TOTALWELLBEING

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2025 FTI U.S. Benefits

Frequently Asked Questions

FTI CONSULTING | TOTALWELLBEING

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 (including prescription drug), dental, vision and other insurance 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. Through BenX, FTI is providing means for employees to have multiple options when purchasing insurance coverage for themselves and for their families.

2. How does BenX work and what benefits are offered?

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

- **Lots of choices and more flexibility**. Through BenX, you're able to choose from at least four 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.

  In addition to medical, dental and vision benefits, you will have the opportunity to enroll in other valuable benefits, including supplemental life, accidental death and dismemberment ("AD&D"), critical illness, accident, hospital indemnity, legal services, identity theft protection and pet insurance, as well as long-term disability buy-up insurance (if eligible). You may also enroll in flexible spending accounts ("FSA") or a Health Savings Account ("HSA").

  Please note: Commuter benefits can be elected through **MyHRIS** at any time on **FTI *Atlas***.

  Employees do not need to elect the below benefits, as FTI provides these to all benefits-eligible employees **without a premium charge to the employee**:
  - Short-term disability coverage
  - Long-term disability coverage
  - Basic life insurance
  - Basic AD&D insurance

- **Competitive pricing**. BenX creates a marketplace where 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 the U.S. Benefits page on FTI *Atlas* for the access code**.
    - **Watch videos** to learn about BenX.
    - **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.

- **U.S. Benefits page on FTI *Atlas***: The **U.S. Benefits page on FTI *Atlas*** links to external benefits resources and houses all internal benefit-related communications.
- **Enrollment website**: You will enroll on the **Make It Yours** 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 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**, or **1.312.843.5256** for international callers, 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. You may schedule an appointment to speak with an FTI Benefits Center representative. Simply log on to the **FTI Benefits 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**: Visit **fticonsulting.makeityoursource.com** to learn about your coverage options and choose 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 you enroll, take advantage of the **Interactive Pricing Tool** to help you compare the costs of your healthcare options. Refer to the **U.S. Benefits page on FTI *Atlas*** for the access code.
- **The FTI Benefits Center website and Alight Mobile app**: When it's time to enroll, log on to the **FTI Benefits Center** website or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options and prices, get helpful decision support and enroll.
- **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 Lisa, 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 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 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 Inside Scoop** on how to work the healthcare 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.
- **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?

Through BenX, you decide how much coverage you want to buy. You have 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 you enroll, 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.

Go to the **U.S. Benefits page on FTI *Atlas*** for the **Interactive Pricing Tool** access code. When you enroll, you will be able to see the contribution from FTI and your price options on the **FTI Benefits Center** website or the Alight Mobile app.

To track your personal healthcare spending for 2025, visit your insurance carrier's website to view their tools and resources that will help track your claims.

6. Do I get to keep the FTI contribution if I don't enroll in coverage?

No. FTI's contribution toward the cost of medical, dental and vision coverage is only factored in when you purchase coverage. A cash refund or credit for other benefits is not available.

Enrollment

7. What will I need to do?

You must enroll by your deadline or you will not have coverage for medical (or prescription drug), dental or vision through FTI for 2025. To contribute to a health savings account ("HSA") (if eligible) or to flexible spending accounts ("FSA") for healthcare and/or dependent care for 2025, you must also make an active election.

To enroll, log on to the **FTI Benefits Center** website 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 2025.
  - Confirm that the information for your dependents is listed correctly and select the dependents you wish to cover for each benefit plan in 2025.
  - **Any newly added or re-enrolled dependent will need to complete verification through our Dependent Verification Center. If not verified, coverage may be terminated retroactively to the start date.**
- Choose the insurance carriers and coverage levels you want for your medical, dental and vision benefits.
- Enroll for supplemental life insurance and/or supplemental AD&D coverage for you, your spouse and/or your children.
  - If you elect coverage beyond the guaranteed issue amounts, you will need to complete an evidence of insurability questionnaire.
- Elect your contribution amounts, if participation is desired, for a health care FSA and/or a dependent care FSA.
- Contribute to an HSA if you are enrolling in the Bronze Plus or Silver plan.
- Evaluate the voluntary benefit options available to you – hospital indemnity, critical illness, accident, legal services, identity theft protection and pet insurance.

After you enroll, you will be mailed a summary of your benefit elections to review your benefits that will be effective January 1.

My Options

8. 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.

9. Does medical coverage differ among insurance carriers?

In general, at each coverage level, carriers have agreed to the majority of standardized plan benefits recommended by BenX. The **FTI Benefits Center** website provides a more detailed look at these and additional coverage details and also accounts 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.
- Another option to help with unexpected medical expenses is to consider **enrolling in the critical illness, accident and/or hospital indemnity insurance plans**. These policies are designed to provide a lump sum payment to you in the event of being hospitalized, diagnosed with a critical illness or involved in an accident. These funds can be used for whatever you need, including covering deductibles and out-of-pocket costs, lost wages of the ill or injured or other unplanned expenses which may occur.
- 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.

With BenX, 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 through BenX, 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 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 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.

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 offers 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' networks. 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 the **U.S. Benefits page on FTI *Atlas*** for the access code.
- Watch videos to learn about BenX.
- Browse **The Inside Scoop** resources page for information on how to be a smarter healthcare consumer.

When you enroll, 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, once logged on to the **FTI Benefits Center** website, look for the "**Need Help?**" icon to ask Lisa, 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**, or **1.312.843.5256** for international callers, 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. Why is there such a large discrepancy between costs of some insurance carriers within the same coverage level?

The intent of BenX is to drive competition among the carriers to ensure they are "playing their best cards" at a competitive price within each market. It requires carriers to compete in all regional markets in which they have a viable network. However, carriers have different strengths and weaknesses across varying geographies. For example, in some markets "Carrier A" may have negotiated better discounts with providers and medical facilities or better prescription drug rebates, which allows them to price their coverage more aggressively. In addition, BenX requires the carriers to quote their pricing 'blind,' meaning they do not have visibility to how the competing carriers have priced within a given region. The only information provided to the carriers is high-level directional information on the competition's pricing alignment (i.e., identifying to the carrier if they are the low-cost carrier in a specific region). As a result, it is not uncommon to see a carrier priced significantly higher in a given year and in a specific region based on that carrier's market presence, negotiated discounts and market share strategy.

19. Will pre-existing conditions be covered?

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

20. 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 enrolling:

- 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.

When you enroll:

- 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. 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.

21. What is the brand name prescription penalty 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 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 to confirm coverage for your specific prescriptions.

22. 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.

23. 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.

24. What other benefit options are available to me through BenX?

In addition to medical coverage, you may choose the following:

- Dental insurance
- Vision insurance
- Supplemental life insurance
- Supplemental accidental death and dismemberment ("AD&D") insurance
- Long-term disability buy-up insurance (if eligible)
- Health Savings Accounts ("HSA")
- Flexible Spending Accounts ("FSA") – Health Care and/or Dependent Care
- Pet insurance
- Accident insurance to cover out-of-pocket medical costs if an accident occurs
- Critical Illness insurance to cover out-of-pocket medical costs for serious health conditions
- Hospital Indemnity insurance to cover out-of-pocket costs associated to hospitalizations
- Legal Services to help with a variety of personal legal matters from a network of participating attorneys
- Identity Theft Protection to limit the damage if your personal or financial information is stolen

For the benefits listed above, employees must enroll before their deadline to have coverage in 2025. Only commuter benefits can be elected through **MyHRIS** via **FTI *Atlas*** at any time. Pet insurance may be elected by logging into the **FTI Benefits Center**, selecting "Other Benefits," then "Pet Insurance."

There are also certain benefits that you do not need to elect as shown below. FTI provides these benefits to all benefits-eligible employees without a premium charge to the employee:

- Short-term disability coverage
- Long-term disability coverage
- Basic life insurance
- Basic AD&D insurance

Detailed information about these benefits can be found on the **Make It Yours** website.

25. What is Hospital Indemnity insurance?

Hospital Indemnity insurance pays you a single lump-sum benefit in the event you or a family member covered under this plan is hospitalized, including maternity stays. The benefit is based on the type of hospital stay.

26. What is the Legal Services Plan?

The Legal Services Plan through LegalEASE provides you, your spouse and dependents with easy, affordable access to experienced attorneys for an unlimited number of personal legal matters. When you use a Network Attorney for covered services, all attorney fees are paid for by your legal plan. In addition to representation, your plan provides consultation for a variety of personal legal matters to include:

- Family Law, now with expanded services
- Wills and Estates
- Debt Matters
- Real Estate, including first time homebuyer support
- Traffic
- Injury and Insurance

For more detailed plan coverage information, visit **legaleaseplan.com/fticonsulting**.

27. What is the Identity Theft Services Plan?

If you are an existing member, Norton LifeLock will automatically transition your existing membership to the new Norton LifeLock Benefit Plan through FTI, in most cases.

There are some circumstances that may require you to request termination of your current account before the new benefit membership can take effect, such as:

- Members enrolled in a Norton LifeLock retail plan with family members that are not enrolling in the benefit offering (Norton LifeLock does not auto-terminate members, leaving them without protection).
- Members enrolled through a third-party partner and not billed directly by Norton LifeLock.
- Members enrolled through a different Norton LifeLock employee benefit plan, as the primary or dependent member.

In order for you to complete your transition, please call **Norton LifeLock Member Services** at **1.800.607.9174**. Please mention to the representative that you would like to cancel your retail plan in order to enroll through FTI's benefit program.

28. 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 networks. 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.

29. 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 networks. 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.

30. What else is available to me through BenX?

As part of our participation in BenX, we are able to take advantage of group negotiated discounts through FTI's voluntary plan options for the following: hospital indemnity, critical illness, accident, legal services, identity theft protection and pet insurance.

You also have access to bill negotiation services. This service offers assistance reviewing out-of-network medical bills, negotiating medical bill costs with doctors and hospitals and creating a payment plan for medical-related expenses. For help when you need it, call the **FTI Benefits Center** available 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.

More details are available on the **Make it Yours** website.

31. 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 healthcare 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 healthcare 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 healthcare expert.

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

- 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.

Savings and Spending Accounts

32. 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 healthcare costs now or in the future, tax-free. It's never too early to start saving for future healthcare 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.

How it works:

- Contribute funds into your HSA, up to the annual maximum, when enrolled in an HSA-qualified health plan.
- Use funds from your HSA when you need to pay for qualified healthcare expenses — now or anytime in the future.
- One of the biggest benefits of all, there are no "use-it-or-lose-it" rules. Any unused funds in your HSA roll over from year-to-year. It doesn't matter if you change jobs, change healthcare plans or retire — it's yours for life.

33. 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.

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

Below is a chart explaining the differences between an HSA and a Health Care FSA:

	HSA	Health Care FSA
Do I need to be enrolled in a particular medical coverage level to participate?	Yes. You must be enrolled in a Bronze Plus or Silver medical plan.	No. But if you enroll in the Bronze Plus or Silver, you are not allowed to enroll in the Health Care FSA.
Can I contribute to my account before taxes?	Yes	Yes
Do unused dollars roll over from year to year?	Yes	Yes, up to $660
Does the money in the account earn interest?	Yes	No
Can I use a debit card to pay for expenses?	Yes	Yes
Can I use the account to pay for vision or dental expenses?	Yes	Yes
How much can I contribute to the account per year*?	For 2025, the annual limits set by the IRS are $4,300 for Employee Only coverage, and $8,550 for Family coverage. If you are age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	$3,300
Can I change my contributions at any time during the year?	Yes	No. Changes are only allowed if you experience a qualified life event, such as marriage, birth, etc.
How is the account funded?	Your pre-tax contributions are applied to your HSA each pay period; therefore, your HSA balance grows over the course of the year.	Although you still have pre-tax deductions, your FSA includes the entire annual election available for use at start of the year.

*Limits change per IRS regulations. For more information, go to **www.irs.gov**.

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

No. If you enroll in the Bronze Plus or Silver medical plan, you can participate in an HSA but not the Health Care FSA. You cannot contribute to an HSA and participate in the Health Care FSA at the same time. **Please note** that having an HSA will not impact your participation in the Dependent Care FSA.

36. 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.

37. Can I keep my current HSA?

Yes. If you currently have an HSA and you have a balance, the unspent funds will remain in your HSA, earn tax-free interest and be available for qualified healthcare expenses at any time in the future. Consider continuing your HSA contributions with FTI's administrator, Bank of America.

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 veterans' 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).

38. 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.

39. 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 starting from the first month your Medicare coverage begins. However, you can still continue to withdraw funds from your HSA to pay for eligible medical expenses such as deductibles, copayments, coinsurances and Medicare premiums.

If you are eligible for Medicare but have **not yet enrolled** and maintain coverage under a high deductible health plan, such as the Bronze Plus or Silver plan, you may continue to contribute to an HSA. Once you enroll in Medicare, even retroactively (as some enrollments can be backdated up to 6 months), your eligibility to contribute to an HSA ends. If you have signed up for Social Security and are automatically enrolled in Medicare Part A at age 65, you may no longer contribute to an HSA.

Given the complexity and potential tax implications when approaching Medicare eligibility, we recommend consulting with a tax advisor before making any decisions regarding Medicare and company-sponsored healthcare plans. For assistance with Medicare coordination, Alight Advocacy services are available. Just call the **FTI Benefits Center** 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.

40. 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*