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.

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The Aon Active Health Exchange™

1. What is an exchange?

An exchange is a way for you to get medical along with prescription drug coverage. It is an online insurance marketplace where buyers like you 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 choice and price competitiveness that comes from free-market competition.

The Aon Active Health Exchange is America's first national, large-employer, multi-insurance carrier exchange. Its website 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 medical coverage options for your circumstances and budget.

2. Is Aon's 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 applicable law and guarantees coverage for those eligible, regardless of pre-existing conditions.

3. What are the advantages of the exchange?

The medical along with prescription drug benefits available through the exchange offer you:

- **Lots of choices.** Traditionally, you got to choose from the health plan options offered by the company. Through the exchange, you're able to choose from several coverage levels, 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, Exela will provide an employer contribution (credit) to use 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 question #4 for details about tools and resources.

4. 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 **exela.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.
- **The Exela Health Benefits website**—When it's time to enroll, visit **exela.makeityoursource.com** and click **Enroll Now** to log in and compare your options and prices, get helpful decision support, and enroll.

  Questions? Once logged on to the Exela Health Benefits 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. For additional support, you can schedule an appointment with a customer service representative through the Exela Health Benefits website or call **1.877.772.7266 (press 2)** from 10:00 a.m. to 7:00 p.m. CST, 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 "**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.
- **The Exela Health Benefits 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 Alight Advocacy Services (Health Pros). Health Pros can explain how benefits work and help resolve issues.

Enrollment

5. What will I need to do?

You must enroll or you will not have medical coverage through Exela. Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either. And, to contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election.

To enroll, visit **exela.makeityoursource.com** and click **Enroll Now** to log in to the Exela Health Benefits website. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover under medical benefits in 2024.
- Choose the insurance carriers and coverage levels you want for your medical benefits.
- Make your dental, vision, HSA, and flexible spending account (FSA) elections for 2024.

Note: If you add new dependents, in order for them to be covered, you will be required to provide the necessary documentation to confirm their benefits eligibility.

My Options

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

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, and Gold. 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.

7. What happens if I enroll in a Bronze medical option and have expenses shortly after my coverage begins?

If you enroll in a high-deductible medical option (Bronze), 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. If you find you need more time to pay the provider, contact the provider directly (e.g., hospital, surgeon) to ask about setting up a payment plan if they allow for such arrangement.

8. 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, Blue Cross and Blue Shield of Texas, 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.

9. 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 Exela Health Benefits 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.

10. 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.

11. 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.

If your insurance carrier name includes a state, this refers to the location the carrier operates from (i.e., which state has primary jurisdiction over the laws, rules, and regulations the carrier follows). In general, it isn't a reference to the network—many offer coverage nationally.

12. 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 at **exela.makeityoursource.com** to access videos, details about your options, comparison charts, and more.

Then, when you enroll, you'll be able to see the employer contribution (credit) amount from Exela and your price options. 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 Exela Health Benefits 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. For additional support, you can schedule an appointment with a customer service representative through the Exela Health Benefits website or call **1.877.772.7266 (press 2)** from 10:00 a.m. to 7:00 p.m. CST, Monday through Friday.

13. 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.

14. How will my prescription drugs be covered?

Your prescription drug coverage will be provided—as part of your medical coverage—through your medical insurance carrier's pharmacy benefit manager. 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 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 carrier each year.** Visit the Make It Yours website for a list of questions to ask.

15. What is "prior review" 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 review" (also referred to as prior authorization 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 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 insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you don't get preapproved, 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.

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

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

Paying for Coverage

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

During the enrollment window, you'll be able to see the employer contribution (credit) amount from Exela and your price options when you enroll on the Exela Health Benefits website.

18. Do I get to keep the Exela employer contribution (credit) if I don't enroll in coverage?

No. The employer contribution (credit) you get from Exela is for the medical/prescription drug coverage you purchase through the exchange. A cash refund or credit for other benefits is not available.

19. 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.

The Bronze, Bronze Plus, Silver, 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 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.

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

The Bronze, Bronze Plus, Silver, 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.

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.

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

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

22. 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.
- You can invest your HSA balance that exceeds $1,000. Any investment earnings are tax-free as well.

23. 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.

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

Yes. If you enroll in the Bronze coverage level, 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 purpose" and can only be used to pay for eligible dental

and vision expenses. However, once you meet the medical deductible, then it can be used toward eligible medical and prescription drug expenses as well. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses.

25. 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.

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 purpose Health Care FSA to pay for those expenses with tax-free money once the medical deductible is reached.

26. 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 be considered other health coverage and you would not be eligible to contribute to an HSA.

27. 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 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.

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).