AON ACTIVE HEALTH EXCHANGE™

Make It Yours To Go

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Eligibility

Any personnel who wish to apply for Domestic Partner benefits must do so during Open Enrollment or following a qualifying event by logging on to the **Grant Thornton Benefits Center website**.

- Children of eligible domestic partners are eligible for benefits under the same conditions as are the children of personnel's legal spouses.
- Enrollment of domestic partners and eligible dependent children is subject to the same rules as enrollment of other dependents.

If the domestic partnership ends, the Firm Partner/employee must report a family status change within 45 days of the event. To report the Family Status Change completing the Family Status Change form by logging on to the **Grant Thornton Benefits Center website**.

Questions regarding domestic partner benefits should be directed to the National Benefits Group.

Medical Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you **do your homework** before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different **insurance carriers** at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE PLUS	SILVER	GOLD	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO that offers limited benefits for out-of-network care**
Paycheck contributions	$	$$	$$$	$$$$
		Annual Deductible		
In-network (individual / family)	$2,450 / $4,900	$1,500 / $3,000	$800 / $1,600	$250 / $500
Out-of-network (individual / family)	$2,450 / $4,900	$1,500 / $3,000	$1,600 / $3,200	$5,000 / $10,000
Traditional or true family?	True family	True family	Traditional	Traditional
		Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$3,900 / $7,800	$3,800 / $7,600	$3,600 / $7,200	$2,300 / $4,600
Out-of-network (individual / family)	$11,500 / $23,000	$8,000 / $16,000	$7,200 / $14,400	$11,500 / $23,000
Traditional or true family?	True family	True family	Traditional	Traditional

		In-Network Benefits		
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 15% after deductible
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 25% after deductible	You pay 15% after deductible

**For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

Prescription Drug Coverage

	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive drugs	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**
		30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50
		90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $100	You pay $75

Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**.

California Residents: Your options will be different, depending on the insurance carrier you choose. See **what's different**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **digital.alight.com/grantthornton** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier’s pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Employees who enroll under Aetna, Blue Cross and Blue Shield of Illinois, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by CVS Caremark.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you’re comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It’s easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

California Medical Coverage Level

Live In California?

Your options will be different, depending on the insurance carrier you choose.

For starters, each **insurance carrier** in California has the option to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** 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 offers **only** in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Blue Cross Blue Shield of Illinois	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Health Net	**Northern California** In-network only **Southern California** In- and out-of-network	**Northern California** In-network only **Southern California** In- and out-of-network	N/A	In-network only	**Northern California** In-network only **Southern California** In- and out-of-network
Kaiser Permanente	In-network only	In-network only	N/A	In-network only	In-network only
United Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Medical Coverage Level

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	HMO	PPO that offers limited benefits for out-of-network care**
Paycheck contributions	$	$$	$$$	$$$	$$$$
			Annual Deductible		
In-network (individual / family)	$2,450 / $4,900†	$1,500 / $3,000†	$800 / $1,600	N / A	$250 / $500
Out-of-network (individual / family)	$2,450 / $4,900†	$1,500 / $3,000†	$1,600 / $3,200	N / A	$5,000 / $10,000
Traditional or true family?	True family	True family	Traditional	N / A	Traditional
			Annual Out-of-Pocket Maximum		
In-network (individual / family)	$3,900 / $7,800‡	$3,800 / $7,600‡	$3,600 / $7,200	$5,400 / $10,800	$2,300 / $4,600
Out-of-network (individual / family)	$11,500 / $23,000‡	$8,000 / $16,000‡	$7,200 / $14,400	N / A	$11,500 / $23,000
Traditional or true family?	True family	True family	Traditional	Traditional	Traditional
			In-Network Benefits		
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit	You pay $25 for PCP visit and $40 for specialist visit, no deductible

Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 30%	You pay 15% after deductible

**For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

†Under Health Net and Kaiser Permanente, if you cover dependents, no covered member pays more than $2,800 toward the family deductible. Also, these options feature a traditional annual deductible.

‡Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.

Prescription Drug Coverage

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive drugs	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**	You pay $0 after the deductible is met**
			30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $10	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $40	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $60	You pay $50
			90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $25	You pay $25	You pay $20

Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $100	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

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For a more detailed look at these and additional coverages, go to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **digital.alight.com/grantthornton** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It's easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the **insurance carrier**.

It Depends On Your Medical Coverage Level

Gold and Platinum have a traditional deductible.

Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

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

Bronze Plus and Silver have a "true family deductible". 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 the Bronze Plus and Silver coverage levels when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family deductible is met.

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

Do You Use Out-of-Network Providers?

Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do **not** cover out-of-network benefits at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

Here’s how the out-of-pocket maximum works if you have family coverage:

It Depends On Your Medical Coverage Level

Gold and Platinum 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.

It doesn't include amounts taken out of your paycheck for health coverage. Also, if you choose coverage under Kaiser Permanente, copays for certain medical benefits may not apply towards the annual out-of-pocket maximum under the Gold and Platinum options.

Bronze Plus and Silver have a "true family out-of-pocket-maximum". 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 the Bronze Plus and Silver coverage levels when you have family coverage.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?
Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Medical Price

When you make a purchase, you decide how you want to pay. Would you rather pay cash now, or use credit and pay later?

It's the same idea with the exchange. You get to decide if you'd rather **pay now or pay later**.

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care.

How much you'll pay for medical coverage depends on:

The Amount Of Your Credit (The Firm's Contribution As Applicable) From Grant Thornton

Grant Thornton subsidizes the cost of employee premiums. You'll see this credit (the firm's contribution as applicable) amount from Grant Thornton and your price options for coverage when you **enroll**.

In addition, if you participate in the annual Healthy Lifestyle activity, partners and employees can earn a credit of $50/month to offset premium costs.

The Coverage Level You Choose

The Bronze Plus and Silver coverage levels cost less per paycheck, but you will pay a higher deductible before your coverage kicks in. Under these coverage levels, you have the option to set aside dollars in your HSA to help cover the deductible or future expenses.

The Gold and Platinum coverage levels cost more per paycheck but you'll probably pay less out of pocket for services throughout the year.

Learn more about coverage levels.

The Insurance Carrier You Choose

During enrollment, you can see which insurance carrier offers the lowest paycheck amount for each coverage level. For example, if you know you want a Silver option, you can look to see how much each insurance carrier would charge you for it. **Learn more about insurance carriers.**

Important: Choose an insurance carrier whose network includes providers critical to your care. If you see an out-of-network provider, your medical insurance carrier could pay a much lower benefit—leaving you to pay the rest.

Your Dependents

You can enroll any combination of you, your **eligible** spouse/domestic partners, and your children in the option you choose.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best deal on your total health care costs.

Would you rather pay **less** now and **more** when you need care? Or pay **more** now and **less** when you need care?

Pay Less *Now*

The Bronze Plus and Silver coverage levels cost less per paycheck, but your deductible is higher. That means you'll pay more out of your pocket when you need care.

Make sure you know **how the deductible works**. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an **HSA** when you enroll in a Bronze Plus or Silver coverage level.

Pay Less *Later*

The Gold and Platinum coverage levels cost more per paycheck, but your deductible is lower. If you don't expect to have a lot of health care needs, you could be spending money for benefits you don't use.

How to Get the Right Medical Option

Don't wait. **Get ready** now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to 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.

If you travel outside the carrier network for work or pleasure, you will want to understand the impact to your cost of care should you get sick or have an accident requirement treatment. For example, national carriers may have in-network options in many states while regional carriers might have less flexibility.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Do **not** rely on your provider's office to know the carriers' network(s). To search for providers:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. For the best results, search for your provider by name—not medical practice—and only the office location where you will visit the provider.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty or, for instance, you will cover out-of-area dependents, you need to call the insurance carrier to confirm whether a provider participates in a **carrier's network**.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider networks before making a decision.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a covered family member regularly takes medication, make sure you're comfortable with the carrier's coverage for drugs you and your covered family members need:

- Call CVS Caremark (if you're considering coverage under Aetna, Blue Cross and Blue Shield of Illinois, Cigna, and UnitedHealthcare) or the medical insurance carrier (for all other carriers) before you enroll. Get a list of **prescription drug questions** to ask the insurance carriers.
- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.

- When it’s time to enroll, you can use the prescription drug search tool to look up your medication, see how it will be classified (Tier 1, Tier 2, Tier 3), and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage.

What to Do
If you need help deciding, there are tools to help you:

- Get an overview of your medical **coverage levels**.
- See which coverage level could be **best for you** with the Help Me Choose tool. By answering a few questions about your preferences when you enroll, you can see which option could be a good fit for you and your family.
- Compare your options side by side when you enroll on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. Just check the boxes next to medical options you want to review and click **Compare**. You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price for each coverage level, and you'll be able to see all of the prices in one place on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. (**Note:** The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- See how other people rate their health carriers on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** anytime.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking **Compare**. That makes it easy to see which carrier is offering you the best deal. (You may also find Summaries of Benefits and Coverage for comparison on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**.)
- Browse the carrier preview sites to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? **Find out how.**

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze Plus or Silver coverage level. If you also have coverage under a second medical plan, it must also be a high-deductible option for you to use an HSA.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to **decide how much to save**.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze Plus or Silver coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee playing basketball. With a high deductible, you might worry about how you're going to afford the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy! You could already have the money you need saved up.

An HSA allows you to set aside tax-free money to pay for qualified health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

If you want, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on qualified health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on your qualified medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

Wondering what the difference is between an HSA and a Health Care Flexible Spending Account (FSA)? **Find out.**

Questions?

Get answers to your questions, including eligibility rules and what happens if you already have an HSA or FSA.

If you enroll in a Bronze Plus or Silver coverage level, learn how the HSA works in the **HSA User's Guide** (PDF).

HSA vs FSA

Wondering how an HSA is different from a Health Care Flexible Spending account (FSA)? Here's how:

	HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
When to Use	You can use the HSA to pay for eligible medical, dental, and vision expenses under the Bronze Plus or Silver coverage levels.	You can use the Health Care FSA to pay for eligible medical, dental, and vision expenses under any coverage level.
Contributions	You can contribute to your account before taxes. For 2022, the annual limits set by the IRS are $3,650 for individual coverage, and $7,300 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	You can contribute to your account before taxes up to $2,850. For more information on eligible expenses and any known special circumstances, please review **Frequently Asked Questions**.
Fund Availability	You can use up to the total amount you have contributed to your HSA.	The total amount of your annual election is available at the beginning of the plan year.
Rollovers	Unused dollars roll over from year to year. The funds are always yours to keep, even if you leave the company or retire.	Typically, FSA funds must be used for eligible expenses incurred no later than Dec. 31 of the current plan year.
Earning Interest	The money in your HSA earns interest.	The money in your FSA does **not** earn interest.
Debit Cards	Yes, a debit card is available.	Yes, a debit card is available.
Investment Option	You can open an investment account when your balance reaches $1,000.	You cannot invest your FSA balance.

Which Account Should I Use

If you enroll in the Bronze Plus or Silver coverage level, you can use an HSA, a Health Care FSA, or both an HSA and Health Care FSA. If you contribute to an:

- HSA **or** Health Care FSA, you can use your account to pay for qualified medical, dental, and vision expenses.
- HSA **and** Health Care FSA, your Health Care FSA will be "limited use" and can only be used to pay for qualified dental and vision expenses. However, once you meet the medical plan deductible, then it can be used toward qualified medical expenses as well. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Gold or Platinum coverage level, you can use the Health Care FSA to pay for qualified medical, dental, and vision expenses.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2022, you can save up to $3,650 if you're covering just yourself, or $7,300 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Note: If you want to, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit. If you do contribute after-tax dollars to your HSA, you'll also be able to take a deduction on your personal tax return for after-tax contributions. There are tax savings advantages for before- and after-tax contributions.

Prescription Drugs

This is a really big deal! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Employees who enroll under Aetna, Blue Cross and Blue Shield of Illinois, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by CVS Caremark.

That means your prescription drug coverage depends on the medical coverage level you choose **and** your medical insurance carrier.

Your Coverage Level Matters

Once you've met the deductible, you pay nothing for preventive drugs, as determined by your insurance carrier. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze Plus or Silver
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

Gold or Platinum
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your specific prescription coverage is based on the medical coverage level you select. **Get the details**.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—**before** choosing an insurance carrier.

Get a list of **prescription drug questions** to ask the insurance carriers.

Prescription Drug Questions

Do you or a family member take medications? This could be a big deal for you!

Your prescription drug coverage will be provided through your **insurance carrier's** pharmacy benefit manager. Your prescription drug coverage depends on the **medical coverage level** you choose.

However, each pharmacy benefit manager has its own rules about how prescription drugs are covered. So **you need to do your homework** to find out how your medications will be covered—**before** you choose an insurance carrier.

What To Ask

Here's a list of questions to ask CVS Caremark (if you're considering coverage under Aetna, Blue Cross and Blue Shield of Illinois, Cigna, and UnitedHealthcare) or the medical insurance carrier (if you're considering coverage under other carriers).

Tip: You can also print out the **Prescription Drug Transition Worksheet** (PDF) and use it to take notes.

Is my drug on the 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. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified by your pharmacy benefit manager—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, pharmacy benefit managers can classify higher-cost generics as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information on the carrier preview sites. Or you can use the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical pharmacy benefit managers will require you to pay the copay or coinsurance of a higher tier—**plus** the cost difference between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% (after the deductible) when you fill them in-network. But each pharmacy benefit manager determines which drugs it considers "preventive." If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many pharmacy benefit managers require approval of certain medications before covering them. This may apply for costly medications that aren't considered medically necessary.

Will I have a step therapy program?
If this applies to one of your medications, you'll need to try using the most cost-effective version first—usually the generic. A more expensive version will be covered only if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

We’ll Help You Through The Transition

After you enroll, check out things to know **before your benefits start**.

Medicare Basics

Medicare is a federal medical insurance program, which includes Original Medicare. Original Medicare is a low-cost government insurance program that guarantees access to health insurance for Americans age 65 and older and younger people with certain medical disabilities. It pays for many health care expenses, but not all.

How It Works

Medicare covers its share of an approved amount and you pay the rest through deductibles and coinsurance. Original Medicare is made up of two parts:

- **Part A is hospital insurance.** It covers inpatient hospital care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.
- **Part B is medical insurance.** It covers things like clinical research, ambulance services, durable medical equipment, mental health services, limited outpatient prescription drugs, and more.

You are automatically eligible for Medicare Parts A and B when you become Medicare-eligible. If you are receiving Social Security benefits, you may be enrolled in Medicare automatically.

If you have to sign up to get coverage, you can enroll starting three months before the month you turn age 65. The deadline to enroll is three months after the month you turn age 65. (Note: You can wait to enroll in Part B; however, you may have to pay a late enrollment penalty. However, in general, you can wait to enroll in Medicare Part B without facing a late enrollment penalty until your active employment ends or the date your coverage under your employer's plan ends, whichever occurs first. Consult your Medicare advisor for more details.)

Part D is optional prescription drug coverage. You can enroll in Part D if you want coverage to help pay for your prescription drug costs.

How Medicare Works With Company Coverage

If you are actively employed, your company's health plan will be your primary medical coverage, and, if you choose to enroll in Medicare, Medicare will be your secondary coverage. Please note, once you are enrolled in any part of Medicare (Parts A or B), you can no longer make contributions to an HSA, even if you are also covered by an HSA-eligible medical plan.

If you are retired and have coverage through your previous employer, Medicare will be your primary medical coverage, and your company's health plan will be your secondary coverage.

As you prepare to transition to Medicare, you will want to understand if your dependents under age 65 will be eligible for coverage under your company's health plan. To understand your options, contact the Grant Thornton Benefits Center at **1.833.476.2341** from 8 a.m. to 5 p.m. CT, Monday through Friday.

How Medicare Works With COBRA

If you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. COBRA coverage pays secondary to Medicare Parts A and B. Therefore, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did

not actually enroll in Medicare.

If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later.

If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

To Learn More

Start **here** (PDF) to better understand Medicare, your options, impacts to your current coverage, and more. Below are resources where you can find additional information and help:

- Visit the **Aon Retiree Health Exchange** or call **1.833.791.0780**
- Visit the **Social Security website** or call **1.800.772.1213** (TTY **1.800.325.0778**) between 8:00 a.m. and 7:00 p.m. Monday through Friday
- Review the **Medicare & You** handbook from the Centers for Medicare & Medicaid Services

Dental Plan

Grant Thornton offers a dental plan administered by MetLife. The Preferred Dentists Program (PDP) offers a choice of two benefit levels: in-network and out-of-network. Participation in this benefit is voluntary and may be purchased as a standalone benefit, whether or not you elect medical coverage.

MetLife Preferred Dentists Program

Plan feature	In-network	Out-of-network
Annual maximum benefit	$2,000	$2,000
Annual deductible – individual [1]	$50	$75
Annual deductible – family [1]	$150	$225
Type A services: exams and cleanings	100% of PDP fee [2]	90% of R&C fee [3]
Type B services: filings, extractions and oral surgery	80% of PDP fee [2]	70% of R&C fee [3]
Type C services: bridgework, crowns and dentures	50% of PDP fee [2]	50% of R&C fee [3]
Type D services: orthodontia	50% of PDP fee [2]	50% of R&C fee [3]
Lifetime maximum benefit — orthodontia	$1,500	$1,500

[1] Applies only to Type B and C services.
2 PDP fee refers to the fees that participating Preferred Dentists Program dentists have agreed to accept as payment in full, subject to any copays, deductibles, coinsurance and benefit maximums.
3 R&C fee refers to the reasonable and customary charge, which is based on the lowest of (i) the dentist's actual charge, (ii) the dentist's usual charge for the same or similar services, or (iii) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

For More Information
If you have specific questions regarding benefit structure, limitations or exclusions, contact MetLife at **1.800.942.0854** or **metlife.com/mybenefits**. Detailed plan information is also available on **Canvas>Life and Career>my Benefits**.

Vision Plan

Grant Thornton offers a vision benefit, separate from the medical plan, through Vision Services Plan (VSP). Participation in this benefit is voluntary and may be purchased as a standalone benefit, whether or not you elect medical coverage.

VSP Vision Insurance

Plan Feature	**In-network**	**Out-of-network**
Claim forms	Not required	Required
Examination (once every 12 months)	100% after $10 copay	Up to $45
Lenses (once every 12 months)		
• Single	100% after $20 copay	Up to $30
• Bifocal	100% after $20 copay	Up to $50
• Trifocal	100% after $20 copay	Up to $65
• Lenticular	100% after $20 copay	Up to $100
Frames (once every 24 months)	100% up to $175	Up to $70
Contact lenses (instead of a complete pair of prescription glasses)		
• If elective (not medically necessary)	Up to $175	Up to $105
• If medically necessary (means by doctor's authorization glasses cannot be worn)	100% after $20 copay	Up to $210

For more information

More information can be obtained by calling VSP at **1.800.877.7195** or accessing **vsp.com**. Plan information and claim forms are available at vsp.com or **Canvas>Life and Career>my Benefits**.

Life, Accident, and Disability

As an employee of Grant Thornton, you have the opportunity to enroll in many additional benefits.

Basic Group Life
Life insurance coverage is provided by MetLife. Grant Thornton provides basic life insurance equal to one times your annual base salary up to a maximum of $50,000. Additional supplemental life insurance is available to all employees.

Supplemental Employee Group Variable Universal Life (GVUL)

- You can elect coverage from 1 to 10 times your salary up to a maximum amount of $3,000,000.
- Increases to coverage amounts and enrollments during the open enrollment period may be subject to underwriting.

Spousal life insurance

- Employees who choose supplemental employee GVUL insurance may also purchase spouse life insurance coverage. Coverage may be chosen in increments of $10,000 up to a maximum of $250,000, but cannot exceed the amount of the employee's own coverage.
- Increases to coverage amounts and enrollments during the Open Enrollment period are subject to underwriting.

Child life insurance

- Employees who choose supplemental employee GVUL life insurance may also purchase child life insurance coverage.
- You may choose either $10,000 or $25,000 in coverage.
- Increases to coverage amounts and enrollments during the Open Enrollment period are subject to underwriting.

Accident insurance
Accidental death and dismemberment insurance (AD&D) is administered by MetLife. Grant Thornton provides $20,000 of AD&D to employees.

In addition, employees can elect additional voluntary AD&D coverage for themselves, their spouse and dependent children.

Disability insurance

- Grant Thornton provides a short-term disability benefit up to 12 weeks of pay for eligible employees unable to work due to a non-work related injury or illness.
- You may purchase basic group long-term disability (LTD) coverage through Lincoln Financial for income protection on your first $150,000 of income. If your approved disability continues beyond 90 days, this benefit will provide approximately 60% of pay with a maximum benefit of up to $7,500 per month (depending on your coverage level). The group LTD benefit is subject to a reduction, or offset, for other group disability benefits that you receive. For example, any Social Security disability benefits, will be offset from your LTD benefit, thereby reducing the

benefit received under the plan. Employees enrolling for the first time may be subject to evidence of insurability.

- If your annual earnings are greater than $150,000, you may also purchase Guardian Individual Disability Income (IDI) protection. When combined with the basic group LTD, this coverage allows you to increase your total monthly benefit up to a maximum of $22,500 per month (higher limits available for managing directors), depending on your earnings. Review the Benefits Handbook, located on **Canvas>Life and Career>my Benefits** for additional information on **how the LTD and IDI plans work together** to provide income protection in the event you're not able to work due to a disability. The Guardian IDI protection benefit is individual coverage and is not reduced, or offset, for other group disability benefits that you receive.

Managing Directors are required to sign up for a minimum monthly benefit amount of $1,250 of IDI coverage which is paid for by the firm. Based on your income, additional coverage may be available to purchase if you wish to do so.

International Vacation Medical

Is your family covered for health care outside the U.S.?

International vacation medical offers affordable, comprehensive coverage for covered family members when traveling outside the U.S. It can supplement any coverage offered by your medical insurance carrier. Coverage also includes claims support, translation services, a direct bill payment option, and more.

Have an international trip(s) coming up? Click **here** to learn more. Or, call GeoBlue at **1.844.358.7278** for more information. You do not need to enroll for coverage during enrollment.

Note: This plan can also be used for short-term business travel out of the country (i.e., trips less than one month). If you are going overseas for more than one month, contact the mobility team for further guidance.

Paying For Coverage

You'll pay by credit card only if you buy coverage.

Things To Consider

When deciding whether to buy international vacation medical coverage, be sure to consider the following:

Your Medical Coverage
First, check with your medical insurance carrier to see how they will cover you and your family when traveling internationally. If coverage is limited or unavailable, having international vacation medical coverage could give you peace of mind.

Cost
Your cost of coverage is based on age, length of stay, policy amount, and deductible selected.

Your Personal Situation
Do you or an eligible family member have an ongoing health condition or often require health care? If you answered "yes" and your medical carrier offers limited or no international coverage, having international vacation medical coverage could be valuable.

Bill Negotiation Services

You don't have to be a health care expert when you have one in your corner.

Bill negotiation services puts years of health care and billing expertise to work for you. When you're facing a large bill from an **out-of-network** provider, negotiators are available to partner with you and your providers to make sure the amount billed to you is appropriate (which could reduce the amount you owe). In many cases, negotiators can help save you 20% or more.

Bill negotiation services is administered by MCA. You do **not** need to enroll for coverage. When you have a bill of at least $300, you can sign up and get started at **www.medicalcostadvocate.com/aon**. Or, call **1.844.891.8981** for more information.

Paying For Coverage

If you don't save any money through bill negotiation services, it's totally free. If you **do** save money through bill negotiation services, you'll pay 35% of your savings.

Things To Consider

When deciding whether to use bill negotiation services, be sure to consider the following:

It's Risk-Free
Because you only pay if negotiators save you money, you have nothing to lose—and a smaller provider bill to gain.

Peace of Mind
Do you think you've been overcharged for health care services? Do you lack the time, expertise, and energy needed to successfully negotiate health care charges? If you answered "yes" to these questions, bill negotiation services could give you peace of mind.

Provider Network
Bill negotiation services can save you money on large, out-of-network provider bills. Just remember, you will receive the highest benefit by using in-network providers. And **Health Pros** are available to help with benefits or billing issues.

Additional Benefits

Critical care insurance
MetLife's critical care insurance pays a lump-sum benefit payment in the event you experience a covered medical conditions—cancer, heart attack, stroke, kidney failure, major organ transplant or coronary artery bypass graft.

Legal services
Prepaid legal services are provided by MetLife Legal Plans. The level of consultation received depends on the specific situation. Generally, you may receive legal services in the following areas: estate planning, real estate, family law, finance, defense of civil lawsuits, traffic offenses, consumer protection, immigration assistance, juvenile matters, and document preparation and review. There is no additional cost when services are rendered by a MetLife Legal Plans participating attorney.

Identity theft protection
This voluntary benefit provides protection from identity theft and online risks by securing personal data and other vital information. Through Allstate Identity Protection, you and your family can enjoy the same proprietary technology that is used by law enforcement agencies worldwide.

Auto and home insurance
MetLife offers a wide range of personal property and casualty products at special discounted rates. You receive a 5% discount for payroll deduction and an additional discount for each five years of service with Grant Thornton.

Pet insurance
This benefit, administered by Nationwide, provides coverage for thousands of pet medical conditions. Optional coverage is available for routine and preventive care.

How to Enroll

Log on to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** to enroll in your benefits for 2022.

Logging on for the first time? From the Grant Thornton Benefits Center website, register as a new user and follow the prompts to provide requested information and set up your username and password.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success **after you enroll**.

Questions?

Start with the **Frequently Asked Questions** (PDF). If you still have questions, you can reach a customer service representative by web chat through the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. You can also call the Grant Thornton Benefits Center at **1.833.476.2341** from 8 a.m. to 5 p.m. CT Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do **now** to use your benefits successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

If you are covered by Aetna, Cigna, Blue Cross and Blue Shield of Illinois, or United Healthcare, your prescription drug coverage is provided by CVS Caremark. If you are covered by another medical carrier, your prescription drug coverage is provided through your medical insurance carrier's pharmacy benefit manager, who sets the rules for how medications are covered. Don't be caught by surprise! Check with CVS Caremark or the medical insurance carrier for information about your medications. And, check out the **Prescription Drug Transition Worksheet** (PDF) for tips and questions you may need to ask your carrier.

Check the 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. **Check** with CVS Caremark (if you have coverage under Aetna, Blue Cross and Blue Shield of Illinois, Cigna, or UnitedHealthcare) or the medical insurance carrier (if you have coverage under another carrier) to make sure your drug is listed on the formulary **before** you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they **typically** cost less. And, because brand name drugs can be expensive, some pharmacy benefit managers don't cover them **at all** if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new pharmacy benefit manager, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized! Print the **Prescription Drug Transition Worksheet** (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your **new** medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, **call customer service** at your **new** medical insurance carrier as soon as possible to ask for help with "transition of care."

Give your new insurance carrier information about your treatment and the providers you use today.

Track your to-dos and get organized! Print the **Transition of Care Worksheet** (PDF).

Avoid Unexpected Out-Of-Network Costs

It’s very important to know whether your doctor participates in your medical insurance carrier’s network.

You Could Pay a Lot More for Out-of-Network Care

Your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network 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.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 45% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 45% of $2,000 and 100% of the remaining $3,000, for a total of $3,900.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 45% of $3,000 and 100% of the remaining $2,000, for a total of $3,350.

Take These Steps to Protect Yourself

If you *didn’t* check your doctor’s status before you enrolled or you want to look up a different doctor, do it *now*—before making an appointment with that doctor.

You can check the provider directory through the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** or your medical insurance carrier’s website.

Important! Do not rely on your provider’s office to know the carriers’ network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you’re keeping the same insurance carrier, the provider network could be different. **Always** check the provider directories on the carrier preview sites before making a decision.

If your doctor is out-of-network and you still want to see him or her, check the cost with your doctor *before* you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you’ll be responsible. That way you’ll be prepared for any potentially significant costs.

When To Expect New Cards

You’ll receive a new ID card when you enroll for the first time or change insurance carriers or coverage levels. If you enroll with Aetna, Blue Cross and Blue Shield of Illinois, Cigna, or UnitedHealthcare, you'll receive a separate prescription drug ID card from CVS Caremark. If you enroll with any other medical carrier, you'll use your ID card for medical and prescription drug needs.

For questions about ID cards, **contact the insurance carrier**. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze Plus or Silver coverage levels, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing HSA Bank debit card. New money added to your account will be accessible through your current debit card.

Your HSA debit card gives you instant access to your HSA dollars. When you get your debit card, sign the back of it and follow the instructions to activate it.

If you **don't** receive your HSA debit card, contact HSA Bank at **1.800.357.6246** to request one be mailed to you.

HSA vs. FSA: Which One Should You Use?
Heads up: If you enrolled in an HSA **and** a Health Care Flexible Spending Account (FSA), you will use the same debit card for **both** accounts. And HSA Bank will automatically follow IRS guidelines on how to use each account. So when you use the debit card to pay for medical, dental, or vision expenses, the expense will automatically be deducted from the correct account.

If you currently have money in a Health Care FSA, use it before you begin contributing to your HSA. This includes any "grace period" that applies during a new plan year (generally before April).

Transfer Existing HSA Balances

If you enrolled in the Bronze Plus or Silver coverage levels, you'll have access to an HSA.

If you already have an HSA with an account balance, you can continue to use it for qualified health care expenses at any time in the future. Or, you can transfer unspent money into your new HSA so you don't have to manage two separate accounts. During the plan year, you can find a "transfers form" and directions through the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. There are no tax penalties for transferring money from one HSA to another.

Want To Print?

Track your to-dos and get organized! Print these worksheets and get a step-by-step guide to what to do and what to ask as you get ready to use your new coverage.

Prescription Drug Transition Worksheet (PDF)
Transition of Care Worksheet (PDF)

How to Get Care

When you get care, it helps to know what you can expect:

Getting Care At The Doctor’s Office

Present your medical ID card at your doctor’s office to get discounted rates. If you're enrolled in the Bronze Plus or Silver coverage levels, you can wait to pay until your insurance carrier processes the claim and you get your doctor's bill.

When it's time to pay, you can **pay with your HSA**, FSA, or pay another way—it’s your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical ID card each time you drop off a prescription. If payment is due, you pay out of pocket. Or you can **pay with your HSA** or FSA if you have one.

Know When You’ll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you’ll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You’ll Pay Less With In-Network Providers

You can check the provider directory on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** or refer to your **insurance carrier’s website**.

If a doctor is out-of-network and you still want to see him or her, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you’ll be prepared for any potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying for Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay **a lot** less when you see in-network providers. You can check the provider directory on the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** or refer to your **insurance carrier's website**.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is **not** a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket. Or, you can **pay with your HSA** or FSA for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze Plus or Silver coverage level. When it's time for you to pay for care or prescription drugs, your HSA gives you options:

Use Your HSA Debit Card

Just use it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card for eligible expenses, and that you have enough money in your HSA to cover it.

Log on to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** to transfer money from your HSA to your regular bank account. If you need help with this, contact HSA Bank at **1.800.357.6246**.

Set Up Direct Payments

Another option is to have HSA Bank make direct payments to your provider from your HSA. Log on to the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton** to set up direct payments.

Eligible Expenses

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Always remember to save your receipts when you make payments from your HSA, in case you need to provide proof of your eligible expenses to the IRS. In fact, you can store photos of your receipts on the HSA Bank website and easily tag it to reimburse yourself.

Questions?

Learn more in the **HSA User's Guide** (PDF).

Your Carrier Connection

Check out your health care insurance carrier choices—and see all the unique features and services they have to offer YOU. Discover what each provides, see the doctors included in their network—then decide for yourself.

Medical

Carrier Name: **Aetna**

Areas We Serve: Offered in all states except AK, ID, MT, WY, and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/si/2022

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Pharmacy Contact (CVS Caremark): 1.888.202.1654

Who We Are: At Aetna, we're not just a health insurance company. We're a health company that understands that your health is about more than just coverage and costs.

Learn More

Carrier Name: **Blue Cross Blue Shield**

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.bcbsil.com/aonsi

Once you're a member (website): https://www.bcbsil.com/member/register

Customer Service Hours: Monday - Friday 8:00 a.m. - 6:00 p.m. CT

Phone Number: 1.855.212.1617

Pharmacy Contact (CVS Caremark): 1.888.202.1654

Who We Are: Find out why nearly one in three Americans choose a Blue Cross and Blue Shield Plan. Access to a large, national provider network, wellness resources, discount and points programs, and great service are just a few of the features you get when you sign up with Blue Cross and Blue Shield of Illinois.

Learn More

Carrier Name: **Cigna**

Areas We Serve: Generally offered in most states, except MN, ND. Limited availability in MI.

Before you're a member (preview site): https://connections.cigna.com/aonactivehealth-withyou-2022/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna One Guide® personal guides are available Monday - Friday: 8:00 a.m. - 9:00 p.m. EST.

Outside of the standard hours, customer service advocates are available 24 hours a day, 7 days a week.

Phone Number: 1.855.694.9638, For Cigna company names and product disclosures, visit Cigna.com/product-disclosure

Pharmacy Contact (CVS Caremark): 1.888.202.1654

Who We Are: For over 225 years, Cigna has made it our mission to improve the health, well-being, and peace of mind for our customers - delivering quality care at an affordable price. Especially in times of uncertainty, you can count on us to work hard and help you safeguard your health and financial stability.

Learn More

Carrier Name: Dean/Prevea360

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours: Mon - Thurs: 7:30 a.m. - 5:00 p.m. CST
Friday: 8:00 a.m. - 4:30 p.m. CST

Phone Number: 1.877.232.9375

Who We Are: With access to more than 4,000 practitioners and close to 200 primary care sites and 28 hospitals, Dean Health Plan connects a strong network of health care providers, innovative hospitals, and comprehensive insurance coverage into one integrated health care system working for you.

Learn More

Carrier Name: Geisinger Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://geisinger.org/aon

Once you're a member (website): https://www.geisinger.org/member-portal

Customer Service Hours: Monday - Friday: 7:00 a.m. - 7:00 p.m. EST
Saturday: 8:00 a.m. - 2:00 p.m EST

Phone Number: 1.844.390.8332

Who We Are: Choosing a good health insurance plan is more important than ever. With Geisinger Health Plan, we cover the services you need and help you stay healthy by better managing your healthcare needs.

Learn More

Carrier Name: Health Net

Areas We Serve: Oregon and select markets in California
Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PT

Phone Number: 1.888.926.1692

Who We Are: Health Net.… Coverage for every stage of life™

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours:
CA: 24/7 except major holidays
CO: Mon - Fri: 8:00 a.m. - 6:00 p.m. MST
GA: Mon - Fri: 7:00 a.m. - 7:00 p.m. EST
DC, MD, VA: Mon - Fri: 7:30 a.m. - 9:00 p.m. EST
OR and WA (Vancouver/Longview area): Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number:
1.877.580.6125, CA Post-enrollment: 1.800.464.4000
CO Post-enrollment: 1.303.338.3800
GA Post-enrollment: 1.404.504.5712
DC, MD, VA Post-enrollment: 1.800.777.7902
OR and southwest WA Post-enrollment: 1.800.813.2000

Pre-enrollment Phone Number: 1.877.580.6125

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/wa/aonactivehealth

Once you're a member (website): https://wa-member.kaiserpermanente.org

Customer Service Hours: Monday - Friday: 8:00 a.m. - 5:00 p.m. PST

Phone Number: 1.855.407.0900

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Medical Mutual

Areas We Serve: Generally available in OH

Before you're a member (preview site): http://www.medmutual.com/aon

Once you're a member (website): https://member.medmutual.com

Customer Service Hours: Monday- Thursday: 7:30 a.m. - 7:30 p.m. EST Friday: 7:30 a.m. - 6:00 p.m. EST Saturday: 9:00 a.m. - 1:00 p.m. EST

Phone Number: 1.800.541.2770

Pre-enrollment Phone Number: 1.800.677.8028

Who We Are: We care about the health and wellbeing of Ohioans. That's why we offer high-quality health insurance plans with access to the doctors and hospitals you know and trust. Plus, prescription drug coverage, personalized wellness programs and more.

Learn More

Carrier Name: Priority Health

Areas We Serve: Available in the lower peninsula of MI

Before you're a member (preview site): https://www.priorityhealth.com/aon

Once you're a member (website): https://member.priorityhealth.com/

Customer Service Hours: Monday -Thursday 7:30 a.m. -7:00 p.m. EST
Friday 9:00 a.m. - 5:00 p.m. EST
Saturday 8:30 a.m. - noon EST

Phone Number: 1.833.207.3211

Who We Are: Looking for a health plan that fits with your lifestyle? We work hard to create health insurance plans that work for you, your family, your health status and your budget. From cost cutting tools to nationally-recognized customer service, Priority Health delivers a better experience.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://eims.uhc.com/aon8

Once you're a member (website): http://myuhc.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. all time zones

Phone Number: 1.888.297.0878

Pharmacy Contact (CVS Caremark): 1.888.202.1654

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: UPMC Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours: Monday-Friday: 7:00 a.m. - 7:00 p.m. EST Saturday: 8:00 a.m. - 3:00 p.m. EST

Phone Number: 1.844.252.0690

Phone Number: 1.844.252.0690

Who We Are: Here's the plan for getting the high-quality care you and your family deserve: Choose UPMC Health Plan. When you do, you can expect the best.

Learn More

Get Carrier Ratings

See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available at **digital.alight.com/grantthornton** during enrollment and throughout the year.

Your specific medical options are based on where you live. You'll be able to see the options available to you when you enroll. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: Coverage may be slightly different than the Silver option on this site. Refer to **digital.alight.com/grantthornton** for details.).

Contacts

You can reach a customer service representative by web chat through the Grant Thornton Benefits Center website at **digital.alight.com/grantthornton**. You can also call the Grant Thornton Benefits Center at **1.833.476.2341** from 8 a.m. to 5 p.m. CT Monday through Friday. If you don’t connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Health Pros are also available to assist with tough issues like claims and billing disputes.

Questions About Coverage?
Start by contacting the **insurance carrier** directly. They know their coverage rules best.

If you enrolled in a Bronze Plus or Silver medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Have questions about your claims or coverage? Start by contacting your **insurance carrier** directly. They know their coverage rules best and have the final say on all claims and billing questions.

Sometimes you need more help than your insurance carrier can provide. If you have a billing issue, such as your provider charging you more than the amount your Explanation of Benefits (EOB) says you owe, or you believe your plan covers more than what your EOB shows, Alight Advocacy Services is available. Alight Health Pros are experts in handling and resolving your claims and billing issues. Find more information about Health Pros **here**.

If you aren't satisfied with the resolution, you can file an appeal through your insurance carrier, who will be able to direct you through that process.

Have a large provider bill? **Bill negotiation services** may be able to save you 20% or more.

Questions?

Don't worry. You have backups. When you face a billing issue:

1. Start with your insurance carrier.
2. Email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530** if you need help.
3. File an appeal if you're unhappy with the final outcome.

Get the Answers

Have a question? We've got you covered.

Start with the **Frequently Asked Questions** (PDF).

Wondering what something means? Check out the **Glossary**.

Just want to talk to a real person? No sweat! Here's who to **contact**.

Glossary

Wondering what a term means? Find it here!

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Coverage Level
A benefit level that determines how services are covered.

Credit
Grant Thornton's contribution towards your medical coverage (as applicable). This is separate from the Healthy Lifestyles credit that eligible employees can earn each year to also offset premiums.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. **How the deductible works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual deductible. They only count toward your out-of-network deductible.

EOB
Also known as an Explanation of Benefits. An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
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. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and effective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for qualified health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. **How the out-of-pocket maximum works** depends on your coverage level. 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.

Pharmacy Benefit Manager
The insurance carrier or third-party administrator who manages your retail and mail-order prescription drug benefit.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a specific area for a specific service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

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.

True Family Deductible
The entire family deductible must be met before your insurance will pay benefits for any covered family member.

True Family Out-of-Pocket Maximum
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.

Newly Eligible for Benefits?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in Grant Thornton benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2022 benefits, you can start here:

- **Quick Guide**
- **Enrollment Checklist**
- **Medical**

Make It Yours

Once you’ve done your homework, if you want coverage through Grant Thornton, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug coverage through Grant Thornton for you and your family.

Enroll now

Questions?

Check out the **Frequently Asked Questions** (PDF) for more details.

Helpful Documents

Additional Resources

- **Enrollment Checklist**
- **Carrier Listing by State and Shortcut to Find Your Doctors**
- **Instructions for "Help Me Choose" Enrollment Experience**

Resources for Active Employees Only

- **Quick Guide**
- **Frequently Asked Questions (FAQs)**
- **Example of Basic Group LTD and Supplemental Individual Disability Insurance coordination**
- **Prescription Drug Worksheet**
- **Transition of Care Worksheet**

COBRA Coverage Options

If you leave the company or lose coverage due to a status change, your COBRA enrollment notice has details regarding your options.

If you choose not to enroll by your COBRA enrollment deadline, you will not be able to enroll in COBRA coverage in the future. Also, once enrolled, you can make changes to your elections only during enrollment or following a qualified change in status.

You will receive additional information—including prices—once you lose access to health benefits through the company.

Your COBRA Coverage Options

You can start by reviewing your **medical** coverage level options.

You'll also want to review your **insurance carrier** options.

How To Enroll

To enroll in COBRA coverage when eligible, follow the instructions on the COBRA enrollment notice mailed to you.