FAQs

Click on a question below to be taken directly to the answer.

The Aon Benefit Experience

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

The Aon Benefit Experience (BenX) is a way for you to get medical, dental, vision, and other 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. BenX merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

BenX is America's first national, large-employer, multi-insurance carrier marketplace. The 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 coverage options for your circumstances and budget.

2. What are the advantages of BenX?

The medical and **prescription** drug, dental, and vision benefits available through BenX offer you:

- **Lots of choices.** Through BenX, 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 rates.

In addition, you have the option to enroll in other benefits that might be valuable to you—including supplemental life and disability insurance, supplemental medical insurances (i.e., critical illness, hospital indemnity, and accident), legal services, and identity theft protection. Also, you can get discounted rates for auto and home insurance, pet insurance, and international vacation medical coverage.

Finally, you also have help choosing and using your benefits. There are great tools and resources to help you every step of the way. See question #3 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	After you enroll
Make It Yours website	Learn about what coverage options you may have, and tips for choosing the right coverage for you. From the home page of the **My Health Benefits** enrollment website, click the ***Make It Yours*** tile.	Visit year-round for practical tips that help you to get the most out of your benefits. Click, "The Inside Scoop" to learn how to work the health care system, be a savvy shopper, and even save money.
Your Carrier Connection *(a section within the **Make It Yours** website)*	Access carrier preview sites here to get up to speed on provider networks, prescription drug information, and other carrier resources. You can contact **insurance carriers** directly with specific questions.	Take advantage of all 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. (contact information is available on **Your Carrier Connection** website).
My Health Benefits enrollment website	During enrollment log on to the **My Health Benefits** enrollment website or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options, get helpful decision support, and enroll.	**Once coverage begins:** Access your personalized coverage details and manage your benefits throughout the year.

	Before and during enrollment	After you enroll
	You'll also see the credit amount from Tapestry and rates by option. If you need additional help, you can reach a customer service representative by web chat or schedule an appointment through the **My Health Benefits** enrollment website. You can also call the **My Health Benefits Center** at **833-692-6387 (833-MYBNFTS)**, Monday through Friday, from 9:00 a.m. to 6:00 p.m. ET. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.	If you need help with more complex coverage issues, call the **My Health Benefits Center at 833-692-6387 (833-MYBNFTS)** and ask to be connected with a Health Pro. Health Pros help you with billing concerns, resolve issues, and help you understand how benefits work. For bill negotiation, contact MCA and speak to a representative at **201-891-8989, Monday through Friday**, from 9:00 a.m. to 6:00 p.m. ET.

Enrollment

4. How do I enroll?

To enroll, log on to the **My Health Benefits** enrollment website or the Alight Mobile app during the enrollment period. Click the "get started" tile to begin enrollment.

5. How do I create my user ID and password for the My Health Benefits enrollment website?

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

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

6. How do I reset my password for the My Health Benefits enrollment website?

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

7. What happens during enrollment?

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

- Enroll any eligible dependents you want to cover in 2025. If you are enrolling dependents, you will need to enter your dependent and beneficiary information, including Social Security number and date of birth.

  Please note: If you are adding a dependent to coverage, you will be asked to submit documentation to confirm dependent status if they were not verified earlier this year. Once the election is made, you will have 60 days to submit this documentation. If documentation is not submitted, or is insufficient, the dependent will be dropped from coverage. If you have any questions or concerns, please reach out to the My Health Benefits Center at 833-692-6387 and mention Dependent Verification in the automated system to be routed appropriately.

- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits.

You can get information about the enrollment process and available tools by logging on to the **My Health Benefits** enrollment website and clicking the ***Make It Yours*** tile.

8. What happens if I don't enroll?

If you don't enroll you will not have medical, dental, or vision coverage. To contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account for 2025, you must actively enroll.

My Options

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

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

10. How much will each option cost?

The amount you pay for coverage will depend on several factors, including where you live, which option and carrier you choose, and which family members you enroll. You can find out how much you'll pay in 2025 by accessing the interactive pricing tool available on the Loop, under HR> Benefits>United States>Quick Links>Benefits Cost Per Paycheck>2025 US Medical Dental and Vision Rates.

11. What happens if I enroll in a Bronze Plus or Silver 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 out-of-pocket up to the amount of your deductible right away—in case you have significant medical expenses shortly after the plan year begins.

When enrolled in a high-deductible medical option, you're eligible to enroll in an HSA. 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 qualified expenses out of pocket and then, when your account balance grows enough to cover the expense, reimburse yourself from your HSA.

It's particularly important to make sure you save enough money for unexpected medical expenses when enrolled in a high-deductible option. **Learn about HSAs**.

12. 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.

Learn more about your California coverage options and insurance carriers on the **Make It Yours** website at **tapestry.makeityoursource.com**.

13. Will I be able to use the same doctors and hospitals as I do today?

This depends on which carrier you choose. 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 them in its network. If you can or want to change 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 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 Health Benefits** enrollment 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 will need to call the insurance carrier.

14. Why should I use in-network providers?

Seeing out-of-network providers may 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 won't cover out-of-network services at all.

15. 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 (Aetna, Anthem, Cigna except in California, or UnitedHealthcare) that offer national provider networks so that your dependents have access to in-network providers in most locations.

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.

16. 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. Here's a few steps you can take to make the best decision:

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

2. When you enroll on the **My Health Benefits** enrollment website or the Alight Mobile app, use the "Help Me Choose" feature to evaluate the different components of your options and identify the best choices for you.
3. As you consider your options, take note of the credit amount from Tapestry and your rate options to make sure you're choosing options right for your budget.
4. If you need additional help, reach a customer service representative by web chat or by scheduling an appointment through the **My Health Benefits** enrollment website. You can also call the **My Health Benefits Center** at 833-692-6387 (833-MYBNFTS), Monday through Friday, from 9:00 a.m. to 6:00 p.m. ET. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

17. Will pre-existing conditions be covered?

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

18. How will my prescription drugs be covered?

Your prescription drug coverage will 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 an insurance carrier.

If you or a covered family member regularly take medication, please call the medical insurance carrier before you enroll to be sure you 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. Visit the **Make It Yours** website for a **list of questions** to ask.

19. 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. Getting "prior review" (also known as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensures you're getting care that makes sense for your condition, and confirms how the bill will 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 have to pay most or **all** the bill. 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.

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

Just like 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' network(s). To see whether your dentist is in network:

- Before enrollment, check out the **insurance carrier** preview sites.
- During enrollment, check the networks of each insurance carrier you're considering on the **My Health Benefits** enrollment website. You'll be able to use the "Help Me Choose" feature, which will indicate if your provider(s) are in or out of network.

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 network. Platinum networks could be considerably smaller than others, 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.

21. 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:

- Before enrollment, check out the **insurance carrier** preview sites.
- When you enroll, check the network of each insurance carrier you're considering on the **My Health Benefits** enrollment website.

22. What other benefit options are available to me?

You can choose to supplement your medical coverage with:

- **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 lump-sum benefit in the event you or a family member covered under this plan is hospitalized
- **Accident insurance:** Pays a lump-sum benefit to help cover your needs in the event you or a family member covered under this plan is in an accident (such as transportation costs if you suffer a broken foot and can't drive)

You can also choose to enroll in:

- **Supplemental life insurance:** Protects your family financially in the event of a death
- **Supplemental long-term disability coverage:** Provides you with additional income, on top of basic long-term disability coverage, if you are disabled for more than 180 days
- **Legal services:** Covers attorney fees for things like divorce and separation, real estate matters, and more
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud

You can get detailed information about these benefits on the **Make It Yours** website.

23. What else is available to me?

We are able to take advantage of group negotiated discounts for:

- **Auto and home insurance:** Special group rates and policy discounts on auto and home insurance
- **Pet insurance:** Assists in paying veterinary expenses for your sick or injured pet
- **International vacation medical:** Covers any medical needs that arise during non-work-related travel outside the United States. For information regarding medical coverage for work-related travel, please **visit the Travel Medical Coverage page on the Loop**.
- **Bill negotiation services:** Assistance reviewing out-of-network medical bills, negotiating medical bill costs with doctors and hospitals, and creating a payment plan for medical-related expenses

You can get detailed information on these offerings on the **Make It Yours** website.

Paying for Coverage

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

During the enrollment window, you'll see the credit amount from Tapestry that will apply to your cost of coverage and the costs of different plans.

Before the enrollment period starts, you can find out how much you'll pay in 2025 by accessing the interactive pricing tool available on the Loop, under HR>Benefits>United States>Quick Links>Benefits Cost Per Paycheck>2025 US Medical Dental and Vision Rates.

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

No. The credit you get from Tapestry is for the medical and dental coverage you purchase. A cash refund or credit for other benefits is not available.

26. 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 what the 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 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 these coverage levels when you have family coverage.

  For example, if you choose a Bronze Plus or Silver coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, then, 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.

For all coverage levels, out-of-network charges do **not** count toward your in-network annual deductible; they only count toward your out-of-network deductible, or the amount you pay out of your own pocket for out-of-network providers before your insurance carrier pays a share of your costs.

[1]**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 deductible.

27. 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 Gold and Platinum coverage levels.

How the annual out-of-pocket maximum works depends on your coverage level:

The 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."[1] 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.

For all coverage levels, 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 or Silver coverage level, you will have a *traditional* annual out-of-pocket maximum.

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

An HSA is a special bank account that you can have when you enroll in a Bronze Plus or Silver coverage level. It allows you to set aside 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 Plus or Silver coverage level, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Make sure you use money in your HSA only for qualified health care expenses. See the following question for more information on the importance of this.

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 will stay in your account year to year and earn tax-free interest. Some people use HSAs to save for medical expenses in retirement. If you have questions about an HSA as it applies to your specific situation, you should consult a tax professional.

29. What do I need to know about taxes and my HSA?

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out, lowering your income.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on the HSA dollars when you use them to pay eligible expenses.
- If you use money in your HSA for ineligible expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65.
- Keep records of your health care expenses and withdrawals from your HSA in case you ever need to provide proof that your expenses were eligible.

30. 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**.**

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

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

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

The links to the enrollment site in this copy are SSO links that utilize your Tapestry credentials. You can also reach the enrollment site here by creating a username and password for the enrollment site.