only: **$24.88** Employee + Spouse: **$61.07** Employee + Child(ren): **$56.54** Employee + Family: **$106.29**

The American Worker MEC Value (Agent Hourly) Deduction Per Paycheck:

Employee Only: **$49.92** Employee + Spouse: **$87.96** Employee + Child(ren): **$84.60** Employee + Family: **$136.28**

PREVENTIVE SERVICES	
Minimum Essential Coverage (MEC)	Plan pays 100% for all ACA required preventive care services. **You MUST visit a PHCS Network provider for Preventive services to be covered.**
FIXED INDEMNITY SERVICES	**STANDARD PLAN**
Physician's Office	$60 per day; 6 days per year
Outpatient Diagnostic Lab	$75 per testing day; 2 days per year
Outpatient Diagnostic X-Ray	$75 per testing day; 2 days per year
Surgical Indemnity Benefit -Daily Inpatient Surgical -Daily Outpatient Surgical -Daily Outpatient Minor -Outpatient Benefit Maximum	 $500 per day, 1 day per year $250 per day $50 per day 1 day per year
Anesthesia	30% of Surgical Benefit
Hospital Admission	$500 lump sum per confinement
Daily In-Hospital Indemnity **Intensive Care Unit** **Substance Abuse** **Mental Illness** **Skilled Nursing (Inpatient)**	$300 per day; 500 day lifetime max $600 per day; 30 days per year $150 per day; 30 days per year $150 per day; 30 days per year $150 per day; 60 days per stay
Inpatient Miscellaneous	$100 per day, 60 days per year
***Accident Medical Expense**	$5,000 maximum benefit per injury
***Accidental Death & Dismemberment**	$15,000 Employee / $7,500 Spouse / $3,000 Child
***HealthiestYou**	No cost access to doctors by phone or online
***Prescription Drugs**	Copay Rx Plan
***PHCS Network**	Physician and Hospital

*Services not underwritten by Nationwide Life Insurance Company.
Fixed Indemnity Plans are not available to residents of NH, VT & WA.
MEC will be your primary plan if you are also enrolled in a spouse's plan at another company.

Limited Medical Benefits Plan Cont'd

MEC Value Plan

Additional Plan Features

PHCS PPO Limited Benefit Network

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates.

- **Limited Benefit Network:** www.Multiplan.com/awp
- **Preventive Services Network (for MEC Basic Plan):** www.Multiplan.com/awpmec
- **Call:** (888) 371-7427

Healthiest You

HealthiestYOU provides covered individuals with 24/7 access to U.S. licensed physicians that can provide general advice and recommendations, diagnostic medical consultations, and write non-controlled prescriptions when appropriate. HealthiestYOU also provides members with access to an online wellness platform to help improve the member's overall health.

- **Visit:** www.Healthiestyou.com
- **Call:** (866) 703-1259

Copay Rx Plans

COPAY RX PLAN 1

- **Tier 1 (Most Generics):** $10 Co-Pay
- **Tier 2 (Some Generics & Preferred/Formulary Brand Name):** $50 or 50%; whichever is greater
- **Tier 3 (Non-Preferred / Non-Formulary Brand Name):** Employees pay 100% of the cost after pharmacy discounts
- **Monthly Maximum:** $100 Employee / $200 Family
- No Deductible
- Restricted Formulary

Mail Order option available for 90 day prescription supply.

- **Tier 1:** $25 copay
- **Tier 2:** $125 or 50%

CERPASSRX

- **Visit:** www.cerpassrx.com
- **Call:** (844) 636-7506

Find a Provider:
To locate a participating **PHCS Limited Benefit Network** provider in your area, please call **PHCS at (888) 371-7427** or visit www.multiplan.com/chc.

Find the Formulary List:
To find the formulary list, please go to www.cerpassrx.com in the plans section.

All of the above benefits are per covered person per Benefit Year.
"Benefit Year" means the 12 consecutive months beginning on the group's effective date of coverage.

Telemedicine
(Available if enrolled in the MEC Value Plan)

If you are enrolled in the MEC Value Plan, you can get the health care you need without all the hassle. Have a health question? Under the weather? You don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.

With Telemedicine you can speak directly with a doctor within 20 minutes or less through a virtual session on your personal PC, tablet, or mobile phone.

When Can You Use Virtual Visits?

As always, you should call 911 with any emergency. Otherwise, you can use Virtual Visits whenever you have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year.

dr. on demand

HPI – Virtual Visits
doctorondemand.com/health-plans-inc

1. Download the app or access doctorondemand.com/health-plans-inc
2. Create your account and enter insurance (HealthPlans Inc.) and pre-consult information.
3. Complete a questionnaire of current symptoms and medical history.
4. Pay cost-share via app or website
5. Receive an email following your virtual physician visit to share with your PCP.
6. Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.

hy healthiestyou

MEC – Healthiest You
member.healthiestyou.com

Telemedicine Visits are Good for:

- Allergies
- Bladder/Urinary Tract Infection
- Bronchitis
- Cough/Cold
- Diarrhea
- Fever
- Migraine/Headache
- Pinkeye
- Rash
- Seasonal Flu
- Sinus Problems
- Sore Throat
- Stomachache
- Quick Assessment of Severity

Download the apps on the App Store and Google Play store

Dental Plans

Keep your teeth pearly white! Alorica provides dental coverage that is designed to help keep you and your family smiling with coverage through a choice of the Cigna Dental HMO Plan or the Cigna Dental PPO Plan.

Dental Plan Options:

Cigna DENTAL HMO PLAN *(Not available in all areas. The Employee Benefit Resource Center enrollment system will identify if you live in a city where the DHMO plan is available.)*
You and your eligible dependents must select a primary dentist from the Cigna network. There is no deductible or annual benefit maximum. Copayments are required for basic, major, and orthodontia services. Network providers may be accessed online through www.mycigna.com or by calling Customer Service at **(800) 244-6224**.

Bi-Weekly Rates for the Cigna Dental HMO plan are (per paycheck):

Employee only: **$6.08**
Employee + Child(ren): **$12.75**
Employee + Spouse: **$10.64**
Employee + Family: **$17.93**

Cigna DENTAL PPO PLAN
You have the flexibility of receiving your care from an in-network or out-of-network dentist. The Cigna PPO network is a nationwide network of participating dentist locations consisting of carefully credentialed general and specialty dentists, such as orthodontists, endodontists and periodontists. Network providers may be accessed online through www.mycigna.com or by calling Member Services at **(800) 244-6224**.

Bi-Weekly Rates for the Cigna Dental PPO plan are (per paycheck):

Employee only: **$15.35**
Employee + Child(ren): **$22.69**
Employee + Spouse: **$27.39**
Employee + Family: **$38.67**

BENEFIT ATTRIBUTES	Cigna DHMO[1] In-Network	Cigna DPPO	
		In-Network DPPO Advantage	Out-of-Network[2]
Annual Deductible Individual	None	$50 per person	
Annual Maximum	None	$1,500 per person[3]	
Preventive Services	**Member Pays**	**Member Pays**	
X-rays **Exam** **Cleaning** *(limit 2 per calendar year)*	No Copay No Copay No Copay	0% Deductible Waived	10% Deductible Waived
Basic Services	**Member Pays**	**Member Pays**	
Fillings **Extractions / Oral Surgery** **Endodontic** **Periodontics**	$30 - $120 $35 - $150 $45 - $415 $60 - $425	20% After Deductible	30% After Deductible
Major Services	**Member Pays**	**Member Pays**	
Crowns **Bridge Work** **Dentures** **Dental Implants**	$265 - $365 $265 - $365 $65 - $425 Not Covered	50% After Deductible	60% After Deductible
Orthodontics	Children - $1,800 Adults - $2,400 plus initial consultation, banding and retention charges	50%	50%
Orthodontics Lifetime Maximum		$1,500 Children & Adults	$1,500 Children & Adults

1. Please refer to the full CIGNA Patient Charge Schedule for detailed information on covered services and member copayments. To obtain a copy, contact Cigna at (800) 244-6224.
2. Out-of-Network coinsurance may differ for employees in LA, MS, OK, TN, TX, and UT (list subject to change). Please review the specific benefit summary for details.
3. Preventative services do not count towards the annual maximum.

The information contained in this summary is not intended to take the place of, or change the carrier's schedule of benefits. In the event the information contained herein varies from the carrier's schedule of benefits, the carrier information shall prevail.

Vision Plan

Hindsight is 20/20. Shouldn't your *nowsight* be the same? Alorica offers comprehensive vision benefits to you and your eligible dependents through UHC Vision. You may begin receiving substantial savings on your eye care and eyewear needs at any one of UHC's thousands of provider locations, including optometrists, ophthalmologists and opticians located throughout the country. Network providers may be accessed online at www.myuhcvision.com.

When you use a UHC provider, you are responsible for a copay at time of service. The provider will file a claim for you and you will be reimbursed directly from UHC. If you see an out-of-network provider, you pay all expenses at time of service and submit a claim for reimbursement up to the allowance shown in the Vision Highlights chart below. Remember to ask your UHC provider about special discounts for additional pairs of glasses, special lens options and other vision services including LASIK surgery. You will not receive a UHC Vision ID card. Select a UHC provider from www.myuhcvision.com or by calling Member Services at **(800) 839-3242**.

Bi-Weekly Rates for the UHC vision plan are (per paycheck):

Employee Only: **$2.97**

Employee + Spouse: **$4.77**

Employee + Child(ren): **$5.72**

Employee + Family: **$6.67**

PLAN HIGHLIGHTS	UHC VISION		
	In Network	Out-of-Network	Frequency
Annual Deductible	None	None	N/A
Well Vision Exam	$10 Copay	$50 Allowance	Every 12 Months
Prescription Glasses **Lenses** Single Vision Lined Bifocal Lined Trifocal	 $25 Copay $25 Copay $25 Copay	 $50 Allowance $75 Allowance $100 Allowance	 Every 12 Months Every 12 Months Every 12 Months
Frames	$150 Allowance	$70 Allowance	Every 24 Months
Contact Lens Care (in lieu of frames/lenses) **Fitting Exam & Contact Lens**	$150 Allowance	$150 Allowance	Every 12 Months

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Employee Assistance Program (EAP)

There are times we could all use a little advice, a little guidance, even a little pick-me-up. And that's why the confidential **Employee Assistance Program** is here—to help with issues like stress, chemical dependency, relationships, estate planning, adoption, buying a house, identity theft, child care and general wellness.

This program, known as **Live Better Well-Being**, is available through MHN to all benefit-eligible employees, and is provided by Alorica at no cost to you, regardless of whether or not you enroll in any other benefit plans.

Live Better Well-Being entitles you to three face-to-face sessions (or phone or web-video consultations) per incident per year.

You can access confidential assistance 24/7/365, via phone, e-mail, online chat, or SMS text.

Toll-free number: 1-844-442-5046

Or visit: mhn.advantageengagement.com and register with company code: alorica

Disability Benefits

Short Term Disability (STD)*

Short Term Disability (STD) is offered through Prudential. The STD plan pays a percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury. Rates are based on your age. Your base pay just prior to the date of disability will be used to determine your benefit.

Benefits begin on the 15th day for sickness or injury. The benefit will provide up to 60% of your weekly earning to a maximum of $1,500 for up to 24 weeks.

NOTE: If you reside in a state with a state disability program, your benefits may be reduced. The following states have a State Disability Program: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island.

Long Term Disability (LTD)*

The Long Term Disability plan benefits offered through Prudential help to provide you with monthly income if you become disabled and are unable to work.

After you have been disabled for 180 days due to sickness or injury, this benefit will provide up to 60% of your monthly base pay to a maximum of $10,000. If you are permanently disabled, you could receive this benefit up to your Social Security Normal Retirement Age (SSNRA). Rates are based on your age.

If you apply more than 30 days after your initial eligibility date, your coverage will be medically underwritten, and you will be required to qualify based on information you provide on your overall medical health. An Evidence of Insurability form is required, and you may be denied coverage.

LTD rates are age-banded. When an employee has a birthday and moves into the next age bracket, the rate will change on the next policy anniversary date.

Prudential

NOTE: Both the STD and LTD include pre-existing condition limitations. Please review the plan summaries posted online in AloricaBenefitsUS.com for more details.

Earnings for STD and LTD benefits are based on your base annual earnings and do not include other income such as bonuses and commissions.

*STD and LTD benefits may not be available to all WAH employees.

Group Term Life Benefits

Group Term Life/AD&D*

Life and AD&D insurance is available for employees and their eligible dependents through Prudential. Rates are based on your age.

For Yourself

You may apply for term life insurance in increments of $10,000 up to five (5) times Basic Annual Earnings; the maximum amount of $1,000,000. During your initial eligibility, you may elect up to $350,000 with no medical underwriting.

If you apply after your initial eligibility date, your coverage will be medically underwritten and you will be required to qualify based on information you provide on your overall medical health. An Evidence of Insurability form will be required, and you may be denied coverage.

For Your Spouse/Registered Domestic Partner (RDP)

If you enroll, your spouse/RDP may also apply for term life insurance in increments of $5,000 not to exceed 100% of the employee's Life amount; the maximum amount is $500,000. During your spouse/ RDP's initial eligibility, he or she may elect up to $50,000 with no medical underwriting.

If your spouse/RDP applies after their initial eligibility date, their coverage will be medically underwritten and they will be required to qualify based on information they provide on their overall medical health. An Evidence of Insurability form will be required, and he/she may be denied coverage. If your eligible dependent is totally disabled, your dependent's coverage will begin on the first day of the month following the date your dependent is no longer totally disabled.

Note: You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

For Your Children

If you enroll, child life coverage is also available. You may purchase life insurance for children in $2,000 increments up to $10,000. The premium payment for child coverage is based on one child, regardless of the number of children with coverage.

Note: No child may be covered by more than one employee in the plan. No child can be covered as both an employee and a dependent.

Life rates are age-banded. When an employee has a birthday and moves into the next age bracket, the rate will change on the next policy anniversary date.

*Life and AD&D benefits may not be available to all WAH employees.

Prudential

Voluntary Benefits

LifeTime Benefit Term Coverage

LifeTime Benefit Term coverage through Chubb offers a guaranteed premium for the duration of your life insurance policy, AND has a Long Term Care benefit that pays if you need care while you're living.

- **Long Term Care (LTC)** – If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. You get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.
- **Guaranteed Premiums** – Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue.
- **Terminal Illness Benefit** – After your coverage has been in force for two years, you can receive 50% of your death benefit, up to $100,000, if you are diagnosed as terminally ill.

You can only enroll in this plan when you are first eligible.

Critical Illness Coverage

Critical Illness Coverage through Aflac pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, childcare, travel, home health care costs or any of your regular household expenses.

Plan Highlights:

- Guaranteed Issue (no medical questions)
- Children are covered at NO COST when you elect employee coverage
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis (illness or occurrences prior to the effective date of coverage will not be payable events)
- $75 annual Wellness Benefit is payable for each covered member for completing certain wellness screenings such as cholesterol test, colonoscopy or stress test (once per year per covered person)
- $200 annual mammography benefit payable once per calendar year per insured

Coverage Amounts

Employee only: **Choose from $10,000, $20,000, or $50,000 coverage**

Spouse: **100% of the Employee benefit amount**

Children: **50% of the Employee benefit amount**

COVERED CONDITIONS*

Enrolled employees and spouses receive 100% of the below benefit amount when a diagnosis or event occurs after your plan is effective. Children receive 50% of the benefit for no cost.

Benign Brain Tumor	100%	**Cancer Benefits**	
Bone Marrow Transplant (Stem Cell Transplant)	100%	**Cancer (Internal or Invasive)**	100%
Coma	100%	**Non-Invasive Cancer**	25%
Coronary Artery Bypass Surgery	25%	**Skin Cancer**	$250 per calendar year
Heart Attack (Myogardial Infarction)	100%	**Childhood Conditions**	
Kidney Failure (End Stage Renal Failure)	100%	**Cystic Fibrosis**	100%
Loss of Sight, Speech and Hearing	100%	**Cerebral Palsy**	100%
Major Organ Transplant	100%	**Cleft Lip or Cleft Palate**	100%
Paralysis	100%	**Down Syndrome**	100%
Severe Burns	100%	**Phenylalanine Hydroxylase Deficiency Disease (PKU)**	100%
Stroke (Ischemic or Hemorrhagic)	100%	**Spina Bifida**	100%
Sudden Cardiac Arrest	100%	**Type 1 Diabetes**	100%

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

Voluntary Benefits Cont'd

Hospital Indemnity Coverage

Hospital Indemnity Coverage through Aflac pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or every-day expenses such as groceries and utilities.

Benefits are payable for pregnancy on the first day of coverage, so even if you or your spouse are already expecting, you can elect coverage to start on your coverage effective date (delivery must occur on or after the coverage effective date). Coverage is guaranteed issue (no medical questions).

You must be admitted to the hospital and stay at least 24 hours to receive a benefit.

SUMMARY OF BENEFITS*	
Hospital Admission (per confinement)	$1,000 (One per covered sickness or accident per calendar year)
Hospital Confinement (per day)	$200 (maximum 31 days per covered sickness or accident)
Hospital Intensive Care (per day)	$200 (maximum 31 days per covered sickness or accident)
Mammography Benefit	$100 (payable once per calendar year per insured)

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Aflac, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. This coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

SUMMARY OF BENEFITS*			
Hospital Admission	$1,000	**Concussion**	$150
Hospital Confinement	$200 per day (up to 365 days)	**Major Diagnostic Testing**	$100
Hospital Intensive Care	$200 per day (up to 30 days)	**Coma**	$10,000
Dislocations and Fractures	up to $7,500	**Inpatient Surgery and Anesthesia**	$750
Ambulance	Ground: $200 / Air: $500	**Outpatient Surgery and Anesthesia**	up to $250
Initial Treatment Emergency Room / Urgent Care / Doctor's Office	$150 / $150 / $50	**Blood / Plasma / Platelets**	$400
X-Ray	$25	**Therapy**	$25
Accident Follow Up Treatment	$50	**Appliances**	$100
Burns	up to $10,000	**Down Syndrome**	100%

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

Voluntary Benefits Cont'd

Pet Assure Discount Plan
To cover the needs of a pet, discounted pet care is offered through Pet Benefit Solutions. Every pet is covered and there are no deductibles or maximum number of claims per year. Discounts on services are applied at time of purchase at the veterinary clinic.

PETPlus Plan
PetPlus is a wholesale pricing club that will save you money on all your pets' prescriptions and preventatives. It includes a 24/7/365 Ask-A-Vet service. You can enroll any type of cat or dog or an unlimited number of pets.

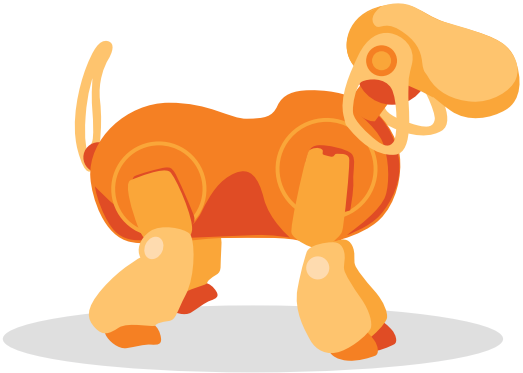
pet BENEFIT SOLUTIONS

Auto & Property Insurance

Alorica understands the importance of protecting your property and other items critical to maintaining your lifestyle. Through Liberty Mutual, Alorica employees receive discounted group rates on insurance for Homeowners, Renters, Automobiles and Additional Property.

How to Enroll

Visit www.libertymutual.com/alorica or call Liberty Mutual Member Services at **844-814-0939**.



401(k) Highlights – Agent

Eligibility and Enrollment

- All employees may join the plan
- You need to be 18 and work for at least 90 days to contribute to the plan; you are free to enroll any time after that.
- You need to be 18 and work for at least 6 months to receive any company match
- Company match is 50% of 5% of pay contributed (match is discretionary)

Your Contributions (Pre-Tax)

- You may contribute between 1% and 100% of your pay, subject to the maximum allowed by law
- The IRS maximum contribution for 2021 is $19,500
- You may contribute an additional $6,500 (a catchup contribution) if you will be 50 or older in 2021
- Any contributions and earnings grow tax-free until distribution
- Are deducted automatically from your paycheck

Additional After-Tax

- You may contribute between 1% and 100% of your pay as after tax contributions
- Earnings on your additional after-tax contribution grow tax-deferred

Roth After-Tax

- You may contribute between 1% and 100% of your pay as after tax contributions
- Any contributions and earnings may be distributed tax-free

Vesting

- You are always 100% vested in your contributions and earnings on your contributions
- Your company matching contribution will be fully vested after 5 years of service

Distributions

Distributions are available in the following situations:

- Age 59½ withdrawal
- Hardship withdrawal
- Normal retirement (age 55)
- Termination of employment
- Death
- Disability

Loan Policy

- You may borrow the lesser of 50% of your vested account balance, or $50,000 (less the highest outstanding loan balance in the past 12 months)
- The minimum loan amount is $1,000
- The interest rate is the prime rate + 1%
- One outstanding loan at a time

Get Answers and Take Action Now

Contact The Atlantic Group at Morgan Stanley at 1-877-988-6521 for questions about investments or general questions about the plan.

To learn more about enrollment or additional general questions, contact a Customer Service Representative at MassMutual, Monday through Friday from 8:00 a.m. – 9:00 p.m. ET at 1-877-474-5016.

Commuter Benefits

We think the journey should be as insanely great as the destination. So with that in mind, we're thrilled to be offering benefits to offset the cost of your daily commute.

Transit & Parking Reimbursement Accounts

Transit and Parking Reimbursement accounts allow you to set aside funds through payroll deduction to pay for work-related transportation and/or parking expenses.

Types of Allowable Expenses:

- **Mass Transit/Vanpool** – $270 Maximum Monthly Pre-Tax Contribution: If employees commute to work via mass transit (i.e. public transportation including bus, train or rail systems) or by vanpool, employees can use pre-tax dollars to pay for those mass transit costs related to their commute.
- **Parking** – $270 Maximum Monthly Pre-Tax Contribution: Employees who commute to work by car and pay to park, or commute via mass transit and pay to park at or near the mass transit site, can use pre-tax dollars to pay for parking costs related to their commute to work.

Features of the Transit and Parking Reimbursement Accounts include:

- Members can change their elected contribution amount on a monthly basis.
- Unused balances can be rolled over month to month.
- Members save money by reducing their taxable income.
- Once you terminate employment, only claims incurred before your date of termination are eligible for processing.
- You may access your account to check balances and submit claims by visiting the Employee Benefit Resource Center.
- 24/7 online account access
- Mobile apps and text alerts
- Single sign-on for all reimbursement accounts
- Use the same debit card to access both parking and transit funds

Simple Access to Your Funds

With the benefits debit card, participants can pay providers at the time of service directly from their transit and/or parking account. If the parking facility does not accept debit card payments, participants may also pay out of pocket and then submit a reimbursement request. Participants may submit parking claims to Employee Benefit Resource Center at AloricaBenefitsUS.com. Sign up for free direct deposit to receive your reimbursement as quickly as possible.

Parking and transit receipts may or may not be required, depending on your employer's plan setup. However, we recommend that participants keep receipts for their own records regardless of whether receipts are required for the plan.

Metro Commuters

If you live in the Washington, D.C. area, your commuter benefits may work a bit differently. You will be able to load commuter funds onto your WMATA SmarTrip® card from a commuter page on your consumer web portal.

Interested in Commuter Benefits?

The knowledgeable Employee Benefit Resource Center Participants Services team is available from 8:00 am to 8:00 pm CST Monday through Friday. Please contact them with any questions about your benefit plan.

Toll-Free: 877-801-7928
Go to AloricaBenefitsUS.com

Medical Plans

Applies to Agent Hourly 30

We know that keeping you and your family healthy is a top priority—and it's our priority to provide you with health care benefits that help keep you healthy and provide quality coverage when you or your dependents are ill.

Our benefit program offers the following medical plan choices to our employees and their dependents:

- HPI Health Select Option & Optum Health Savings Account (HSA)
- HPI Health Choice PPO
- American Worker MEC Value

Please review the Medical Plan Comparison Charts for the Health Select and Health Choice Options on pages 24 and 25 for premium rates, a summary of plan benefits, copayments, deductibles, maximum out-of-pocket expenses and other components. For HPI plan information on network providers you can go online at www.healthplansinc.com or by calling Member Services at 888-711-6766. For information on providers in the HPI plan you can visit www.multiplan.com/search.

HPI Plans - Value Based Pricing

Alorica offers its employees more ways to save on their health care expenses, while offering more freedom of choice with the HPI plans.

Both plans feature an expansive physician (and other non-hospital services) provider network through PHCS. The Plan also provides its members with the freedom of choice for inpatient and outpatient hospital and facility based services. You choose the hospital or facility and our new Third Party Administrator (TPA), HealthPlans, Inc. (HPI), negotiates a value-based price for the care and services you need—saving you on out of pocket costs and balance billing.

How Does Value-Based Pricing Work?

Savings are achieved through a partnership between HPI and HST. HST is a company that negotiates value-based prices based on a percentage of what Medicare pays. You can get support through ***Pathways Medical Concierge Services***—learn more on page 23.

1. If you need hospital based services, your physician or other health care provider will contact HPI at the number listed on your ID card to confirm your eligibility and request pre-certification.
2. HPI will review your physician's request and, if authorized, submit the authorization to HST, who contacts the hospital to negotiate a value-based price for the care and services. This pre-certification process confirms the total price for the services with the hospital or facility based on a reference determined by Medicare. (If the costs are unusually high, you'll be notified of other high-quality facilities where you may decide to receive care at a lower cost.)
3. HPI does all the work for you and will notify you in advance of your procedure of your-of-pocket costs—no surprises.
4. Following your procedure, your provider will submit a claim to HPI priced at the agreed amount. When the claim is received, HPI will suspend the claim for 72 hours to allow HST time to review the claim and verify all billed charges are accurate, reasonable, and allowed.
5. Once approved, HPI will process the claim according to the negotiated price and issue payment to your provider. You will receive an EOB only if you are responsible for paying a deductible and/or coinsurance amount to the hospital or facility. If you do receive a balance bill, call Pathways Medical Concierge Services at 888-711-6766 and they will direct you on how to get assistance to advocate on your behalf.
6. **If you are admitted to the hospital through the emergency room your services will be certified post service. You will only be responsible for your deductible and coinsurance, up to the annual out-of-pocket maximum if you notify the plan within 24 hours of your ER visit.**

Medical Plans Cont'd

Applies to Agent Hourly 30

Plan Highlights

HPI Health Choice PPO – The PPO plan provides you with access to an expansive network of providers and offers members a level of benefits should they choose to seek care outside the network, normally at a higher coinsurance and/or deductible level. The PPO plan does not require members to designate a "primary care physician" to coordinate care, nor are specialist referrals required for eligible services. Services for preventive care, such as routine physical exams, health screenings, immunizations and well-child visits are covered at 100% in-network before the deductible is met. Copayments, coinsurance and deductibles accumulate towards the out-of-pocket maximum.

HPI Health Select & Health Savings Account (HSA) – Health Select provides you with access to an expansive network of providers and offers members a level of benefits should they choose to seek care outside the network, normally at a higher coinsurance and/or deductible level. Services for preventive care, such as routine physical exams, health screenings, immunizations and well-child visits are covered at 100% in-network before the deductible is met.

If you choose to enroll in the Health Select option you can also choose to take advantage of enrolling in the Health Savings Account (HSA). This account is funded by you along with a 50% company match up to $500 per year for individual coverage or $1,000 for family coverage. If you are eligible for the company match the annual amount will normally be applied across all paychecks for the year. However, if you are hired after January 1st, the employer match will be prorated, with a maximum of $19.23 per pay period for individual or $38.46 per pay period for family up to the annual limits.

HEALTH SAVINGS ACCOUNT - HOW IT WORKS

You can contribute up to $3,600 per year for individual coverage or $7,200 for family coverage (you can contribute another $1,000 per year if you are over 55 years of age). Your contributions along with the Company match count towards meeting the annual limits.

Your contributions are deducted from your paycheck on a pre-tax basis.

No matter what—the money in the account is yours. In other words, there is no "use it or lose it" rule—meaning you can roll it over from year to year or take it with you if you leave the company.

You have access to whatever contributions are in your account—you can only spend contributions that have already been deposited in your account. However, you can always reimburse yourself later once you have funds available.

You can use your funds to pay for eligible health care related expenses like...deductibles, coinsurance, prescription co-pays, etc.

You will get a debit card and checkbook so you can easily access your funds.

You must be enrolled in the Health Select Option plan and cannot be enrolled in another plan including Medicare.

Medical Plans Cont'd

Applies to Agent Hourly 30

Remember These Three Simple Steps to Get the Most Out of Your HPI Medical Plan:

1. Access outpatient physician services and care through the PHCS Provider Network. The PHCS provider network consists of physicians, specialists and other non-hospital service providers such as laboratories and imaging centers. When you access care or services from these providers you will be required to satisfy a calendar year deductible and/or pay copays or coinsurance until you reach the annual out-of-pocket maximum.
2. **If you need an inpatient or outpatient hospital based procedure, you have the freedom of choosing any provider. There is no prescribed network, but your services must be pre-certified to ensure you receive the lowest out-of-pocket costs with no balance billing. Your share of the costs will accumulate towards the in-network annual out-of-pocket maximum.**
3. Stay In-Network! If you elect to receive care or services from an out-of-network provider, you will be subject to higher out of pocket costs. In addition, if you receive inpatient or outpatient hospital based services that have not been pre-certified, you may be balance-billed for any amounts above the amount negotiated by the plan, and these balance-billed amounts will not accumulate towards your annual out-of-pocket maximum—exposing you to even more out-of-pocket costs.

NOTE: If your spouse/domestic partner is employed and is offered coverage through his/her employer but joins one of the Alorica HPI plans, a spousal surcharge of $46.15 will be added to your per pay period contribution amount.

Pathways Medical Concierge Services

Pathways connects you to an advisor who can support you throughout your healthcare journey. The Concierge team understands your benefits and can assist you with many of the confusing aspects of accessing appropriate and quality healthcare services and alternative options available.

What are the types of things my concierge can help me with?

- Addresses benefit questions and coverage such as co-pays, deductibles, provider balance billing, etc.
- Locates providers and facilities based on costs, quality outcomes and geographic proximity
- Review of cost effective treatment options and available alternatives
- Preparation and education for your hospitalization or procedure
- Assistance with claim and billing issue resolution, grievances and appeals

What does it cost? The Pathways Concierge program is part of your benefit plan. There is no cost to you to speak with your concierge or care team.

Is my information confidential? ABSOLUTELY! We take every precaution to make sure your information is secure. Your data is encrypted ensuring your health and personal information is kept private. Your records are never shared with your employer or other entity without your written approval unless required by law.

Who is MedWatch and why would they contact me? MedWatch, a Health Plans, Inc. partner company, has been entrusted to provide medical concierge services to you. MedWatch may contact you regarding this service in an effort to assist you in your healthcare needs.

Medical Plan Summary

HPI Health Choice PPO

Applies to Agent Hourly 30

Bi-Weekly Rates for the HPI Health Choice PPO plan are (per paycheck):

Employee Only: **$85.69** Employee + Spouse: **$290.85** Employee + Child(ren): **$237.97** Employee + Family: **$318.27**

BENEFIT ATTRIBUTES	In-Network	Out-of-Network
Annual Deductibles Individual Family[1]	 $2,000 $4,000	 $4,000 $8,000
Annual Out-of-Pocket Maximum Individual Family[2]	 $5,000 $10,000	 $10,000 $20,000
Coinsurance Percentage *After Plan Deductible*	Plan Pays 80% Member Pays 20%	Plan Pays 50% Member Pays 50%
Professional Services		
Office Visits Primary Care Provider Specialist	 $35, Deductible Waived $50, Deductible Waived	50% of Allowed Amount
Doctor on Demand Virtual Physician Visit	$10, Deductible Waived	Not Covered
Preventive Care	No Charge	Not Covered
Routine Lab and X-Ray - Outpatient	20% After Deductible	50% of Allowed Amount
Chiropractic Care *24 visits per calendar year*	$35, Deductible Waived	50% of Allowed Amount
Urgent Care[4]	$35, Deductible Waived	50% of Allowed Amount
Hospital Services[3]		
CT, MRI, PET scans	20% After Deductible[3]	N/A
Inpatient Services	20% After Deductible[3]	N/A
Outpatient Services	20% After Deductible[3]	N/A
Hospital Emergency Room[3, 4]	20% After Deductible[3, 4]	N/A
CVS Caremark Prescription Benefits		
Retail (30-day supply)[5] Contraceptives (ACA) Generic Preferred Band[4] Non-Preferred Brand	 No Charge $15 $40 50% *(minimum of $40 up to mamaximum of $250)*	
Mail Order (90-day supply) Contraceptives (ACA) Generic Preferred Band[4] Non-Preferred Brand	 No Charge $30 $80 50% *(minimum of $80 up to a maximum of $500)*	Not Covered

To find the formulary list, please go to www.caremark.com.

1. For employees with family coverage, no one in the family is eligible for benefits until the full family coverage deductible is met.
2. All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount. Copayments, coinsurance and deductibles accumulate towards the out-of-pocket maximum.
3. Precertification required for all inpatient and outpatient facility based services, including advanced imaging and diagnostics.
4. Urgent/Emergency services will be certified post service if you notify the plan within 24 hours of your visit.
5. Mandatory Generic medications must be used when available; otherwise, the member will pay the cost differential between the Generic medication and the Preferred Brand medication plus the Preferred Brand copay.

The information contained in this summary is not intended to take the place of, or change the carrier's schedule of benefits. In the event the information contained herein varies from the carrier's schedule of benefits, the carrier information shall prevail.

To manage your prescription benefits, please download the CVS Caremark mobile app; you can learn more about the app on page 26.

Medical Plan Summary Cont'd

HPI Health Select Option

Applies to Agent Hourly 30

Bi-Weekly Rates for the HPI Health Select HSA plan are (per paycheck):

Employee Only: **$56.31** Employee + Spouse: **$290.85** Employee + Child(ren): **$237.97** Employee + Family: **$318.27**

BENEFIT ATTRIBUTES	In-Network	Out-of-Network
Health Savings Account Match Alorica will match 50% of your HSA contributions up to a maximum amount of:	$500 Individual / $1,000 Family	
Annual Deductibles Individual Family[1]	$1,500 $3,000	$3,000 $6,000
Annual Out-of-Pocket Maximum Individual Family[2]	$5,000 $10,000	$10,000 $20,000
Coinsurance Percentage *After Plan Deductible*	Plan Pays 80% Member Pays 20%	Plan Pays 50% Member Pays 50%
Professional Services		
Office Visits Primary Care Provider Specialist	20% After Deductible	50% of Allowed Amount
Doctor on Demand Virtual Physician Visit	20% After Deductible	Not Covered
Preventive Care	No Charge	Not Covered
Routine Lab and X-Ray - Outpatient	20% After Deductible	50% of Allowed Amount
Chiropractic Care *24 visits per calendar year*	20% After Deductible	50% of Allowed Amount
Urgent Care[4]	20% After Deductible	50% of Allowed Amount
Hospital Services[3]		
CT, MRI, PET scans	20% After Deductible[3]	N/A
Inpatient Services	20% After Deductible[3]	N/A
Outpatient Facility Services	20% After Deductible[3]	N/A
Hospital Emergency Room[3, 4]	20% After Deductible[3]	N/A
CVS Caremark Prescription Benefits *After the above annual deductible is met, you pay:*		
Retail (30-day supply) Contraceptives (ACA) Generic Preferred Brand[5] Non-Preferred Brand	No Charge $15 $40 50% *(minimum of $40 up to a maximum of $250)*	
Mail Order (90-day supply) Contraceptives (ACA) Generic Preferred Brand[5] Non-Preferred Brand	No Charge $30 $80 50% *(minimum of $80 up to a maximum of $500)*	Not Covered

To find the formulary list, please go to www.caremark.com.

1. For employees with family coverage, no one in the family is eligible for benefits until the full family coverage deductible is met. Preventive medications are not subject to the deductible. However, the copays and coinsurance would still apply to the medications.
2. All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount. Copayments, coinsurance and deductibles accumulate towards the out-of-pocket maximum.
3. Precertification required for all inpatient and outpatient facility based services, including advanced imaging and diagnostics.
4. Urgent/Emergency services will be certified post service if you notify the plan within 24 hours of your visit.
5. Mandatory Generic medications must be used when available; otherwise, the member will pay the cost differential between the Generic medication and the Preferred Brand medication plus the Preferred Brand copay.

The information contained in this summary is not intended to take the place of, or change the carrier's schedule of benefits. In the event the information contained herein varies from the carrier's schedule of benefits, the carrier information shall prevail.

To manage your prescription benefits, please download the CVS Caremark mobile app; you can learn more about the app on page 26.

CVS Caremark™ Mobile App

Manage your Rx on your own Time

We make it easy to keep track of your Rx, check for savings and more from your mobile device.
CVS mobile app gives you a secure, simple way to manage your prescription benefits and plan member information. You'll find easy-to-use tools that help you save time, get organized and stay on your path to better health. Find a nearby pharmacy no matter where you are. Learn about your medication and get information you can trust day or night. Do all this —and much more—at your convenience.

- **Check the status of your order.** Anytime, anywhere.
- **Place an order on-the-go.** No need to call or even sign in.
- **Look up your current Rxs when you need them.** Like at your doctor's office.
- **Easily access your member ID.** Free up some extra room in your wallet.
- **Share your current Rx list with health care providers.** No more memorizing details.

To download the CVS mobile app, visit Caremark.com/mobile (after your benefits begin).

CVS caremark™

Flexible Spending Accounts (FSA) Applies to Agent Hourly 30

Who doesn't want a little extra cha-ching? One way to keep more in your pockets is to reduce the amount you pay in taxes by reducing your taxable income. Flexible Spending Accounts (FSA) can help. As an employee of Alorica, you can reduce your taxable income by participating in the FSA program.

Your FSA Options

You may choose to participate in one or both of the following accounts:

- **General Purpose Health Care Account** (for employees/families **NOT** enrolled in the Health Select Option) $2,750 maximum limit per plan year. $100 minimum contribution per plan year.
- **Limited Purpose Health Care Account** (for employee/families who **ARE** enrolled in the Health Select Option) $2,750 maximum limit per plan year. $100 minimum contribution per plan year. Eligible expenses limited to dental and vision.
- **Dependent Care Account—$5,000** household maximum limit per calendar year (or $2,500 if married and filing separately). $100 minimum contribution per plan year.

The money that you contribute is deducted from each paycheck throughout the year on a pre-tax basis before Federal, State and Social Security taxes are taken out.

You may use an FSA Debit Card to pay for your eligible FSA expenses. All enrollees will be issued a debit card that can be used for both health care and/or dependent care expenses. And while most transactions will not require additional substantiation, we recommend that you always save your receipts and documentation.

Your Health Care FSA

The Health Care FSA lets you pay for eligible out-of-pocket healthcare costs from your FSA such as:

- Deductibles and copayments for your medical (general purpose FSA only), dental and vision plans
- FSA-eligible expenses that are not covered by your plans
- Any other healthcare expenses that qualify under Internal Revenue Service (IRS) rules

Health Care FSA Carryover: The Alorica Health Care FSA plan allows employees to carryover up to $550 of their unused healthcare FSA balance into the next Plan Year. Employees may use this carryover balance for claims incurred during the next Plan Year, in addition to any newly elected FSA contributions. Balances above the $550 carryover amount that are remaining from the prior Plan Year will be forfeited.

NOTE: Please contact the Employee Benefit Resource Center at 877-801-7928 for additional information on the $550 carryover.

Your Dependent Care FSA

The Dependent Care FSA gives you the opportunity to pay for childcare, elder care, or other dependent care services so that you and your spouse/RDP can work or attend school full-time. In order to qualify for reimbursement, services need to be related to the care of:

- Children under the age of 13 who are listed as dependents on your income tax return (if your child turns 13 during the year, contributions do not stop, so plan accordingly)
- Dependents of any age who are incapable of caring for themselves and who regularly spend at least 8 hours a day in your home

Important FSA Rules to Remember

- Any money in your account(s) that is not used by the end of the plan year (December 31) will be forfeited (with the exception of amounts eligible under the health care carryover provision).
- You cannot stop or change contributions during the year unless you have an IRS qualified life event change (see page 6).
- Once you terminate employment, only expenses incurred before you terminate are eligible, unless you elect to continue your FSA through COBRA.
- Dependent care providers must have a valid tax ID # or U.S. Social Security Number.
- You will be reimbursed for dependent care expenses only up to the funded amount.

Look Back Measurement Method

You and your dependents are eligible for the agent medical plans if you are a full-time employee. A full-time employee is generally an employee who works on average 30 hours paid or more per week, as defined by the ACA. ACA full-time status can affect or determine Agent Hourly 30 medical benefits eligibility but is not a guarantee of benefits eligibility. Alorica uses the Look-Back Measurement Method to determine whether an employee meets this eligibility threshold.

New Employees

If you are a new employee hired to work at least 30 hours a week, you will be offered medical benefits the 1st of the Month following 30 days of employment.

If—as of your date of hire—Alorica is unable to determine that you are a full-time employee, you will not be offered Agent Hourly 30 medical benefits immediately. Instead, you will be placed into an Initial Measurement Period; an 11-month period to determine whether you are a full-time employee and eligible for benefits. Employees hired with the following schedules will be placed into an Initial Measurement Period, including those hired into a:

- Hourly position
- Position where hours vary and Alorica is unable to determine whether you will work on average 30 or more hours a week
- Seasonal position where you are expected to work for six (6) consecutive months or less (regardless of monthly hours worked)

Your Initial Measurement Period will begin on your date of hire and will last for 11 months. If, during your Initial Measurement Period, you average 30 or more paid hours a week over that 11 month period, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage during your 13th month of employment. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing Employees

Alorica uses the look-back measurement method to determine medical plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire Standard Measurement Period. A Standard Measurement Period is the 12-month period of time over which Alorica counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages 30 or more paid hours a week over the 12-month standard measurement period. Those employees who average 30 or more paid hours a week over the 12-month standard measurement period will be full-time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period, which is the same as our plan year.

Full-time status will be in effect for the 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered coverage under COBRA. Alorica uses the Standard Measurement Period and associated Stability Period annual cycle outlined below.

Standard Measurement Period Time to determine if you work 30 paid hours per week on average–used to establish if you are “full-time” or “part-time” for medical eligibility	October 13 – October 12
Stability Period Time during which you will be considered “full-time” or “part-time” for medical plan eligibility - based on hours worked during preceding Measurement Period	January 1 – December 31

Required Federal Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistanceprogram that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employersponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: medicaid.georgia.gov/health-insurance-premium-paymentprogram-hipp Phone: 1-678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: in.gov/medicaid/ Phone: 1-800-457-4584
CALIFORNIA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Website: dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-916-440-5676	Medicaid Website: dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KANSAS – Medicaid**
Health First Colorado Website: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ Website: colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Phone: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI) Website: colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service Phone: 1-855-692-6442	Website: kdheks.gov/hcf/default.htm Phone: 1-800-792-4884

Required Federal Notices Cont'd

KENTUCKY– Medicaid	NORTH CAROLINA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: kidshealth.ky.gov/Pages/index.aspx KCHIP Phone: 1-877-524-4718 Kentucky Medicaid Website: chfs.ky.gov	Website: medicaid.ncdhhs.gov/ Phone: 919-855-4100
LOUISIANA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MAINE – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Enrollment Website: maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Website: maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: insureoklahoma.org Phone: 1-888-365-3742
MASSACHUSETTS – Medicaid and CHIP	**OREGON – Medicaid**
Website: mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: www.healthcare.oregon.gov/Pages/index.aspx www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MINNESOTA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/ Phone: 1-800-657-3739	Website: dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
MISSOURI – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: www.eohhs.ri.gov/ Phone: 1-855-697-4347 Direct Rite Share Line: 1-401-462-0311
MONTANA – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: scdhhs.gov Phone: 1-888-549-0820
NEBRASKA– Medicaid	**SOUTH DAKOTA - Medicaid**
Website: ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: dss.sd.gov Phone: 1-888-828-0059
NEVADA– Medicaid	**TEXAS – Medicaid**
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: gethipptexas.com/ Phone: 1-800-440-0493
NEW HAMPSHIRE – Medicaid	**UTAH – Medicaid and CHIP**
Website: dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free for HIPP Program: 1-800-852-3345, ext 5218	Medicaid Website: medicaid.utah.gov/ CHIP Website: health.utah.gov/chip Phone: 1-877-543-7669
NEW JERSEY – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: greenmountaincare.org/ Phone: 1-800-250-8427
NEW YORK – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282

Required Federal Notices Cont'd

WASHINGTON – Medicaid	WISCONSIN – Medicaid and CHIP
Website: hca.wa.gov/ Phone: 1-800-562-3022	Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WEST VIRGINIA – Medicaid	**WYOMING – Medicaid**
Website: mywvhipp.com/ Toll-Free Phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Required Federal Notices Cont'd

Important Notice from Alorica

About Your Prescription Drug Coverage and Medicare under the HPI Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Alorica and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

> Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
>
> Alorica has determined that the prescription drug coverage offered by the HPI plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicareduring a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Alorica coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Alorica coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Alorica and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

Required Federal Notices Cont'd

For More Information about *This Notice or Your Current Prescription Drug Coverage…*
Contact the person listed at the end of these notices for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Alorica changes. You also may request a copy of this notice at any time.

For More Information about *Your Options under Medicare Prescription Drug Coverage…*
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2021
Name of Entity/Sender:	Alorica
Contact—Position/Office:	Human Resources
Address:	5161 California Avenue, Ste. 100 Irvine, CA 92617
Phone Number:	877-801-7928

Required Federal Notices Cont'd

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 877-801-7928.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 877-801-7928.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 877-801-7928.

Who to Contact

Questions Regarding	Contact	Group Number	Phone Number	Website/Email
Benefits Q&A, Technical Support and Enrollment Assistance				
• Plan coverage questions • Assistance with online enrollment	Employee Benefit Resource Center		(877) 801-7928	AloricaBenefitsUS.com
The American Worker MEC Plan				
• Questions and/or Assistance • Claims • Locate a participating provider	American Worker PHCS Limited Benefit Network	CHC3001	(888) 371-7427	www.multiplan.com/awp www.multiplan.com/awpmec www.cerpassrx.com
HPI Medical Plans				
• Questions and/or Assistance • Claim Forms • Locate a participating provider	HealthPlans, Inc. Member Services	001WA3	888-711-6766	www.healthplansinc.com/members
CVS Caremark				
• Questions and/or Assistance • Formulary guidelines	CVS Caremark Member Services	Employee ID Number	855-656-0367	www.caremark.com
Dental Plan				
• Eligibility • Locate a dental provider • Check Status of a Claim	Cigna DPPO Cigna Dental Care DHMO Member Services	3330355	(800) CIGNA24 (800) 244-6224	www.cigna.com www.mycigna.com
Vision Plan				
• How to use the plan • What is covered	UnitedHealthcare Member Services	752845	(800) 638-3120	www.myuhcvision.com
MHN Employee Assistance Program				
For EAP Assistance	MHN	Alorica	Toll-free 24/7 (844) 442-5046	www.mhn.advantageengagement.com Company Code: Alorica
Disability				
Short Term Disability (STD)	Prudential	70426	800-842-1718	www.prudential.com/mybenefits
Long Term Disability (LTD)	Prudential	70426	800-842-1718	www.prudential.com/mybenefits
Life				
Life and AD&D	Prudential	70426	800-524-0542	N/A
Voluntary Benefits				
Accident Insurance & Critical Illness	Aflac	N/A	(800) 433-3036	www.aflac.com/alorica
Auto & Property Insurance	Liberty Mutual	117687	(844) 814-0939	www.libertymutual.com/alorica
Pet Discount Program	Pet Benefit Solutions	82	(888) 789-7387	www.petassure.com
Hospital Indemnity Insurance	Aflac	N/A	(800) 433-3036	www.aflac.com/alorica
LifeTime Benefit Term Coverage	Chubb	N/A	(855) 241-9891	N/A
Flexible Spending Account / Commuter Benefits				
• Download Reimbursement Form • Online Claims Submission • Order Passes	Alight Smart-Choice Accounts	N/A	877-801-7928	www.AloricaBenefitsUS.com
Other				
Health Savings Account (HSA)	Optum Bank HSA	N/A	(844) 326-7967	www.optumbank.com
401(k)	Mass Mutual	N/A	(800) 743-5274	www.retiresmart.com

ID & Debit Cards:

- HPI Health Plans – All HPI medical plan members will receive an ID card from HPI. The ID cards will list all your enrolled dependents.
- CVS Caremark Prescription – All new medical plan members will receive an ID card from CVS Caremark. Applies to the HPI medical plans only.
- American Worker MEC Plans – All members will receive an ID card following enrollment. The ID card will include your ID number and prescription information. The cards will include your dependents.
- Cigna DHMO – New Cigna DHMO members will receive a personalized ID card.
- HSA Debit Cards – All HPI HSA medical plan participants will receive an Optum Bank HSA debit card. Optum Bank HSA Customer Service line: 844-326-7967
- Cigna PPO – This plan does not require you to show an ID card when you receive services. If you would like a generic card, you can download one at www.mycigna.com.
- UHC Vision – This plan also does not require you to show an ID card when you receive services. If you would like a card, you can print one at www.myuhcvision.com.
- Alight Smart-Choice Accounts – New FSA participants will receive two ID cards following enrollment.

Please note: If you need additional ID cards, you may visit any of the above carrier websites to register and print temporary ID cards or to request additional ID cards.

Notes

Trouble Enrolling Online? Have a Benefit Question?

Employee Benefit Resource Center:

1-877-801-7928

Monday-Friday from 8am to 8pm Central Time

alorica