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2026 Acuity U.S. Benefits Open Enrollment

Frequently Asked Questions

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Your Benefits Marketplace

1. What is your benefits marketplace?

Your benefits marketplace is a way for you to get medical (including prescription drug), dental and vision insurance coverage. It is a way for you to shop for coverage from multiple health insurance carriers who are competing for your business. It merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition. Through the marketplace, FTI is providing the means for employees to have multiple options when purchasing insurance coverage for themselves and for their families.

2. How does a benefits marketplace work and what advantages are offered?

The medical (including prescription drug), dental and vision benefits available offer you:

- **Lots of choices and more flexibility.** You're able to choose from at least four medical insurance carriers, which may vary based on your region, and from four coverage levels with a range of costs: Bronze Plus, Silver, Gold and Platinum.

What does this mean for you? Simply put, you have the *option* to:

- Select a network plan that includes your preferred doctors.
 - Choose the level of coverage that makes the most sense for you and your family.
 - Reduce your out-of-pocket costs, depending on your coverage selections and your individual needs.
- **Competitive pricing.** Insurance carriers are competing for your business, so it is in their best interest to offer the best prices. It merges the best of both worlds: group rates with more individual choice and the price competitiveness that comes from free-market competition. By design, this helps slow the upward trend of total healthcare costs.
 - **Help when you need it.** There are great tools and resources to help you every step of the way. These include:
 - Make It Yours website: The **Make It Yours** website is the resource that can help you:
 - Review various **plan details**.
 - Compare your costs with the **Interactive Pricing Tool**.
 - **Refer to previous communications you received for the access code.**
 - **Watch videos** to learn about your benefits marketplace.
 - Browse **The Inside Scoop** resources for information on how to be a smarter healthcare consumer.
 - Get answers by browsing Frequently Asked Questions ("FAQs").
 - **Insurance carrier "preview" websites:** Available via Your Carrier Connection on the **Make It Yours** website, these sites assist in getting you up to speed on provider networks, prescription drug information and other carrier resources.
 - **Open Enrollment website:** During the Open Enrollment period (October 10 through October 27), you will enroll on the **FTI Benefits Center** website or the Alight Mobile app (available through the **Apple App Store** or **Google Play**), as well as have access to decision support tools to help you make your choices. Further, the insurance carriers and the FTI Benefits Center will be available to answer questions.
 - **FTI Benefits Center:** Call **1.844.249.8586**, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET. The customer service representatives at the FTI Benefits Center are available to help answer your questions about FTI's benefits and the enrollment process. They can help connect you with insurance carriers for any questions that are better answered directly by the carrier. During the Open Enrollment period, you may schedule an appointment time to speak with an FTI Benefits Center representative. Simply log on to the FTI Benefit Center website and look for the appointment link. You will be guided through the process to pre-schedule a convenient day and time for your call. The representative will call you at the number you provide.

3. Where can I get more information?

Details of where to find information on your benefits and enrollment resources are listed below.

Before and During Enrollment:

- **Make It Yours website** (2026 information will be available on October 6): Visit acuity.makeityoursource.com to learn about your coverage options and choosing the right coverage for you and your family.
- **Your Carrier Connection** (available through the Make It Yours website): Each insurance carrier has an available website that you may visit prior to becoming a member of the insurer. Visit these preview websites, using the provided links, so that you may get up to speed on provider networks, prescription drug information, and other insurance carrier resources.
- **Interactive Pricing Tool** (available through the Make It Yours website): Before your enrollment period starts, take advantage of the **Interactive Pricing Tool** to help you compare the costs of your healthcare options. Refer to previous communications you received for the access code.
- **The FTI Benefits Center website and Alight Mobile app**: When it's time to enroll, log on to **FTI Benefits Center** website or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options and prices, use helpful decision support tools like Help Me Choose, and enroll.
- **FTI Benefits Center**: If you need additional support, once logged on to the **FTI Benefits Center** website, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. Customer service representatives are available through online chat or the FTI Benefits Center at **1.844.249.8586**, or **1.312.843.5256** for international callers, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET. You may also schedule an appointment time to speak with an FTI Benefits Center representative. Log on to the **FTI Benefits Center** website and look for the appointment link. You will be guided through the process of picking a convenient day and time for your call. The representative will call you during your pre-scheduled appointment time at the phone number you provide.

Managing your benefits beginning January 1:

- **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 insurance carrier. They know their plans best and have the final authority on all claims, billing disputes, etc.
- **The FTI Benefits Center website and Alight Mobile app**: Access your personalized coverage details and manage your benefits throughout the year.
- **Your carrier's mobile app and member website**—The carriers have mobile apps and member websites that connect you to a host of tools and resources including virtual care, mental health and wellbeing programs, and tools to look up potential costs for care.
- **Additional support**: If you need help with more complex coverage issues, call the FTI Benefits Center at **1.844.249.8586**, or **1.312.843.5256** for international callers, and ask to be connected with a Health Pro who can explain how benefits work and help resolve issues you may be experiencing.

Paying for Coverage

4. Will I have to pay a lot out of my paycheck for medical coverage?

You decide how much coverage you want to buy. It gives you the opportunity to choose the coverage level you want from the insurance carrier you want. There are other factors that impact how much you pay, including your contribution from FTI and how many family members you cover. The result is that you could end up paying less — or more — for coverage than you do today.

Please note: You'll pay the cost of medical, dental and vision coverage with before-tax dollars.

5. How can I compare plans and find pricing before enrolling?

Before the Open Enrollment period starts, take advantage of the **Interactive Pricing Tool** to compare costs of healthcare options based on your needs. You can even see how costs stack up against other coverage options available.

Refer to Open Enrollment Refer to open enrollment emails you received for the access code. During Open Enrollment, you will be able to see your price options on the **FTI Benefits Center** website or the Alight Mobile app.

To track your personal healthcare spending for 2026, visit your insurance carrier's website to view their tools and resources that will help track your claims.

Open Enrollment

6. What will I need to do?

Between **October 10 and October 27, you must enroll**, or you will not have coverage for medical (or prescription drug), dental or vision insurance through FTI for 2026. To contribute to a health savings account ("HSA") (if eligible), you must also make an active election during Open Enrollment.

To enroll, log on to the **FTI Benefits Center** website or Alight Mobile app during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2026.
 - Confirm that the information for your dependents is listed correctly and select the dependents you wish to cover for each benefit plan in 2026.
- Choose the insurance carriers and coverage levels you want for your medical, dental and vision benefits.
- Contribute to an HSA if you are enrolling in the Bronze Plus or Silver plan.

Once Open Enrollment ends, you will be mailed a summary of your benefit elections in early November to review your benefits that will be effective January 1.

My Options

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

Four coverage levels are offered to you: Bronze Plus, Silver, Gold and Platinum. Each coverage level is available from multiple insurance carriers at different costs. Prior to making your selection, you'll be able to compare benefits and features across your medical options via the **Interactive Pricing Tool** on the **Make It Yours** website.

8. Will my elections from 2025 carry over automatically for 2026 coverage?

Your medical, dental, vision and HSA **DO NOT** automatically roll over into the new year. You must take action and re-enroll for those plans if you wish to continue coverage.

9. Does medical coverage differ among insurance carriers?

In general, at each coverage level, carriers have agreed to the majority of standardized plan benefits. The **FTI Benefits Center** website provides a more detailed look at these and additional coverage details — and does account for some carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the plans you want to review and click **Compare**. Call the carrier directly to get the most comprehensive information about any specific coverage.

When medical plan changes are requested to be made by all insurance carriers, there are occasions when not all carriers are able to comply with the requested changes. This can be due to state insurance filings, system/provider/contracting limitations and/or interpretation of federal/state mandates. Please check with your insurance carrier for specific details on coverage availability.

Please note: For additional comparison, select **Summaries of Benefits and Coverage** on the **FTI Benefits Center** website.

10. What happens if I enroll in a Bronze Plus or Silver medical option and have expenses early in the year before I have funds in my HSA?

If you enroll in a high-deductible medical option (e.g., the Bronze Plus plan or Silver plan), you should be prepared to pay up to the cost of your deductible — in the case that you have significant medical expenses shortly after the plan year begins. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover unexpected medical expenses early in the year.

- One option is to pay for early qualified expenses out-of-pocket and then, when your account balance grows enough to cover the expenses, reimburse yourself from your HSA. This is a good reason to make sure you are saving enough in your HSA.
- Additionally, **providers/facilities are often willing to set up payment plan agreements** with participants for significant medical expenses. For medications not covered under your current benefits, you can also check the drug manufacturer's website as **the manufacturer may offer additional discounts or payment options** directly to the consumer.

11. I live in California. Are my medical options different?

The options for California residents will be different, depending on the insurance carrier you choose.

Insurers in California choose to offer coverage either as a preferred provider organization ("PPO") style plan (i.e., offering in- and out-of-network benefits) or as a health maintenance organization ("HMO") style plan (i.e., offering only in-network benefits). There may be a few carriers offering coverage as a PPO-style plan and a few carriers offering coverage as an HMO-style plan — you may choose among all these options.

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 HMO-style plan.

Find additional details on the [California page](#) of the [Make It Yours](#) website.

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

Each **insurance carrier** has its own network of preferred providers (e.g., doctors, specialists and 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 your current insurance carrier is available, the provider network offered by the insurance carrier 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' networks. To see whether your doctor is in the network:

- Check out the **insurance carriers'** preview websites
- When you enroll, check the networks of each insurance carrier you're considering on the [FTI Benefits Center](#) website. You can access this information by using the Help Me Choose tool's provider search or 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.

Please Note: 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.

13. Why should I use in-network providers?

Seeing out-of-network providers will 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.

14. 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.)

At least one national insurance carrier will be offered in all states. These carriers are Aetna, Cigna, UnitedHealthcare and CareFirst. Some states will have insurance carrier options that are regionally specific, in addition to the national carriers.

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

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

A number of resources are available to help you make smart decisions when selecting a medical plan. You should start by visiting the **Make It Yours** website where you can:

- Review various plan details.
- Compare your costs with the **Interactive Pricing Tool**; refer to previous communications you received for the access code.
- **Watch videos** to learn about your benefits marketplace.
- Browse **The Inside Scoop** resources for information on how to be a smarter healthcare consumer.

Once the enrollment period begins, you'll be able to see the contribution amount from FTI and your price options live on the **FTI Benefits Center** website. You'll also be able to access tools, such as **Help Me Choose**, that give you personalized suggestions, help compare the details of your options and more.

If you need additional help during the Open Enrollment period, once logged on to the **FTI Benefits Center** website, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. Customer service representatives at the FTI Benefits Center will be available Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET at **1.844.249.8586** to answer questions about the enrollment process. You can also call the **insurance carriers** directly with specific questions about the options they offer.

16. In the Platinum plan, why are the deductible and out-of-pocket maximum so high for out-of-network care?

The higher out-of-network deductible is an intentional plan design component of the Platinum medical plan. The plan is designed to provide a richer level of benefits for use of in-network care. Minimizing the out-of-network benefits allows the plan to maximize the cost of premium on potential out-of-pocket expenses. As such, when considering the Platinum medical plan, it is important to determine if the doctors you use most frequently are in-network to maximize the benefit of the Platinum coverage.

17. When would Platinum be a good choice for an employee?

In almost all cases, a selection of Bronze Plus or Silver would be better options from a purely financial perspective. However, there are times when personal preferences and level of risk tolerance will weigh heavier in the decision process. In this situation, a selection of the Gold or Platinum plan may be preferred as these plans have more predictable costs for medical visits due to having to pay a flat co-payment for each visit. For someone who leans toward these preferences and has the potential to use more in-network services, the Platinum plan could be a reasonable choice if the payroll premium is not cost prohibitive.

If you previously enrolled in a Gold or Platinum plan and would like additional information about your total healthcare costs compared to a Bronze Plus or Silver plan, you are encouraged to use the Help Me Choose online decision tool on the **FTI Benefits Center** website.

18. Will pre-existing conditions be covered?

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

19. 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.

If you or a covered family member regularly takes medication, it is strongly recommended that you review your prescription coverage before selecting your insurance carrier. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. There are several ways to better understand how your particular prescription drug(s) will be covered.

Prior to Open Enrollment:

- Visit the insurance carrier's "preview" websites available via the **Make It Yours** website.
- Call the insurance carrier to ask about details on their prescription coverage formulary.
 - A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration ("FDA") and are covered under your prescription drug plan.
- Review the **Make It Yours** website for **helpful questions** on what to ask the insurance carrier.

During Open Enrollment:

- The options listed above will continue to be available.
- Use the **Help Me Choose** online decision tool on the enrollment website to enter your specific prescription and the search results will show you which insurance carrier covers your prescription and at what amount.
- Call the **FTI Benefits Center** to speak with a representative about the options and prescription coverage Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET at **1.844.249.8586**, or **1.312.843.5256** for international callers.

20. When does the brand name prescription penalty apply and is there a way to avoid the penalty?

All insurance carriers, other than Kaiser, apply a "penalty" when requesting a brand name (Tier 2 or 3) drug that has an available generic equivalent. This penalty is an additional cost that is equivalent to the cost differential between the brand name drug and the generic equivalent. The penalty is generally referred to as a dispense as written ("DAW") penalty. You may still receive the brand name drug but will pay more than your plan's coinsurance or copay amount.

When selecting a brand name drug that has a generic equivalent available, you will pay your regular coinsurance amount or copay (depending on your selected plan design) PLUS you will pay the drug cost difference between what the plan would pay for the brand name drug versus the generic drug. For example, if the brand name drug costs the plan \$200 and the generic equivalent costs the plan \$20, you pay the cost differential of \$180 plus your copay or coinsurance. However, you will not pay more than the full cost of the brand name drug.

There are circumstances when the brand name drug is the only medically sound option for the covered person. If you or one of your dependents cannot take the generic equivalent drug, you will need to work with your selected insurance carrier to request an exception to the penalty rule, if available. Each insurance carrier will have a different process for requesting an exception. And, if an exception is granted, it will expire following your insurance carrier's rules and you will need to reapply for a new exception. Please reach out to your selected insurance carrier to learn whether an exception process is available and, if so, what the process requirements are.

It is strongly recommended that before you enroll, check to see how your medication will be covered, whether it is with your current carrier or a newly selected carrier. When you enroll, review how your prescription drugs will be covered in the formulary by using the Prescription Drug Search and the Help Me Choose tools on the **FTI Benefits Center** website. You may also call your insurance carrier before Open Enrollment to confirm coverage for your specific prescriptions.

21. When certain medical care is needed, what is “prior review” or “prior authorization,” and when is it required?

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting “prior review” (also referred to as “prior authorization” or “precertification”) allows the carrier to make sure you are eligible for the services, ensure that you are 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 using providers that are in-network with the insurance carrier, your doctor usually completes the process on your behalf when it is required, but you should always confirm with your doctor to be sure they are handling it.
- When using providers that are 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 do not get pre-approved, you could get stuck paying most or all of the bill or paying a penalty. For that reason, it is 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.

22. How are out-of-network medical charges handled when they are above the carrier’s reasonable and customary amount? Do these charges apply to the out-of-pocket maximum?

If your insurance carrier pays for part of your out-of-network charges, those charges will be applied to your deductible and out-of-pocket expenses. Amounts not covered by the insurance carrier will not apply to your out-of-pocket maximum under your selected plan.

It is important to understand how insurance carriers manage out-of-network charges from your medical provider. Many of the plan choices you have provide for some level of coverage when you receive care from providers not covered in your insurance carrier’s network. When you use an out-of-network provider, it is important to know that insurance carriers may differ in how they determine the level of available coverage for services received. Many insurance carriers develop their own reasonable and customary (“R&C”) allowable charges. Other insurers will use a payment percentage from Medicare’s fee schedule for providers.

- **R&C charges:** Most plans pay for out-of-network care based on a percentage of R&C charges. These R&C charges reflect what providers typically charge for a specific procedure in a given geographic area. Health plans make their own decisions about what is reasonable and customary.
- **Medicare fee schedules:** Medicare’s payments are usually lower than payments from commercial health insurers. Some insurance plans use Medicare fees as a basis for reimbursing service for out-of-network providers. They then multiply that fee by a certain percentage (e.g., 110%) to set the maximum amount that they will pay for that procedure. The rate is often less than what your doctor charges.

Charges for out-of-network claims that exceed what your insurance carrier covers as part of the R&C or Medicare fee calculations may be balanced-billed by your medical service provider. Your medical provider could lower or absorb some of the excess cost, but that is up to your provider.

If you and your family routinely receive care from out-of-network providers, it is extremely important that you understand how your selected insurance carrier manages out-of-network provider payments. Please contact your selected insurer for specific details.

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

Just like the medical insurance carriers, each dental carrier has its own provider networks that can vary by the coverage level you choose. If it is important that you continue using the same dentist, you should check to see whether your dentist is in the insurance carrier’s network before you choose a carrier. As a reminder, it is important to check this each year as dentists within your network can change.

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

- Check out the **insurance carriers'** preview sites.
- Before enrolling, check the networks of each insurance carrier you are considering on the **FTI Benefits Center** website as well as any plan design changes on the **Make It Yours** website.

If you are considering a Platinum dental option:

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

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

Each vision insurance carrier has its own provider networks. If it is 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 insurance carrier's network before you choose a carrier. As a reminder, it is important to check this each year as vision providers within your network can change.

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

- Check out the **insurance carriers'** preview sites.
- When you enroll, check the networks of each insurance carrier you are considering on the **FTI Benefits Center** website.

25. What is Alight Health Pro Advocacy service?

You have access to benefits experts who will, at no cost to you, help with resolving claims and billing issues, understanding what's covered, and much more. Advocacy was created to take the burden of health care problems off your hands—and into the hands of benefits experts. Advocacy is a confidential program offered through FTI at no cost to you. You can call the FTI Benefits Center and ask to speak with the Advocacy team for help with resolving your health care issues.

After you connect with your advocate and explain your issue, they will take it from there. Your advocate will provide regular updates until your issue is resolved. For urgent situations, they will start working right away to resolve the issue.

Your advocate will contact your insurance company, doctor, pharmacy, or medical facility to reach the best solution possible. They will deal with benefits and insurance issues, while you focus on what's important in your life. Think of your advocate as your personal health care expert.

Some issues that Advocacy Health Pros can assist you with are:

- Helping with a medical insurance issue
- Getting answers to questions about coverage for a specific doctor visit, procedure, or treatment
- Preparing to talk with your physician during an upcoming appointment—know the questions to ask!
- Making sense of your doctor or hospital bill, including your Explanation of Benefits statement
- Finding a doctor, hospital, or pharmacy to get the best care at the right cost
- Resolving insurance claims and billing disputes
- Navigating Medicare

For assistance, email your Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530** Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

Health Savings Account

26. What is a Health Savings Account (“HSA”)?

An HSA is a special bank account, fully funded with your tax-free contributions, that you may establish when you enroll in a Bronze Plus or Silver medical plan. It allows you to set aside tax-free money to pay for qualified healthcare 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 medical plan, an HSA is a great way to pay less for those out-of-pocket expenses because you are using tax-free money. You can use your HSA funds to pay for eligible health care costs now or in the future, tax-free. It’s never too early to start saving for future health care needs.

Just make sure you use money in your HSA only for qualified healthcare 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 are under age 65. Keep careful records of your healthcare 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 money you want to contribute. If you don’t use all your HSA funds in the calendar year, 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 personal needs, consult a tax professional.

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

- You must be enrolled in a high-deductible medical option at the Bronze Plus or Silver coverage level.
- You cannot be enrolled in Medicare or a veteran’s medical plan (TRICARE).
- You cannot be claimed as a dependent on someone else’s tax return.
- 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’ healthcare expenses if 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).

27. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified healthcare 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 use all your HSA funds in the calendar year, your money can stay in your account year-to-year.

An HSA has the following tax advantages:

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

28. 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 healthcare coverage and you would not be eligible to contribute to an HSA.

29. What company is managing the HSA?

The HSAs offered are administered by Bank of America. You can transfer any HSA balances from other administrators into your Bank of America HSA and save the hassle of managing two or more accounts and paying additional account fees. You will be provided with directions for opening your new account and for transferring funds after you enroll. There are no tax penalties for transferring money from one HSA to another.

30. If I set-up an HSA while enrolled in the Bronze Plus or Silver plan but then enroll in Gold or Platinum, what happens to the funds in my account?

You may still use the funds in your HSA if they are used for eligible healthcare expenses. However, while enrolled in the Gold or Platinum plan you are not eligible to contribute to your HSA as these plans are not high-deductible plans.

31. Can I contribute to an HSA if I am Medicare Eligible?

If you are enrolled or entitled in Medicare Part A or B, you can no longer contribute to an HSA as of the month in which your Medicare coverage begins. However, you can continue to withdraw money from your HSA once you enroll in Medicare if you use your account funds for eligible medical expenses such as deductibles, copayments, coinsurances and Medicare premiums. However, if you met the requirements for Medicare but have not yet applied, you may continue to contribute to an HSA if you maintain enrollment in a high deductible health plan, such as the Bronze Plus or Silver plan. If you are entitled to Medicare because you signed up for Medicare Part A at age 65 or later and have applied for social security, you may not contribute to an HSA. Given the various decision points and tax implications when you or your spouse are approaching age 65, we recommend that you seek the advice of a tax advisor before making any decisions regarding Medicare and company-sponsored healthcare plans.

32. Can I participate in both an HSA and a Health Care FSA in the same year?

No. IRS rules do not allow you to contribute to a Health Savings Account ("HSA") and a general-purpose Health Care Flexible Spending Account ("FSA") in the same year. Both accounts cover the same types of medical expenses and having both would make you ineligible to contribute to an HSA.

If you enroll in the Bronze Plus or Silver medical plan and want to contribute to an HSA, you cannot enroll in the Health Care FSA for that year.

33. Why do I have to validate my identity for Bank of America to set up my HSA?

HSAs are covered by the U.S. Patriot Act which has strict guidelines in place for verifying the account holder's identity. As part of the verification process, Bank of America must verify the customer's name, physical address, date of birth and SSN. To ensure your account remains active, please provide the requested documentation back to Bank of America.

Sources:

- <https://www.selectaccount.com/wp-content/uploads/HSA-Toolkit-Medicare.pdf>
- <https://www.medicareinteractive.org/get-answers/types-of-medicare-advantage-plans-hmos-ppos-and-more/health-savings-accounts-hsas-and-medicare/health-savings-accounts-hsas-and-medicare>