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.

The Aon Active Health Exchange™

1. What is a health care exchange?

A health care exchange is a way for you to get medical, dental, vision, and other voluntary coverages. 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.

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?

- **Lots of choices.** Each employee can shop and choose from several coverage levels, a wide variety of insurance carriers, and a range of costs.
- **Tools you can use.** The decision support tool guides you step-by-step in making your enrollment decisions. You can easily decide what type of coverage is needed for you and your eligible dependents and how much you want to pay. It's like an online shopping experience with state-of-the-art customer support including a virtual assistant, web chat and live representatives to assist with any questions you may have.
- **Competitive pricing.** The insurance carriers are competing for your business, so it's in their best interests to offer their best prices.
- **Helpful resources.** In addition to employee meetings, there will be great resources to help before, during, and after enrollment.

  The TKC Benefits Portal and Alight Mobile app: After reviewing the information available on the **Make It Yours** website, you can then make your elections during the enrollment window. Employees will enroll through the TKC Benefits Portal or the Alight Mobile app, as well as have access to customer support including a virtual assistant, web chat, and more.

In addition to medical, dental, and vision benefits, employees will have the option to enroll in other valuable benefits—including voluntary life insurance, disability, flexible spending accounts, HSA, vacation buy-up (formerly Purchased PTO), critical illness insurance, hospital indemnity insurance, accident insurance, legal services, and identity theft protection.

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 **tkcbenefitssolution.makeityoursource.com** to learn about the exchange, your coverage options, and choosing the right coverage for you and your eligible dependents.
- **Your Carrier Connection** (available through the **Make It Yours** website)—Visit each carrier's preview site to educate yourself on provider networks, prescription drug information, and other carrier resources.
- **The TKC Benefits Portal and Alight Mobile app**—When it's time to enroll, log on to the TKC Benefits Portal at **digital.alight.com/mytkcbenefits** or the Alight Mobile app (available through the Apple App Store or Google Play, search for "Alight Mobile app") to compare your options and prices, get helpful decision support, and enroll.

  Questions? Once logged on to the TKC Benefits Portal, 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 care representative through the TKC Benefits Portal. You can also call the TKC Benefits Service Center at **1.844.360.4718** from 9:00 a.m. to 6:00 p.m. CT, Monday through Friday.

Managing your benefits throughout the year:

- **The Make It Yours website**—Visit year-round for practical tips that help you and your eligible dependents 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 TKC Benefits Portal and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.

Enrollment

5. What will I need to do?

You must enroll or you will have **NO COVERAGE** through TKC Holdings this year. Keep in mind that if you don't select medical coverage, you won't have prescription drug coverage or the benefit credit either. To contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election.

To enroll, log on to the TKC Benefits Portal at **digital.alight.com/mytkcbenefits** or the 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 2024.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits.

6. What is my user name and password for the TKC Benefits Portal and Alight Mobile App?

Use your UltiPro user name and password. If you need assistance with your user name and/or password, use the TKC IT Portal at help.tkcholdings.com.

My Options

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

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

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

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

9. 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, Anthem, 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.

10. 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.

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

- Review the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the TKC Benefits Portal. 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 travel to.
  - 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.

11. Why should I use in-network providers?

Seeing out-of-network providers will very likely cost you substantially more than seeing in-network providers. For example, you will pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum. And, certain Platinum options (and certain options/carriers in California) won't cover out-of-network services at all.

12. How should I choose a medical insurance carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offer national provider networks so that your dependents have access to in-network providers in most locations. (Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.)

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

13. 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 **tkcbenefitssolution.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 amount from TKC Holdings and your price options on the TKC Benefits Portal at **digital.alight.com/mytkcbenefits** or the Alight Mobile app. You'll also be able to access tools that will give you personalized suggestions, 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 TKC Benefits Portal, 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 care representative through the TKC Benefits Portal. You can also call the TKC Benefits Service Center at **1.844.360.4718** from 9:00 a.m. to 6:00 p.m. CT, Monday through Friday.

14. How can I find the medical option that's most like the one I have today?

That's a good question. You may currently have medical insurance with a carrier who is also an option for you this year. This is not the same plan, and the provider networks are different from what you could have today. You need to take a close look at the coverage options and carrier networks to decide which will best meet your needs.

When you enroll, you'll have lots of tools and resources available to help you make decisions. It will be easy to compare your options on the **Make It Yours** website because you'll be able to sort them by the features that are most important to you. You can also call the insurance carriers with specific questions about the options they offer.

15. Will pre-existing conditions be covered?

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

For pre-existing condition coverages with the voluntary benefits plans, please contact the carrier for more information.

16. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through a pharmacy benefit manager related to the medical plan you choose—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 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.

BE PREPARED TO REQUEST A NEW PRESCRIPTION FROM YOUR PROVIDER WHEN ENROLLING IN YOUR NEW MEDICAL PLAN.

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

Before getting certain types of care, you or your doctor may be required to review it with 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, ensures you're receiving the appropriate level of care for your condition, and confirms how the claim 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. Always confirm with your doctor to be sure they are 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.

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

You'll receive a new ID card when you enroll in medical and prescription drug coverage.

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

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

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

Do not rely on your provider's office to know the carriers' networks. To see whether your dentist is in-network:

- Review the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the TKC Benefits Portal.
- If you or an eligible family member are receiving ongoing Orthodontia treatment, remember to verify your Orthodontist is in the network as well.
    - If you will have a new dental insurance carrier, call your **new** dental insurance carrier as soon as possible to ask for help with "transition of care" for ongoing Orthodontia treatment.

If you are considering a Platinum dental option:

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

20. 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:

- Review the insurance carrier preview sites.
- When you enroll, check the network of each insurance carrier you're considering on the TKC Benefits Portal.

21. What other benefit options are available to me through the exchange?

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 benefit in the event you or a family member covered under this plan is hospitalized
- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan is in an accident
- **Legal services:** Covers attorney fees for things like wills, real estate matters, and more
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud

You can choose to enroll in these non-exchange benefits:

- **Universal life:** Additional life insurance that is portable when you leave the company or retire.

You can get more details on the **Make It Yours** website at **tkcbenefitssolution.makeityoursource.com**.

Paying for Coverage

22. Will I have to pay more for medical coverage?

It depends. You get to decide how much you want to pay for coverage through the exchange. You can choose the coverage level you want from the insurance carrier offering it at the best price. There are other factors that impact how much you pay too, including your employer contribution amount from TKC Holdings and how many family members you cover. The result is that you could end up paying more—or less—for coverage than you do today.

Keep in mind that you'll pay the cost of medical (and dental and vision) coverage with before-tax dollars.

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

During the enrollment window, you'll be able to see the employer contribution amount from TKC Holdings and your price options when you enroll on the TKC Benefits Portal at **digital.alight.com/mytkcbenefits** or the Alight Mobile app.

24. Do I get to keep the TKC Holdings benefits credit if I don't enroll in medical coverage?

No. The benefit credit you get from TKC Holdings is to help to offset the cost of the medical/prescription drug coverage you enroll in. A cash refund or credit for other benefits is not available.

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

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your eligible 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. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, Gold, and Platinum medical coverage levels have a traditional deductible.** Once a covered family member meets the *individual* deductible, your insurance will begin paying benefits for that family member. Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.
- **The Bronze Plus medical coverage level has a "true family deductible."[1]** This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no "individual deductible" in this coverage level when you have family coverage.

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

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

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

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

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

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a calendar 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, Gold, and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

The Bronze, Silver, Gold, and Platinum coverage levels have a traditional out-of-pocket maximum. Once a covered family member meets the *individual* out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

The Bronze Plus coverage level has 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 this option when you have family coverage.

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

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

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

An HSA is a special bank account that you can use when you enroll in a Bronze or Bronze Plus 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 coinsurances. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Bronze Plus coverage levels, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for unqualified expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how muchmoney you want to contribute. If you don't have a lot of health care expenses, your money can stay in your account year-to-year and earn tax-free interest. Also, the money is yours to keep even after you no longer work for the company or retire. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

28. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. You decide how much money you want to contribute, and you can change your contribution election at any time. If you don't have a lot of health care expenses, your money can stay in your account year to year.

The HSA has the following tax advantages:

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

29. How is an HSA different from a Health Care Flexible Spending Account (Health Care FSA)?

While both accounts offer a tax-free benefit when you pay for eligible medical, dental, and vision expenses, they differ in several key ways. Compare their differences on the **Make It Yours** website.

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

No. If you enroll in the Bronze or Bronze Plus 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.

31. 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.

32. 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 or Bronze Plus 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 (children up to age 26).