FAQs

If you have a specific question, see if it's in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, feel free to browse and scan the FAQs at your own pace.

Preparing for Enrollment

1. How should I prepare for enrollment?

The choices you make during enrollment will be effective through December 31, 2024. You **cannot** add or drop coverage until the next Annual Enrollment—held in November of each year—unless you experience a qualifying life event, such as a marriage, birth of a child or change in employment status.

As you prepare to enroll, consider the following questions:

- Which networks do your doctor, dentist and/or optometrist/ophthalmologist belong to? Choosing a carrier that includes your preferred providers in its network will ensure you pay the least for the cost of service you receive from your providers.
- How are your prescriptions covered?
- Who do you want to cover and for which plans?
- Are you expecting any elective surgeries or planning to have a baby in 2024?
- How much do you want to pay for premiums from your paycheck versus from your pocket at the time you receive care?
- Will you set aside money in the available savings/spending accounts so you can pay health care and dependent care expenses tax-free?

2. What will I need to do during enrollment?

You must enroll through the Your Benefits Resources™ website or the Alight Mobile app within 30 days of your hire date or you will not have medical, dental or vision coverage through your company in 2024. Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either. In addition, to contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election to participate in these savings/spending accounts.

Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2024.
- Choose the insurance carriers and coverage levels you want for your medical, dental and vision benefits.
- Confirm and/or enroll in the rest of your benefits, including your available voluntary options.

You can get information about enrollment on the Make It Yours website at **GAF.makeityoursource.com**.

3. What happens if I take no action during enrollment?

If you do not make benefits elections within 30 days of your hire date, **you will not have** medical, dental or vision coverage through your company for 2024. If you do not elect medical coverage, you also will also not have prescription drug coverage. To contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election.

4. If I want to waive coverage for 2024, do I need to take action on the Your Benefits Resources website?

Yes. Even if you don't want benefits through your company for 2024, you should log on to the **Your Benefits Resources website** to waive medical (including prescription drug), dental, and vision coverage, and participation in an HSA or FSA.

5. Can I make changes to my elections after my enrollment window ends?

The choices you make during enrollment will be in effect through December 31, 2024. You cannot add or drop coverage until the next Annual Enrollment—held in November of each year—unless you experience a qualifying life event. The following qualifying life events will allow you to make changes to your current benefits during the plan year:

- Marriage
- Divorce or legal separation
- Birth of a child
- Death of your spouse or dependent child
- Adoption or placement for adoption of your child
- Change in employment status of you, your spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage

6. How do I enroll for 2024 benefits?

You have three options for how to enroll during your enrollment window:

- **Option 1:** Log on to the **Your Benefits Resources website**.
- **Option 2:** Call the Your Benefits Resources hotline at **855-564-6155**, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available. You can also schedule an appointment with a representative through the Your Benefits Resources website year-round. Just log on to the **Your Benefits Resources website** and click on the "Appointment Scheduling" tile, then choose from the available dates and time slots. You'll be asked to provide your name, phone number, and ZIP code and a brief description of what you need help with.
- **Option 3:** Use the Alight Mobile app, available through the **Apple App Store** or **Google Play**.

7. How do I create my user ID and password for the Your Benefits Resources website?

If you are a new user, you will need to set up your user ID and password, which are needed to access your account through the Alight Mobile app (available through the **Apple App Store** or **Google Play**).

- Go to the **Your Benefits Resources website** and select **New User**;
- Enter the last four digits of your Social Security number and your date of birth to authenticate your account;
- Create your user ID and password; and
- Create answers to security questions to verify your identity if you forget your user ID or password in the future.

8. How do I reset my password for the Your Benefits Resources website?

To reset your password, go to the Your Benefits Resources (YBR) website, click **Forgot User ID or Password**, and follow the prompts to reset your password. You will need your user ID and password to access your account on the Alight Mobile app (available through the **Apple App Store** or **Google Play**).

9. Do I need to be on the company network to enroll?

No. You can access the enrollment process on the **Your Benefits Resource website** from any personal device. When you visit the site for the first time, click **"New User?"** and follow the steps to register.

Once you've enrolled, you'll be able to visit the Your Benefits Resources website without your user ID and password while on the company network because you are already "authenticated" (the system knows who you are).

10. What information should I have available when I enroll during enrollment?

When you're ready to enroll, make sure to have your eligible dependent(s) date of birth and Social Security number handy. If you add a dependent to your coverage, you will need to submit documentation confirming the eligibility of the dependents you cover in your company's medical/prescription, dental, vision and life insurance plans. If you add dependents to these plans, you will receive a letter in the mail from the Alight Solutions Dependent Verification Center asking you to prove that your dependents meet the eligibility criteria. The letter will include a list of acceptable documents, the submission instructions and the submission deadline.

When you enroll, you should also be prepared with a list of your (and your family's) preferred providers and the prescription drugs you (and your family) take on a regular basis so you can input them in the **Help Me Choose** tool for personalized coverage recommendations. In order to get the most accurate results, it is recommended that you search for your provider by first and last name—not medical practice. If you entered this data in the Help Me Choose tool last year, it will be available to you for use in your results this year. Access the **Enrollment Checklist** on the Make It Yours website to help you prepare.

If you have trouble finding a provider in the tool, or you're uncertain if your preferred providers are part of a carrier's network, call the **insurance carrier** directly for more information.

11. What is an exchange?

An exchange is a way for you to enroll in medical, dental, vision and certain other coverage. It is a private online insurance marketplace where employees can shop for coverage from multiple health insurance carriers who are competing for your business. An exchange merges the best of both worlds: group rates, with more individual choices through national and regional carrier options, and price competitiveness. The Aon Active Health Exchange is America's first private, large-employer, multi-insurance carrier exchange.

12. Is this exchange sponsored by the government?

No. The Aon Active Health Exchange is a private exchange. It is unrelated to the government-run state and federal health insurance exchanges or marketplaces. However, it does provide benefits consistent with the law and guarantees coverage for those eligible, regardless of pre-existing conditions.

13. Where can I get more information?

- **Make It Yours website**—Visit **GAF.makeityoursource.com** to learn about the exchange, your coverage options and choosing the right coverage for you and your family.
- **Your Carrier Connection** (available through the Make It Yours website)—Visit each carrier's preview site to get up to speed on provider networks, prescription drug information and other carrier resources.
- **Helpful Documents** (available through the Make It Yours website)—Visit the **Helpful Documents** page to access the 2024 Benefits Guide, the Express Scripts Pricing Tool, a list of plan contacts and more.

- **The Your Benefits Resources website and Alight Mobile app**—When it's time to enroll, log on to the **Your Benefits Resources website** or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options and prices, get helpful decision support and enroll.

  Questions? Once logged on to the **Your Benefits Resources website**, look for the "Need Help?" icon to ask Lisa! Lisa is a virtual assistant, to which you can pose questions for an answer. They can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the Your Benefits Resources website. Click on the "Appointment Scheduling" tile, then choose from the available dates and time slots. You'll be asked to provide your name, phone number, and ZIP code and a brief description of what you need help with. You can also call Your Benefits Resources at **855-564-6155**, Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back.

- **Additional support**—If you need help with more complex coverage issues, call **866-300-6530** and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues.

14. How do I decide which medical option is right for me?

Start by visiting the Make It Yours website at **GAF.makeityoursource.com** to access videos, details about your options, comparison charts and more.

Next, during your enrollment, you will have three options for ways to enroll:

1) **Log on to the Your Benefits Resources website** to see your price options and make your selections. You'll also have access to tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings and more.

   Use the **Help Me Choose** tool on the **Your Benefits Resources website** so you can choose a plan with confidence! Answer a few questions about your preferred providers and ongoing prescriptions and the tool will make recommendations for you. Help Me Choose will assign a score to each of your plan options, based on the information you provided. You can then compare the features and prices of each plan and even read carrier reviews from other health care users. You'll also be able to see estimates for your total expected costs for the year ahead.

2) **Contact Your Benefits Resources at 855-564-6155,** Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

3) **Use the Alight Mobile app**, available through the **Apple App Store** or **Google Play**.

15. When will I find out the cost of the various insurance coverage options?

We understand that you may be eager to know the pricing now. The 2024 pricing structure is tailored to your regional area, your salary and your specific coverage needs. Because it is customized, you will be able to access your specific pricing information through the Your Benefits Resources website during your enrollment window. You'll be able to see the pricing for your available options as you enroll on the Your Benefits Resources (YBR) website. To access the YBR website from any personal computer, visit **myhranywhere.com/benefits**. You will need your user ID and password if you use this URL. If you don't have your user ID and/or password, click **"New User?"** and follow the instructions provided.

My Options

16. What are my plan options for medical and prescription drug coverage?

Before you choose your medical insurance carrier, you'll first choose your coverage level. You will choose from four coverage options (Bronze, Bronze Plus, Silver and Gold) that feature different coverage levels, offered by a variety of national and regional insurance carriers (if available in your area). Each combination of coverage level and carrier has different associated costs. When you enroll on the **Your Benefits Resources website** or the Alight Mobile app, you'll be able to compare benefits, features and pricing across your options.

17. What are my medical carrier options?

You'll be able to choose from medical coverage plans offered by national and regional insurance carriers (if available in your area). National carriers include Aetna, Cigna, Anthem Blue Cross Blue Shield and UnitedHealthcare. Regional carriers (if available in your area) include Health Net, Dean/Prevea360, Kaiser Permanente, Geisinger Health Plan, UPMC, Medical Mutual and Priority Health. Learn about each of the carriers and the areas they serve on the **Make It Yours** website.

18. Does medical coverage differ among insurance carriers?

In general, at each coverage level (Bronze, Bronze Plus, Silver and Gold), carriers have agreed to the majority of standardized plan benefits configured by the Aon Active Health Exchange. The **Your Benefits Resources website** provides a more detailed look at these and additional coverage details—and does account for some carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the plans you want to review and click **Compare**. Call the carrier directly to get the most comprehensive information about any specific coverage.

19. What should I consider if I enroll in a Bronze or Silver high-deductible medical option and have expenses early in the year?

If you enroll in a high-deductible medical option (Bronze or Silver coverage levels), you should be prepared to pay up to the cost of your annual deductible—in case you have significant medical expenses shortly after the plan year begins (or after the effective date of your coverage). You will pay full price for the cost of all prescriptions and emergency visits until the annual deductible is met. With the Bronze and Silver coverage levels, you can contribute to a Health Savings Account (HSA), but even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early on. One option is to pay for those early expenses out of pocket, and then, when your account balance grows enough to cover the qualified expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in an HSA (if eligible).

20. I live in California. How are my medical options different?

Your options will be different, depending on the insurance carrier you choose. For starters, each insurance carrier in California can choose to offer each coverage level either as an option that offers in- and out-of-network benefits (the Bronze, Bronze Plus, Silver and Gold plans) **or** as an option that offers in-network benefits only (the Gold II plan, which is available in California only).

Insurance carriers in California can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold option is offered by Aetna, Anthem Blue Cross Blue Shield, Cigna and UnitedHealthcare. The Gold II option is offered by Health Net and Kaiser Permanente.

Learn more about your California coverage options and insurance carriers **here**.

21. Does the company offer family-building benefits?

Yes. Your company provides fertility and family-building benefits through Kindbody, a leader in the family-planning industry. With this benefit, you will have access to comprehensive fertility services through Kindbody Signature Clinics or Kindbody's Centers of Excellent network of partner clinics. Services include, but are not limited to, egg freezing, in vitro fertilization (IVF), intrauterine insemination (IUI), fertility medication, LGBTQ+ support, gynecology and holistic health[1].

Regardless of which path you choose, Kindbody is ready to support you through your family-building journey. You'll have access to a dedicated Care Navigation Team to guide you every step of the way.

You are eligible for up to two (2) cycles (called KindCycles) of services per lifetime through your company's Kindbody benefit. Different services amount to different portions of your 2-cycle limit. Your Care Navigation Team will work with you to understand all of the services covered under your plan.

You must be enrolled in medical coverage through your company to be eligible for Kindbody fertility benefits. Once you've enrolled in a medical plan, you will not be required to enroll in Kindbody benefits separately on the Your Benefits Resources website. Follow the instructions below on how to utilize Kindbody's benefits and services and to create an account.

Your company also offers a reimbursement benefit for costs associated with other paths to parenthood, including adoption, surrogacy and gestational carrier[2].The reimbursement plan does not require enrollment in the company's medical plan[3].

22. Does Kindbody Provide Menopause Support Services?

Yes. Kindbody's menopause benefit includes programs that support gynecological, nutritional, fitness, mental, emotional, holistic and sexual health. Menopause support is delivered by Kindbody's board-certified OB/GYNs and specialized holistic health providers. All employees enrolled in a medical plan will automatically have access to this additional Kindbody benefit.

You must be enrolled in medical coverage through your company to be eligible for Kindbody menopause benefits. Once you've enrolled in a medical plan, you will not be required to enroll in Kindbody benefits separately. Follow the instructions below on how to utilize Kindbody's benefits and services to create an account.

23. How can I begin utilizing Kindbody's benefits and services?

To utilize the Kindbody program, you will need to create an account on the Kindbody website at **kindbody.com/activate-kindbody-benefit**. Once you create your account, use the Kindbody Portal online tools to:

- Schedule an appointment virtually or at a nearby clinic
- Secure message with your Care Navigation Team
- Review results and next steps for your care plan
- Access educational content and video tutorials

To verify your eligibility and activate your benefit, visit the **Kindbody website**. Enter the access code **KINDFAMILY** and use your Unique ID (this is your employee ID; for your spouse or partner, the Unique ID is your employee ID + an "S" at the end). Or, call Kindbody at **855-747-1630**.

[1] Limits apply. You must be enrolled in your company's medical plan to participate in fertility benefits.
[2] Employees covered by a collective bargaining agreement are not eligible for reimbursement benefits.
[3] Reimbursement for eligible Kindbody benefits is taxable. Contact your tax advisor if you should have questions or concerns relative to the taxation of these services.

24. Will I be able to use the same providers as I do today?

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Even if you can keep your current insurance carrier through the exchange, the provider network could be different and can change, so **always** check the provider directories before making a decision.

Do not rely on your provider's office to know the carriers' network(s). To see whether your doctor is in network:

- Check out the **insurance carrier preview sites**.
- When you enroll, check the networks of each insurance carrier you're considering on the **Your Benefits Resources website**. You can access this information by clicking **Find Doctors** when you're selecting your medical plan. For the best results:
  - Search for your provider by name—not medical practice.
  - Check only the office location(s) you are willing to visit.
  - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have **any** uncertainty (for instance, covering out-of-area dependents) or you need the network name, you should call the insurance carrier. Contact information is available on the **Make It Yours** website.

25. Why should I use in-network providers?

Seeing out-of-network providers will most likely cost you substantially more than seeing in-network providers. For example, you will 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, even after you've reached your annual out-of-network out-of-pocket maximum.

26. How should I choose a medical insurance carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offer national provider networks so that your dependents have access to in-network providers in some locations. (Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.)

Do not rely on your provider's office to know the carriers' network(s). You need to call the **insurance carrier** to confirm whether an out-of-area provider participates in a carrier's network.

27. Will pre-existing conditions be covered?

Yes. When you enroll in medical coverage through the exchange, coverage is guaranteed, regardless of whether you and/or your eligible dependents have pre-existing conditions.

28. How will my prescription drugs be covered?

Employees who enroll in a national carrier plan (under Aetna, Anthem Blue Cross Blue Shield, Cigna or UnitedHealthcare) will have their pharmacy benefits managed and covered by **Express Scripts**. **Click here** to use the Express Scripts Pricing Tool. Regional carriers manage their own pharmacy benefits.

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication:

Before you enroll, we strongly recommend that you call the appropriate company to better understand how your particular prescription drug(s) would be covered.

- If you're considering coverage under Aetna, Anthem Blue Cross Blue Shield, Cigna or UnitedHealthcare, call **Express Scripts**; or
- If you're considering coverage under a regional carrier, call the medical **insurance carrier** directly.

Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website for a **list of questions** to ask.

Tip: If you are on a maintenance drug, a drug that you take on a long-term basis, consider enrolling in your prescription carrier's mail-order program. Enrollment is simple and you can get a 90-day supply of medication auto-delivered to your home before you need it and you will save money as compared to costs when filling a prescription at a retail pharmacy.

29. What is "prior authorization" and when is it required?

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting "prior authorization" (also referred to as prior review or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition and confirm how the bill is going to be paid.

Who completes the process depends upon where you get care:

- When you stay in-network, your doctor usually completes the process on your behalf when it's required. But you should always confirm with your doctor to be sure he or she is handling it.
- If you go out-of-network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior authorization is required and you don't get pre-approved, you could get stuck paying most or **all** of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor whether you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

30. Will I receive a new ID card for medical and prescription drug coverage?

Yes. If you enroll in medical/prescription coverage, you will receive an ID card from the respective carrier following your enrollment in coverage. If you need care before you receive your card, you may also register on the carrier websites to download a temporary ID or download the carrier's mobile app to access your card electronically.

Note: If you enroll under Aetna, Anthem Blue Cross Blue Shield, Cigna or UnitedHealthcare for the first time, you'll receive a separate prescription drug ID card from Express Scripts.

If issued, you should receive ID cards before your benefits take effect. If you need an ID card immediately, go to your insurance carrier's website, register online and print a temporary ID card.

31. What do I need to know about dental networks?

Just like the medical insurance carriers, each dental carrier has its own insurance provider networks that can vary by the plan you choose. If it's important that you continue using the same dentist, you should check to see whether your dentist is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' network(s). To see whether your dentist is in network:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the **Your Benefits Resources website**.

32. What do I need to know about vision networks?

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' networks. To see whether your eye doctor or retail store is in network:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the network of each insurance carrier you're considering on the **Your Benefits Resources website**.

33. What other benefit options are available to me through the Enrollment process?

If you are an employee who is not covered under a collective bargaining agreement, you can choose to supplement your medical coverage with these benefits offered through the exchange.

Administered by Allstate:

- **Critical illness insurance:** Pays a benefit if you or a covered family member is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage kidney disease)
- **Hospital indemnity insurance:** Pays a benefit in the event you or a family member covered under this plan is hospitalized
- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan experiences an accident

You can get more details about the above benefits on the Make It Yours website at **GAF.makeityoursource.com**.

Also, during enrollment, you can choose to enroll in the following additional benefits on the **Your Benefits Resources website**.

- **Supplemental life and accidental death and dismemberment insurance:** Administered by Securian Financial, optional life insurance may be purchased for yourself, your spouse and child(ren). This coverage can increase the benefit amount that your beneficiary(ies) would receive under basic life.
  - If you are not covered by a collective bargaining agreement, you can elect increased spouse life and purchase spouse accidental death and dismemberment.
- **Whole life with long-term care (LTC) rider:** Available through Allstate, the whole life plan has many options of coverage volumes and can cover your spouse/domestic partner as well. Rates are guaranteed for the life of the policy. This plan also includes a long-term care rider, which will

help cover you in the event that you incur assisted long-term care expenses in a facility. California Residents: This benefit, if elected, may help you avoid payroll tax implications when long-term care is mandated in your state.

- **Long-term disability:** Administered by Lincoln Financial, this coverage ensures that you continue to receive a percentage of your base pay if you are totally disabled for more than 180 consecutive days.
- **Legal services:** Provides access to professional legal services through MetLife. Benefits include coverage for money matters, home and real estate concerns, estate planning, family and personal issues, civil lawsuits, elder-care issues and vehicle and driving matters.
- **Identity theft protection coverage:** Help better protect the identities of you and your family with ID Watchdog. ID Watchdog provides advanced identity monitoring and fraud protection, credit protection services, a 24/7/365 customer care call center with fully managed resolution services and online tools and resources.

34. Are employees covered under a collective bargaining agreement eligible for the voluntary benefits offered on the exchange?

The whole life, critical illness, accident and hospital indemnity insurance coverages are not available to our union population. There are also certain coverages under life and accidental death and dismemberment benefits for which union employees are not eligible. Furthermore, most union employees are not eligible for legal services, ID theft or long-term disability benefits. If you are eligible for any of these benefits, you will be prompted during the enrollment process (on the Your Benefits Resources website) to enroll or decline coverage.

35. Do I have to verify eligibility of my dependent(s) to be covered on my company benefits?

As a new employee, you will need to verify any dependents that you enroll in your company benefits. After the enrollment process, you will receive instructions for verifying your dependents. Your Benefits Resources will send a request to your home address requiring certain verification documentation; there will be an expressed deadline within this communication. Responding and sending documentation is mandatory. If you do not respond by the deadline, your dependent(s) will be removed from coverage and will not be eligible for COBRA coverage. Individuals found to be ineligible for coverage under the company's plans will be dropped from coverage as well.

Paying for Coverage

36. What does the lowest cost option mean and how does it apply to enrollment choices for 2024?

The lowest cost plan option will vary by geographical area. Make sure you review your options carefully so your elections suit you and your family financially. When you enroll on the **Your Benefits Resources website**, the Help Me Choose tool can help guide you to the medical plans that best meet your needs. You can also click the "Need Help?" icon to ask Lisa! Lisa is a virtual assistant, to which you can pose questions for an answer. They can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative.

37. What's a deductible and how does it work?

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you meet your deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service.

How the medical deductible works depends upon your coverage level:

- **The Bronze, Bronze Plus and Gold medical coverage levels 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 Silver medical coverage level has a "true family deductible."** This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no "individual deductible" with the Silver coverage level when you have family coverage.
    - To clarify, if you choose a Silver coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, you must satisfy the entire family deductible before coinsurance will kick in, even if only one family member had expenses applied to the deductible.

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

Do you use out-of-network providers? It is important to know that out-of-network charges do **not** count toward your in-network annual deductible; they only count toward your out-of-network deductible.

38. What's an out-of-pocket maximum and how does it work?

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage or certain copays under the Bronze Plus and Gold coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

The Bronze, Bronze Plus and Gold coverage levels 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.

The Silver coverage level has a "true family out-of-pocket maximum."[4] This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" with this option when you have family coverage.

Do you use out-of-network providers? 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.

[4] **Exception:** If you live in California, cover dependents and enroll under Health Net or Kaiser Permanente at the Silver coverage level, you will have a *traditional* annual out-of-pocket maximum.

39. Are there additional costs I need to be aware of?

For employees who are not under a collective bargaining agreement: If you use tobacco (including e-cigarettes), an additional $30 per month will be added to your cost of medical coverage. The $30 fee may be suspended if you participate and complete a tobacco cessation program through Virgin Pulse. See the **Your Benefits Resources website** for more information and disclosures.

40. Can I enroll in coverage for my spouse/domestic partner who has access to group medical coverage with his or her employer?

Yes, all employees can select coverage for a spouse/domestic partner who has access to group medical coverage with his or her employer. But if you do, you will pay the Working Spouse/Domestic Partner Surcharge of $100 per month as part of your medical contributions. The surcharge does not apply if you both work at your company. *If a spouse/domestic partner does not have access to group medical coverage, there is no associated fee.*

41. What's a Health Savings Account (HSA)?

An HSA is a special bank account that you can use when you enroll in a Bronze or Silver coverage level. It allows you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Silver coverage levels, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for non-qualified expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute. And if you don't have a lot of health care expenses, your money can stay in your account year to year and earn tax-free interest. Also, the money is yours to keep even after you no longer work for the company. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

42. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles and coinsurance. You decide how much money you want to contribute, and you can change your contribution election at any time. If you don't have a lot of health care expenses, your money can stay in your account year to year.

An HSA has the following tax advantages:

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on the HSA dollars when you use them to pay qualified expenses.

43. How is an HSA different from a Health Care Flexible Spending Account (Health Care FSA)?

While both accounts offer a tax-free benefit when you pay for eligible medical, dental and vision expenses, they differ in several key ways. Compare their **differences** on the Make It Yours website.

44. Can I enroll in both an HSA and a Health Care FSA?

No. If you enroll in the Bronze or Silver coverage level, you can contribute to an HSA. If you enroll in the Bronze Plus or Gold coverage level, you can contribute to the Health Care FSA. You cannot contribute to an HSA **and** participate in the Health Care FSA at the same time.

45. Can I contribute to an HSA if I'm covered under my spouse's general purpose Health Care FSA?

No. If your spouse's general purpose Health Care FSA covers your medical expenses, it would be considered other health coverage and you would not be eligible to contribute to an HSA.

46. Do I need to be enrolled in a medical plan through my company to participate in a Health Care FSA?

No. You can elect to contribute to a Health Care FSA without being enrolled in a medical plan through your company.

47. Can I keep my current HSA?

Yes. If you currently have an HSA and you have a balance, the unspent funds will remain in your HSA, earn tax-free interest, and be available for qualified health care expenses at any time in the future.

In order to contribute to an HSA in 2024, you need to meet the following criteria:

- You must be enrolled in a high-deductible option at the Bronze or Silver coverage level;
- You cannot be enrolled in Medicare or a veteran's medical plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return; and
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option.

Although you can enroll your children up to age 26 in your medical coverage, you can't use money from your HSA to pay their health care expenses unless you claim them as dependents on your federal income taxes (generally children up to age 19 or under age 24 if they are full-time students).

48. Will I receive a company contribution into my HSA?

No. While you will not receive a company contribution into your HSA, the company offers a generous contribution to the shared cost of the Bronze and Silver coverage levels. The savings in premiums can be funded by you to your HSA.

49. What is a Dependent Care FSA and why would I want to enroll in one?

The Dependent Care FSA is an account that helps you save and pay for qualified child (under age 13) and dependent care expenses. Contributions to the account are pre-tax through payroll deduction. Thus, you don't incur tax when you are reimbursed from your account, and your year-end taxable income is lower. You determine the annual dollar amount to contribute when you enroll, up to $5,000 (per family). Unlike an HSA, money in an FSA is "use it or lose it" each year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

You do **not** need to be enrolled in medical coverage to enroll in the Dependent Care FSA.

If you're parenting a young child or caring for an elderly parent, you can use the Dependent Care FSA to pay for preschool, summer camp, before and after school programs and child or elder day care. For other eligible expenses, visit **irs.gov/pub/irs-pdf/p503.pdf**.