EQUITABLE

FAQS

If you have a specific question, it may be in the list below. Click on the associated link to be taken directly to the answer you're looking for. Otherwise, browse the FAQs to learn more about the 2023 Aon Active Health Exchange™.

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The 2023 Aon Active Health Exchange™

1. What is the Aon Active Health Exchange (the exchange)?

The exchange is America's first national large-employer, multi-insurer, insurance marketplace. It is offered through the Equitable Health Plan ("Health Plan").

2. Is the 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. It does, however, provide benefits consistent with the law and guarantees coverage for those eligible in accordance with the terms of the Health Plan.

3. What are the advantages of the exchange?

The medical and prescription drug, dental, and vision benefits available through the exchange offer you:

- **More choices.** Traditionally, you had to choose from the health plan options and provider networks offered through the Health Plan. Through the exchange, you're able to choose from several coverage levels, a variety of medical, dental, and vision insurance carriers, and a range of costs.
- **Competitive pricing.** With the exchange, the medical, dental, and vision insurance carriers are competing for your business, so it's in their best interest to offer their best prices. Plus, when you enroll, Equitable provides a credit for you to use towards the cost of your insurance coverage. You'll be able to see the credit amount and your price options for insurance coverage when you enroll on the Your Total Rewards™ website at **http://digital.alight.com/equitable/**.
- **Help when you need it.** There are many tools and resources to help you during the Open Enrollment process. See question #4 for details about the tools and resources available to you.

4. Where can I get more information?

There are various tools and resources available to help you before, during, and after you enroll, including:

Before and during enrollment:

- **Make It Yours website**—Visit **https://equitable.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.

- **Your Total Rewards and Alight Mobile app** —When it's time to enroll, Your Total Rewards at **http://digital.alight.com/equitable/** 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.
- **Equitable Benefits Center**—You can reach a customer service representative by calling the Equitable Benefits Center at **1.800.829.2633** from 9:00 a.m. to 5:00 p.m. ET, Monday through Friday. 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.

Managing your benefits:

- **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. They know their plans best and have the final authority on all claims, billing disputes, etc.
- **Your Total Rewards and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help with more complex coverage issues, call **1.800.829.2633** and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues. Bill negotiation representatives can help review and negotiate out-of-network medical bills. And, expert second opinion with 2nd.MD makes it easy to get a virtual second opinion from nationally recognized doctors.

Enrollment

5. What will I need to do?

To enroll, log on to the Your Total Rewards website at **http://digital.alight.com/equitable/**. Over the course of the enrollment process, you'll need to:

- Enroll your spouse, domestic partner, and/or eligible dependents you want to cover in 2023.
- Select the insurance carriers for your medical, dental, and/or vision benefits.
- Select the coverage level (Bronze, Bronze Plus, Silver, Gold, or Platinum).
- Review your other benefit coverage and make changes, if necessary.

6. What happens if I don't enroll?

You must take action within 31 days of hire, or you will automatically be enrolled in the Silver medical option with the lowest cost insurer for your region. You will not have any dental or vision coverage for you and your family through Equitable.

7. Who's eligible for benefits?

Your eligibility for benefits depends on your employment status or type of position—full-time salaried employees and Group I part-time employees, benefits-eligible financial professionals, or retail sales managers. For more detailed information, see the Summary Plan Description for the Health Plan and the 2023 Enrollment Guide.

Eligible dependents include:

- Your legal spouse or eligible domestic partner;
- Your eligible children, generally under age 26 (unless state law requires an older age); and
- Your eligible children who became disabled prior to age 26 and who continue to be disabled beyond age 26.

Please refer to the 2023 Enrollment Guide for further information and details regarding eligible dependents.

My Options

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

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

- **Bronze:** A basic High-Deductible Health Plan ("HDHP") that offers access to an HSA and prescription drug coinsurance.
- **Bronze Plus:** A buy-up to the Bronze option—an HDHP that offers access to an HSA and prescription drug coinsurance.
- **Silver:** A preferred provider organization ("PPO") option with prescription drug copays.
- **Gold:** A PPO option that is essentially a buy-up from the Silver option with prescription drug copays.
- **Platinum:** A PPO option with prescription drug copays that covers in-network care and limited benefits for out-of-network care (or, for some medical insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, a health maintenance organization ("HMO") option with prescription drug copays that covers in-network care only).

9. What happens if I enroll in a Bronze or Bronze Plus medical option and have expenses early in the plan year?

If you enroll in a high-deductible medical option, you should be prepared to pay up to the amount of your annual deductible. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services incurred early in the year. Once your HSA account

balance grows enough to cover the incurred expenses, you can reimburse yourself from your HSA. This is a good reason to make sure you're contributing enough to an HSA.

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

If you live in California, your medical 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.

Learn more about your California coverage options and insurance carriers.

11. Which medical insurance carriers will I be able to choose from?

Most of the largest medical insurance carriers are currently participating in the exchange. Keep in mind that carriers may vary by region. Your specific carriers are based upon where you live, and you'll be able to see the carriers available to you when you enroll.

Before you become a member, you can visit specially designed carrier websites to get a "preview" of their services, networks, and more. You should check out the preview websites of the insurance carriers to get a closer look at the coverage you're considering. You can get to the medical insurance carrier preview websites through the Make It Yours website at **https://equitable.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the insurance carrier's main website for personalized information.

During enrollment and throughout the year, you can see how other people have rated their insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. However, such comments and ratings are neither endorsed nor approved by Equitable or the Health Plan. They're available through the Your Total Rewards website at **http://digital.alight.com/equitable/**.

12. I live outside the carriers' service area. How are my medical options different?

Your available options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can enroll in an out-of-area medical option at the Silver coverage level and Aetna will be the insurance carrier.

13. 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 should consider one of the national medical insurance carriers that offer national provider networks, so 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 either call the insurance carrier directly or log on to their website to confirm whether an out-of-area provider participates in a carrier's network.

14. Am I required to designate a primary care physician?

You must designate a primary care physician to coordinate your medical care if you:

- Choose Kaiser Permanente as your medical insurance carrier;
- Live in Northern California and choose Health Net as your medical insurance carrier; or
- Live in Southern California and choose Health Net as your medical insurance carrier and Gold II or Platinum as your coverage level.

15. Is one option level better than another?

One option isn't necessarily "better than" another. They're designed to give you choices so you can find the option that makes sense for your needs. Remember to take your total costs into consideration, which includes what you pay for coverage out of your paycheck *and* what you pay out of your pocket when you receive care (deductibles, coinsurance, copays, out-of-pocket maximums).

For example, the Gold and Platinum medical coverage levels will cost you more each paycheck, but will typically cost you less when you receive care.

The Bronze, Bronze Plus, and Silver coverage levels come with a lower cost per paycheck and will typically cost you more when you receive care. If you don't think you will need a lot of health care services in 2023, you'll generally spend less on your total health care costs by not paying as much in contributions for coverage you don't think you will need.

16. What's the difference between a PPO and an HDHP?

A PPO is a type of medical option that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at costs negotiated by the medical insurance carriers. You can also use out-of-network providers, but you generally pay more out-of-pocket for out-of-network services.

When you enroll in a traditional PPO, like a Gold option, you have to meet a lower annual deductible before the insurance carrier starts paying a percentage of the costs, compared to a Bronze or Silver

plan. For example, the Gold option annual in-network deductible is generally $800 for You Only coverage and $1,600 for Family coverage. In exchange for that lower annual deductible though, you will have higher per-paycheck deductions for the cost of coverage.

An HDHP, as the name suggests, has a higher deductible before your reimbursement for eligible expenses begins. To balance the cost of the high deductible, your per-paycheck deductions for cost of coverage will be lower. You can enroll in an HSA to pay for qualified health care expenses tax-free, subject to certain rules. Once you meet your HDHP annual deductible, you pay a percentage of your ongoing eligible expenses, up to the annual out-of-pocket maximum (including any amount exceeding your allowed amount).

It is important to note that you generally have separate in-network and out-of-network annual deductibles and out-of-pocket maximums. There are also some differences with how the deductible works. Please see questions 35 – 36 for more information.

17. Can each family member choose a different coverage level or medical insurance carrier?

No. All family members must be enrolled in the same coverage level with the same medical insurance carrier.

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

It depends. Each medical 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.

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

- Check out the medical **insurance carrier** preview websites.
- When you enroll, check the provider networks for each medical insurance carrier you are considering. 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. The Equitable Benefits Center can't assist with questions about networks or coverage.

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

You'll have access to a number of resources to help you make your decisions. We suggest that you start by visiting the Make It Yours website at **https://equitable.makeityoursource.com** to access videos, details about your options, and more.

When you enroll, you'll be able to see the credit amount you receive from Equitable as well as your price options on the Your Total Rewards website at **http://digital.alight.com/equitable/** or the Alight Mobile app. You'll also be able to access tools that may help you make decisions, 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, you can reach a customer service representative by calling the Equitable Benefits Center at **1.800.829.2633** from 9:00 a.m. to 5:00 p.m. ET, Monday through Friday. 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. The medical **insurance carriers** can also answer specific questions. Their contact information is available on the Make It Yours site at **https://equitable.makeityoursource.com**.

Please note that these are merely tools to assist you in making decisions. You should make enrollment decisions that fit your and your family's health needs.

20. Will pre-existing conditions be covered?

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

21. What's included in the preventive care that's covered at 100% by all medical options for 2023?

The U.S. Preventive Services Task Force recommendations are used to determine which services are considered preventive services. In general, the following list is an example of outpatient preventive care services that are 100% paid by the insurance carrier when you see an in-network provider, without the need to first meet the deductible. Some limitations vary by medical insurance carrier, so we encourage you to check with your medical insurance carrier if you have any questions.

Examples of preventive care that could be covered at 100% (based on your physician's recommendation and your carrier's medical management rules) include:

- Annual physical exam
- Pediatric exams
- Well-woman exam (includes Pap test)
- Prescription drug contraceptives (will vary by carrier)
- Mammogram

- Bone density screening
- Cancer screenings
- Cardiovascular screenings
- Colorectal screening
- Prostate screening
- Digital rectal exam
- High blood pressure screening (adult)
- Depression screening (adolescent)
- Depression screening (adult)
- Diabetes screening
- Immunizations (child)
- Immunizations (adult)

If the medical services you receive are considered both a preventive service and a non-preventive service in the same visit, only the preventive service will be paid at 100%. Any non-preventive services will be paid based on the terms of your applicable medical option. Please work with your physician, medical facility, and the medical carrier to be certain what will be considered preventive versus non-preventive procedures.

22. How will my prescription drugs be covered?

Your prescription drug coverage continues to be provided through your medical insurance carrier's pharmacy benefit manager—which could be a separate prescription drug company. 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 a medical insurance carrier.

Important: If you or a family member regularly takes prescription medication, it is strongly recommended that you call the medical insurance carrier 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 medical insurance carrier each year. Visit the Make It Yours website for a **list of questions** to ask.

Your prescription drug coverage also depends on your medical coverage level:

- If you enroll in the Bronze or Bronze Plus plan, you'll pay 100% of the cost of covered prescription drugs until you meet the in-network deductible (medical and prescription drug costs combined). After you meet the in-network deductible, you pay 20% coinsurance until you reach the in-network out-of-pocket maximum, and then you'll pay nothing for in-network covered prescription drugs. **Note:** If you have money in an HSA, you can use the current balance in your HSA to pay for qualified expenses.

Please also note that some preventive prescription medications are not subject to the deductible and are covered at 100%. Please contact the medical insurance carrier for more specific information about the list of covered preventive prescription medications as they vary by carrier.

- If you enroll in a Silver, Gold, or Platinum plan, you'll generally pay a flat copay for covered prescription drugs until you reach the in-network out-of-pocket maximum (medical and prescription drug costs combined), and then you'll generally pay nothing for in-network covered prescription drugs.

23. What is "prior review" and when is it required?

Before receiving certain types of care or filling a prescription, you or your doctor may be required to run it by your medical insurance carrier first. Getting "prior review" (also referred to as prior authorization or precertification) allows the medical insurance carrier to make sure you're eligible for the services or prescription drugs, 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 on 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 medical insurance carrier to fill out paperwork and receive the appropriate approval before getting care or prescription drugs.

When prior review is required and you don't get preapproved, you could be responsible for paying most or **all** of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor if you need to do anything in advance and confirm that the services or prescription drugs you need will be covered by your medical insurance carrier.

24. What is Telemedicine and 2nd.MD?

Telemedicine

Telemedicine enables you to obtain a health professional's advice—typically by phone or via web chat—to discuss your symptoms, ask questions, and even get prescriptions (as appropriate and as limited by state law). So if you need care when your primary care physician isn't available, such as on nights or weekends or while you're traveling, you may want to consider using the Telemedicine feature. Please contact your 2023 medical insurance carrier for more information about the Telemedicine feature.

2nd.MD

As part of your employee benefits through Equitable, you have access to 2nd.MD. With 2nd.MD, you can connect with a board-certified, expert specialist for a medical second opinion via phone or video at no cost to you and your family covered under the medical plan through the Aon Active Health Exchange. Activate your membership at **www.2nd.md/equitable**.

25. What are my options for dental coverage?

You have several dental coverage levels to choose from, including:

- **Bronze:** A PPO option that covers in-network and out-of-network care (note that you'll receive a discounted rate with in-network providers), but does not cover major services or orthodontia expenses.
- **Silver:** A buy-up to the Bronze PPO option that covers in-network and out-of-network care (note that you'll receive a discounted rate with in-network providers), including coverage for eligible major services and, for children up to age 19, orthodontia expenses.
- **Gold:** An enhanced PPO option that covers in-network and out-of-network care (note that you'll receive a discounted rate with in-network providers), including coverage for eligible major services and orthodontia expenses for children and adults.
- **Platinum:** A dental health maintenance organization (DHMO) option that covers **in-network care only**, including eligible orthodontia expenses for children and adults (not available in some limited areas).

Each coverage level is available from different dental insurance carriers at different monthly costs. When you enroll, you'll be able to compare benefits and features across your dental options.

26. Am I required to designate a primary care dentist?

You must designate a primary care dentist to coordinate your care if you elect the Platinum coverage level (where available by dental insurance carrier). If you don't designate a primary care dentist when you enroll, one may be assigned to you. To change your primary care dentist, you will need to contact the insurance carrier directly.

27. Which dental insurance carriers will I be able to choose from?

You'll be able to choose from Aetna, Cigna, Delta Dental, DeltaCare USA, MetLife, and UnitedHealthcare.

Before you become a member, you can visit specially designed carrier websites to get a "preview" of the dental insurance carriers' services, networks, and more. You should check out the preview websites to get a closer look at the dental insurance carriers you're considering. You can get to the dental insurance carrier preview websites through the Make It Yours website at **https://equitable.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the dental insurance carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through the Your Total Rewards website at **http://digital.alight.com/equitable/**.

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

Just like the medical insurance carriers, each dental carrier has its own provider network 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 if your dentist participates in the network before you choose a dental insurance carrier.

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

- Check out the applicable dental **insurance carrier** preview websites.
- When you enroll, check the provider network for each dental insurance carrier you are considering. The dental insurance carriers can answer specific questions about their provider networks and coverage.

If you are considering a Platinum dental option:

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

29. Why is the Platinum dental coverage level less expensive than other options?

Dentists who participate in the Platinum (DHMO) network are unique because they get paid a set amount per member no matter how often services are used. That gives DHMO dentists an extra reason to keep their patients healthy and control costs. In addition, individuals who enroll in a DHMO are typically required to select a primary care dentist. Having one dentist coordinate your care also helps to control costs. For these reasons, dental insurance carriers can often offer DHMOs at lower prices than other options.

30. What are my options for vision coverage?

You have three vision coverage levels to choose from, including:

- **Bronze:** Exam-only option that provides in-network discounts for certain materials.
- **Silver:** A PPO option that covers in-network and, for certain services, out-of-network care.
- **Gold:** An enhanced PPO option that covers in-network and, for certain services, out-of-network care.

Each coverage level is available from different vision insurance carriers at different costs. When you enroll, you'll be able to compare costs, benefits, and features across your vision options.

31. Which vision insurance carriers will I be able to choose from?

You'll be able to choose from EyeMed, MetLife, UnitedHealthcare, and VSP.

Before you become a member, you can visit specially designed carrier websites to get a "preview" of their services, networks, and more. You should check out the preview websites to get a closer look at the vision insurance carriers you're considering. You can get to the vision insurance carrier preview sites through the Make It Yours website at **https://equitable.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the vision insurance carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through the Your Total Rewards website at **http://digital.alight.com/equitable/**.

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 participates in the network before you choose a vision insurance carrier.

Do **not** rely on your provider's office to know the carriers' networks. To determine whether your eye doctor or retail store participates in a particular network:

- Check out the applicable vision **insurance carrier** preview websites.
- When you enroll, check the provider network for each vision insurance carrier you are considering. If you have any questions, the vision insurance carriers can answer specific questions about their provider networks and coverage.

Paying for Coverage

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

You'll be able to see the credit amount from the Company and your price options on the Your Total Rewards website at **http://digital.alight.com/equitable/** or the Alight Mobile app when you enroll.

34. What will I have to pay when I need medical care?

Other than covered in-network preventive care, which is paid at 100%, how much you have to pay when you need medical care primarily depends on your coverage level. Find the details for all coverage levels on the Make It Yours website at **https://equitable.makeityoursource.com**.

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

The deductible is the amount you pay out of your own pocket before your insurance begins to pay a share of your costs. If you have a deductible, you pay the full costs of all in-network and out-of-network services until you meet your applicable deductible. The annual in-network and out-of-network deductibles don't include medical or prescription drug copays, as applicable, or amounts taken out of your paycheck for health coverage. Depending on the carrier, the deductibles may also not include any additional amounts you are required to pay, such as additional amounts due if you order a brand name drug when there is a generic drug available.

Each carrier determines its own deductible rules. However, in general, out-of-network charges do not count towards your annual in-network deductible; they only count towards your out-of-network deductible. The same applies for in-network charges; they do not count towards your annual out-of-network deductible.

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, and Gold coverage levels have a "traditional" deductible.** For example, in the Gold plan, generally once a covered family member meets the $800 in-network individual deductible, your insurance will begin paying benefits for that covered family member. Charges for all covered family members will continue to count towards the in-network family deductible. Once the in-network family deductible is met, generally your insurance will pay benefits at the option's set percentage for all covered family members. However, for out-of-network charges, covered family members must meet a separate out-of-network deductible before your insurance begins paying benefits.
- **The Bronze Plus coverage level has a "true family" deductible.*** This means that the entire in-network family deductible must be met before your insurance will pay benefits for any covered family member. There is no "individual deductible" in this plan 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 Platinum coverage level generally does not have an in-network deductible**, but typically has the highest cost per paycheck. Please note, however, that there is a deductible for out-of-network services: $5,000 for individual coverage and $10,000 for family coverage.

***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. No member in the family will pay more than $3,000 towards the family deductible.

For information about your deductible in the dental and vision plans, please see the Make It Yours website at **https://equitable.makeityoursource.com**.

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

The annual out-of-pocket maximum is generally the most you and your covered family members would have to pay in a calendar year for health care costs.

It doesn't include amounts taken out of your paycheck for health coverage or certain copays or additional charges under the Silver, Gold, and Platinum coverage levels. It also doesn't include

amounts above the "allowed amount," which is the most a medical insurance carrier will pay for a service.

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 in-network individual out-of-pocket maximum, your insurance will pay the full cost of in-network covered charges for that covered family member. In-network charges for all covered family members will continue to count towards the in-network family out-of-pocket maximum. Once the in-network family out-of-pocket maximum is met, your insurance will pay the full cost of in-network covered charges for all covered family members.

  However, a separate out-of-network out-of-pocket maximum applies before your insurance will pay the full cost of covered services or supplies, up to the "allowed amount." The allowed amount is the maximum amount the insurance carrier allows for a covered service or supply. This means that even after you reach your annual out-of-network out-of-pocket maximum, you will continue to be responsible for paying the full amount of any out-of-network service or supply charge above the allowed amount.
- **The Bronze Plus coverage level has a "true family" out-of-pocket maximum.*** This means that the entire in-network 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 this option when you have family coverage. This means that you must collectively meet the family deductible before the medical option will pay benefits for any enrolled individual.

***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 out-of-pocket maximum.

Out-of-network charges do not count towards your in-network annual out-of-pocket maximum. They only count towards your out-of-network annual out-of-pocket maximum. The same applies for in-network charges; they do not count towards your out-of-network annual out-of-pocket maximum.

Important note about in-network out-of-pocket maximums versus out-of-network out-of-pocket maximums:

- **In-network out-of-pocket maximum.** Once you have reached your annual in-network out-of-pocket maximum, your insurance carrier will generally pay 100% for any covered in-network service or supply provided to you for the balance of the coverage year, subject to age and frequency limits.
- **Out-of-network out-of-pocket maximum.** The annual out-of-network out-of-pocket maximum works differently. It does not limit what you pay for charges that exceed the "allowed amount"—that is, the maximum amount the insurance carrier allows for a covered service or supply. This means that even after you reach your annual out-of-network out-of-pocket maximum, you will continue to be responsible for paying the full amount of any out-of-network service or supply charge above the allowed amount.

37. Why should I consider using in-network providers?

Seeing out-of-network providers will cost you substantially more than it would cost you if you obtained covered services or supplies from in- network providers. For example, you will pay more for a covered service or supply from an out-of-network provider through a higher out-of-network deductible and higher coinsurance. Also, the service may be more expensive. **You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the "allowed amount," even after you've reached your annual out-of-network out-of-pocket maximum.** The allowed amount is the most a medical insurance carrier will pay for a covered service or supply.

Each medical insurance carrier has its own methodology for determining allowed amounts for out-of-network providers. **Medical insurance carriers under the Aon Active Health Exchange typically use a Medicare-based reimbursement calculation. These Medicare-based allowed amounts typically are substantially lower than what may have been considered "reasonable and customary" in the past.**

If you use out-of-network providers, call the insurance carriers to determine what percentage of Medicare they pay. This can make a big difference in your costs. For example, let's say you have an out-of-network surgery that costs $5,000, and Medicare would pay $2,000:

- If your insurance carrier pays 100% of what Medicare would pay, you would owe the amount over $2,000, which is $3,000 ($5,000 – $2,000 = $3,000).
- If your insurance carrier pays 120% of what Medicare would pay, you would owe the amount over $2,400 ($2,000 x 120% = $2,400), or in this case, $2,600 ($5,000 – $2,400 = $2,600).

The higher the percentage of Medicare your insurance carrier pays, the less you will owe for covered out-of-network services.

38. What is an HSA?

An HSA (or Health Savings Account) is a tax-advantaged medical savings account that you can use when you enroll in a Bronze or Bronze Plus coverage level (HDHP–High-Deductible Health Plan). It allows you to set aside money pre-tax to pay for qualified health care expenses such as medical, dental, and vision copays, deductibles, and coinsurance. In the Bronze and Bronze Plus plans, you are responsible for 100% of your medical and prescription drug expenses (other than covered preventive medical care and preventive prescription medications) until you meet your deductible. An HSA is a great way to save money on out-of-pocket expenses because you're using pre-tax money.

Just make sure you only use money in your HSA for qualified health care expenses for you, your spouse and eligible dependents. For HSA purposes, your eligible dependents are different than for your medical plan. 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). Otherwise, you will pay income taxes on that distribution and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and the corresponding withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified. See the HSA User Guide for additional details.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute when you enroll, up to the applicable IRS annual limits. 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. 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.

You are solely responsible for ensuring that you do not over-contribute to your HSA, as penalties apply for over-contributions.

39. Am I eligible to contribute to an HSA?

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

- You enroll in an option at the Bronze or Bronze Plus coverage level, which are HDHPs;
- You cannot be enrolled in Medicare Part A or Part B 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 an HDHP (other than certain limited types of insurance, such as some AFLAC plans).

If you enroll in Bronze or Bronze Plus and you are also covered by a spouse's/partner's medical plan, special rules may apply to your HSA. See the HSA User Guide for additional details.

40. Can I enroll in both the HSA and a Limited Use Health Care FSA?

Yes. If you enroll in the Bronze or Bronze Plus plan, you can use an HSA, a Health Care FSA, or both an HSA **and** a Health Care FSA. If you have an HSA and a Health Care FSA, in order to contribute to an HSA, your Health Care FSA must be "limited use" and can only be used to pay for eligible dental and vision expenses. However, once you meet the annual combined medical and prescription drug deductible, then the Limited Use Health Care FSA can be used towards eligible medical and prescription drug expenses as well. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses. Be sure you understand the difference between an HSA and FSA. Most people generally do not elect both in the same year.

41. Why would I want to use both an HSA and Limited Use Health Care FSA?

Both an HSA and a Limited Use Health Care FSA allow you to pay for eligible expenses with pre-tax 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. The Limited Use FSA will allow you to carry over a minimum of $50 and maximum of $610 of unused funds each year. Any amount under $50 or over $610 at the end of the year will be forfeited if you do not have eligible expenses for reimbursement.

It may not be advantageous to enroll in both, except in unique situations. For example, if you expect to have higher expenses than your HSA balance can cover (based on the maximum you can contribute each year), you may also want to contribute to the Limited Use Health Care FSA to pay for

those expenses with tax-free money, once the medical deductible is reached or if you anticipate having higher dental and/or vision expenses in the upcoming calendar year.

Both the Limited Use Health Care FSA and HSA can only reimburse eligible expenses that are not otherwise paid or reimbursed by your HDHP or other primary insurance. Eligible expenses not paid or reimbursed by your HDHP or other primary insurance may only be reimbursed once from either the Limited Use Health Care FSA or HSA, but not both.

42. 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 investment gains and/or interest (as applicable), and will be available for qualified health care expenses at any time in the future. If you roll over your HSA from a previous employer into your Optum HSA, your former HSA vendor may charge a transfer fee.

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).

These FAQs are intended to provide you with the information about the Aon Active Health Exchange. These FAQs are not a comprehensive summary of the Health Plan provisions. Full details are contained in the official legal documents governing the Health Plan. If there is any discrepancy or conflict between the official legal documents and the information presented here or otherwise provided to you, the official legal documents will control. Nothing in these FAQs expands or augments your Health Plan eligibility or benefits beyond those provided under the Health Plan's official plan documents.

The Company always reserves the unrestricted right to modify, amend or terminate the Health Plan at any time and for any reason in whole or in part. Accordingly and without limitation, nothing in these FAQs should be construed as, and participation in the Health Plan should not be considered, a promise or guarantee of future benefits or of any level or amount of benefits. In addition, nothing in these FAQs is an employment contract or an offer, promise or guarantee of employment or contract for any duration.