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.

My Benefit Plans 2025

1. What is the Aon Benefit Experience (BenX)?

Your employer benefit plans are offered through the Aon Benefit Experience (BenX). BenX is a private online insurance marketplace where buyers like you can shop for coverage from multiple health insurance carriers who are competing for your business. BenX is easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right coverage options for your circumstances and budget.

2. What are the advantages of BenX?

- **Lots of choices.** Traditionally, you got to choose from the health plan options offered by your employer. Through BenX, you're able to choose from several plan options, a variety of insurance carriers, and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business. So it's in their best interests to offer their best prices. Plus, your employer will provide a credit toward the cost of medical coverage.

You also have help when you need it. There are great tools and resources to help you every step of the way. See below for details.

3. Where can I get more information?

There are lots of resources available to help before, during, and after enrollment.

Before and during enrollment:

- **Make It Yours website**—Visit the **Make It Yours website** to learn about 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.
- **The My Benefit Plans Website**—When it's time to enroll, log on to the **My Benefit Plans Website** to compare your options and prices, get helpful decision support, and enroll.

  Questions? Once logged on to the **My Benefit Plans Website**, look for the "Need Help?" icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. You can also call the My Benefit Plans Center at **1.855.750.2920** from 11:00 a.m. to 8:00 p.m. ET, Monday through Friday.

Managing your benefits throughout the year:

- **Make It Yours website**—Visit year-round for practical tips that help you and your family get the most out of your benefits. Get "**The Inside Scoop**" on how to work the health care system, be a savvy shopper, and save money.
- **Your Carrier Connection** (available through the **Make It Yours website**)—Take advantage of the tools, resources, and information offered through your insurance carrier. For questions about your coverage, always start with your carrier.
- **The My Benefit Plans Website**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help with more complex coverage issues, call **1.866.300.6530** and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues.

Enrollment

4. What will I need to do?

You **must** enroll during your enrollment period or you will not have medical, dental, or vision coverage through your employer.

You must enroll if you want critical illness insurance, hospital indemnity insurance, accident insurance, or identity theft protection. To contribute to a Health Savings Account (HSA) (if eligible) or to a Flexible Spending Account (FSA), you must make an active election.

To enroll, log on to the **My Benefit Plans Website** during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2025. If you add a dependent to your coverage for 2025, you will need to provide documentation confirming the eligibility of the dependents you cover in your employer's medical/prescription, dental, and vision plans. See question #11 for more information.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits.

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

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, Gold, and Platinum. Each coverage level is available from multiple insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your medical options.

6. What happens if I enroll in a Bronze, Bronze Plus, or Silver medical option and have expenses shortly after my coverage begins?

If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible—in case you have significant medical expenses shortly after your coverage begins. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. 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.

7. 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 (e.g., a PPO) or as an option that offers in-network benefits only (e.g., an HMO).

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

The Gold option is offered by Aetna, Highmark 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.

8. 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, 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 **My Benefit Plans 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 need to call the insurance carrier.

9. Why should I use in-network providers?

Seeing out-of-network providers will very 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. And certain Platinum options (and certain options/carriers in **California**) won't cover out-of-network services at all.

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

You'll have access to a number of resources to help you make smart decisions. You should start by visiting the **Make It Yours website** to access videos, details about your options, comparison charts, and more.

Then, when you enroll, you'll be able to see the credit amount from your employer and your price options on the **My Benefit Plans Website**. You'll also be able to access tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings, and more.

If you need additional help, once logged on to the **My Benefit Plans Website**, look for the "Need Help?" icon to ask Lisa, your virtual assistant, any questions you may have. Lisa can also connect you with a web chat representative and other helpful resources. You can also call the My Benefit Plans Center at **1.855.750.2920** from 11:00 a.m. to 8:00 p.m. ET, Monday through Friday.

11. Will I need to provide documentation if I cover dependents?

To manage health care costs for you and your family, your employer audits the eligibility of dependents added to the medical/prescription, dental, and vision plans to ensure benefit plans only cover eligible dependents.

If you add a dependent to your coverage for 2025, you will need to submit documentation confirming the eligibility of the dependents you cover. If you do not respond by the deadline, your dependent(s) will be removed from coverage. You will see a notification on the **My Benefit Plans Website** to verify your dependents. You will also receive a letter in the mail from the Alight Solutions Dependent Verification Center with instructions and a list of acceptable documents. You can also check the **My Benefit Plans Website**.

12. 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 most 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.

13. Will pre-existing conditions be covered?

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

14. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your pharmacy benefit manager—which could be a separate prescription drug company. Employees who enroll under Aetna, Cigna, Highmark Blue Cross Blue Shield, or UnitedHealthcare will have their pharmacy benefits managed by OptumRx. 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, it is strongly recommended that you call OptumRx (if you're considering coverage under Aetna, Cigna, Highmark Blue Cross Blue Shield, and UnitedHealthcare) or the medical insurance carrier (for other carriers) before you enroll to better understand how your particular prescription drug(s) will be covered. 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.

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

Yes. If you enroll in medical/prescription drug coverage, you will receive a new ID card from the respective carrier following your enrollment in coverage. **Note:** If you enroll under Aetna, Cigna, Highmark Blue Cross Blue Shield, or UnitedHealthcare for the first time, you'll receive a separate prescription drug ID card from OptumRx.

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

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

Just like the medical insurance carriers, each dental carrier has its own provider networks that can vary by the coverage level 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' networks. 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 **My Benefit Plans Website**.

If you are considering a Platinum dental option:

- It may cost less than some of the other options, but you **must** get care from a dentist who participates in the insurance carrier's DHMO network. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll.
- The Platinum dental option does **not** provide out-of-network benefits. So if you don't use a network dentist, you'll pay for the full cost of services.

17. 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 **My Benefit Plans Website**.

18. Will I have access to telemedicine services?

Yes. Each medical insurance carrier offers telemedicine services (also called virtual care or telehealth). For more information about the telemedicine services offered by each insurance carrier, visit the **carrier preview sites**, accessible through the **Make It Yours website**.

19. What other benefit options are available?

You can also choose to enroll in:

- **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 is in an accident
- **Supplemental life insurance:** Protects your family financially in the event of a death or a tragic accident

- **Supplemental short term and long-term disability coverage:** Provides you with income if you are unable to work due to an illness or non-work-related injury (your employer may cover you for short term and/or long term insurance—check your Benefits Guide)
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured dog or cat. Policies are also available for some exotic pets. You can enroll in pet insurance directly through the **MetLife website** or by calling **1.866.306.5012**.

You can get more details on the **Make It Yours website**.

20. Is Evidence of Insurability (EOI) required for supplemental life insurance coverage?

If you elect to enroll in supplemental life insurance coverage, Evidence of Insurability (EOI) will be required. You will receive a notification on the **My Benefit Plans Website** instructing you to complete the online EOI form.

Paying for Coverage

21. When will I find out the cost of coverage?

During your enrollment period, you'll be able to see the credit amount from your employer and your price options when you enroll on the **My Benefit Plans Website**.

22. What do you mean by the "credit" and how does this work?

During your enrollment period, you will see the health credit that your employer has assigned to you. This credit can be used to help you pay for your medical plan coverage. Once the credit is applied to your selected medical plan and carrier of choice, you will see how much remaining, if any, you need to pay each month for your selection.

23. Will I receive an HSA contribution from my employer?

This depends on the medical plan and carrier you choose to enroll with. If you enroll in a lower cost High Deductible Plan, you may have left over credits which will then drop into an HSA account attached to your High Deductible Plan. You can also choose to contribute your own pre-tax dollars into your HSA account.

24. Do I get to keep the employer credit if I don't enroll in coverage?

No. The credit you get from your employer is for the medical/prescription drug coverage you purchase. A cash refund or credit for other benefits is not available. You may be eligible to have unused dollars deposited into your paycheck.

25. 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 on your coverage level:

- **The Bronze, Silver, Gold, and Platinum 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 Bronze Plus and Silver medical coverage levels have a "true family deductible."**[1] This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no "individual deductible" in this coverage level when you have family coverage.

  To clarify, if you choose a Bronze Plus coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, though, you must satisfy the family deductible before coinsurance will kick in, even if only one family member has expenses.

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

Do you use out-of-network providers? Out-of-network charges do not count toward your in-network annual deductible; they only count toward your out-of-network deductible.

26. 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, Silver, Gold, and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

The Bronze, Silver, Gold, and Platinum 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 Bronze Plus and Silver coverage levels have a "true family out-of-pocket maximum."[2] This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in these options 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.

[1]Exception: If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a traditional annual deductible.

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

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

An HSA is a special bank account that you can use when you enroll in a Bronze, Bronze Plus, 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, Bronze Plus, 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 unqualified 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. 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.

28. 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.

The 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.

29. 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**.

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

Yes. If you enroll in the Bronze, Bronze Plus, or Silver coverage level, you can use an HSA, a Health Care FSA, or both an HSA and a limited purpose Health Care FSA. If you have an HSA and a Health Care FSA, in order to contribute to an HSA, your FSA will be "limited purpose" and can only be used to pay for qualified dental and vision expenses. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses.

31. Why would I want to use both an HSA and a limited purpose Health Care FSA?

Both accounts allow you to pay for eligible expenses with tax-free dollars. The biggest difference between the accounts is that your HSA balance rolls over from year to year, even if you change medical plans, leave the company, or retire. With the Health Care FSA (whether limited purpose or not), any unused balance exceeding $640 is forfeited at the end of the year.

Using both accounts allows you to maximize your pre-tax savings, as long as you have dental and vision expenses to cover what you are setting aside in the limited purpose account each year.

32. Can I contribute to an HSA if I am 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 considered other health coverage and you would not be eligible to contribute to an HSA.

33. Can I contribute to an HSA?

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

- You must be enrolled in a high-deductible option at the Bronze, Bronze Plus, or Silver coverage level;
- You cannot be enrolled in Medicare (including Part A) 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.

You can use money from your HSA to pay your dependents' health care expenses as long as 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).