FAQs for active employees

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FAQs

The Aon Active Health Exchange™

1. What is a health exchange?

A health exchange is an online insurance marketplace where buyers like you can shop for medical and prescription drug coverage from multiple health insurance carriers who are competing for your business. A health exchange merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

Grant Thornton has chosen to offer your medical benefits through the Aon Active Health Exchange—America's first national, large-employer, multi-insurance carrier private health exchange. Its website is easy to navigate and, just like other online stores, you will be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you have selected the right coverage options for your circumstances and budget.

2. Is Aon's health exchange sponsored by the government?

No. The Aon Active Health Exchange is a private health exchange. It is unrelated to the government-run state and federal health insurance exchanges or marketplaces. It does, however, provide benefits consistent with the law and guarantees coverage for those eligible, regardless of pre-existing conditions.

3. What are the advantages of the exchange?

The medical and prescription drug benefits available through the health exchange offer you:

- **Lots of choices.** Traditionally, you got to choose from the health benefit options and coverage levels offered through a single carrier—Blue Cross Blue Shield of Illinois. Through the health exchange, you are able to choose from health benefit options and coverage levels offered from a variety of insurance carriers, and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business. So it is in their best interests to offer their best prices. Plus, if you participate in this year's Healthy Lifestyle questionnaire, you have the opportunity to earn a credit of $50/month to use toward the cost of your coverage.

You also have help when you need it. There are great tools and resources to help you every step of the way. See question #5 for details about tools and resources.

4. How many carriers will be available to me?

The number of carriers available for you to choose from will vary based on where you live (as defined by your home zip code). Most markets will have up to four national carriers available; other markets will also have regional carrier networks to choose from. See more information in My Options below to understand considerations when evaluating national vs. regional carriers.

5. Where can I get more information?

There are lots of resources available to help before, during, and after enrollment.

<table>
<tr><th></th><th colspan="2">Before you enroll</th><th>When you enroll</th><th>After you enroll</th></tr>
<tr><td>Make It Yours website</td><td colspan="2">grantthornton.makeityoursource.com

Learn how the health exchange works and what coverage options you may have—and get tips for choosing the right coverage for you. You can also watch videos and access the insurance carrier preview sites here.

This is an information only website. You will enroll on the Grant Thornton Benefits Center website (see below).</td><td></td><td>Visit year-round for practical tips that help you to get the most out of your benefits. Get “The Inside Scoop” on how to work the health care system, be a savvy shopper, and even save some money.</td></tr>
<tr><td>Your Carrier Connection

(Available through the Make It Yours website)</td><td colspan="2">Carrier preview sites: Get up to speed on provider networks, prescription drug information, and other carrier resources. Visit the Make It Yours site (click on “Your Carrier Connection” on the home page) to access carrier “Before You’re a Member” preview sites.

And you can contact insurance carriers directly with specific questions (contact information is also available on the Make It Yours website).</td><td></td><td>Once you are a member: Take advantage of all the tools, resources, and information offered through your insurance carrier. For questions about your coverage, always start with your carrier. They know their plans best and have the final authority on all claims, billing disputes, etc. (contact information is available on the Make It Yours website).</td></tr>
<tr><td>The Grant Thornton Benefits Center website</td><td>Not available</td><td></td><td>Log on to the Grant Thornton Benefits Center website found on Canvas, at digital.alight.com/grantthornton, or by using the Alight mobile app where you can compare your options, get helpful decision support, and enroll. You will also see prices by option including the amount of premium you will pay and the amount of the premium that Grant Thornton will pay on your behalf.

If you still have questions, you can reach a customer service representative by web chat through the Grant Thornton Benefits Center website. You can also call the Grant Thornton Benefits Center at +1 833 476 2341 from Monday through Friday, from 8 a.m. to 5 p.m. CT. 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.</td><td>Once coverage begins: Access your personalized coverage details and manage your benefits throughout the year through the Grant Thornton Benefits Center by web, phone, or mobile app. Call center and web chat representatives will be available Monday through Friday, from 8 a.m. to 5 p.m. CT.

In addition, the carriers you have selected will be equipped to answer coverage questions specific to your plan once you are enrolled.

If you need help with more complex coverage issues, call +1 866 300 6530 and ask to be connected with an Alight Health Pro. Health Pros can explain how benefits work and help resolve issues.</td></tr>
<tr><td>“Alight Mobile” app</td><td colspan="3">Download the “Alight Mobile” app from the Apple or Google Play app store. Search for “Grant Thornton” during account setup. When prompted, choose to log on with employer credentials. Enter your Grant Thornton Benefits Center credentials (which are the same you use to log on to Canvas), and then you’re ready to go!

Can’t remember how to log in? The app will walk you through steps to retrieve and/or reset your username and password.</td></tr>
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6. What internet browser should I use to access the Make It Yours site?

Google Chrome is the recommended browser for accessing the Make it Yours site for a more optimal experience. If you are using Internet Explorer, we encourage you to switch to Google Chrome. If you are using an outdated browser, you will see a warning when you visit the site.

Enrollment

7. What will I need to do for enrollment?

You must enroll or you will **not** have medical coverage through Grant Thornton. Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either. If you would like to contribute to a Health Care Flexible Spending Account, Limited Flexible Spending Account, or Dependent Care Spending Account you must actively enroll. While you can set up your HSA funding at any time during the year, you must be enrolled in a Bronze Plus or Silver option in order to contribute.

To enroll, log on to the Grant Thornton Benefits Center website at digital.alight.com/grantthornton (available through single-sign-on from your Grant Thornton computer). You will need to:

- Enroll the eligible dependents you want to cover in 2022.
- Choose the insurance carrier and coverage level you want for your medical benefits.
- Set up funding for spending accounts if you want to participate.
- Enroll in dental, vision, and other insurance coverages.

8. How can I access the Help Me Choose tool?

The Help Me Choose tool can be found on the Grant Thornton Benefit Center website available through single-sign-on from Canvas, via the Alight Mobile app or directly at digital.alight.com/grantthornton.

9. Do we have to use Help Me Choose to see the firm subsidy?

No. You will see the firm's subsidy prior to entering the Help Me Choose experience. Once you log in, you'll be asked to confirm your information, then you'll be taken to a summary of your benefits to begin, where you can choose to be taken through the enrollment flow OR choose to start with medical. At this point, you'll begin "Step 1: Choose who you want to cover" and will be asked to add any dependents, if applicable. Once completed, you will continue to Step 2, where you will be able to see Grant Thornton's subsidy/credit.

My options

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

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

Coverage with the national carriers (BCBSIL, UnitedHealthcare, Aetna, Cigna) will offer prescription drug benefits from CVS Caremark. Regional carriers maintain their own prescription drug networks, so there could be variances in how prescription drugs are covered.

As part of the enrollment experience, you will have tools and resources available to you to check both physician/hospital networks AND prescription drug coverage to ensure you select the coverage option that is best for you and your family.

11. What happens if I enroll in a Bronze Plus or Silver HDHP medical option and have expenses shortly after benefits take effect?

When you make the decision to enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible in case you have significant medical expenses shortly after benefits take effect. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. One option is to pay for those early qualified expenses out of pocket and then, when your account balance grows enough to cover the expense, reimburse yourself from your HSA. This is a good reason to make sure you are saving enough in an HSA.

12. I live in California. How are my medical options different?

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

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

Also, insurance carriers can choose to offer either the standard Gold option or a Gold II option—not both. The Gold II option only offers in-network benefits. You need to give careful consideration to this difference if you travel outside your state for either work or pleasure.

The Gold option is offered by Aetna, Blue Cross Blue Shield of Illinois, and UnitedHealthcare. The Gold II option is offered by Cigna, Health Net, and Kaiser Permanente.

Also, make sure you check the prescription drug benefit with each carrier. Regional carriers will have different prescription drug coverage plans than those with the national carriers.

Learn more about your California coverage options and insurance carriers.

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

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors under "in-network" coverage, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, then select an insurance carrier whose network includes providers critical to your care.

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

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you are considering on the Grant Thornton Benefits Center website available through single-sign-on from Canvas, via the Alight Mobile app or directly at digital.alight.com/grantthornton.

For the best results:

- Search for your provider by name—not medical practice.
- Check only the office location(s) you are willing to visit.
- When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, you need to call the insurance carrier.

14. 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 will also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you have reached your annual out-of-network out-of-pocket maximum. And certain regional carrier options will not cover out-of-network services other than urgent and emergent situations. You must remain in-network and designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold II as your coverage level.

15. What is the definition of "out of network"?

Out of network is using a provider that is not within the carriers' contracted providers, which is driven by zip code. The national carriers have broad networks across the country, so you can see an in-network provider in different states. The regional carriers are more restrictive; for example, Kaiser is available in certain geographies, but if you go to a provider outside their available service area, that service would be billed as out of network. The carrier preview sites do offer the opportunity to enter a zip code and search various areas, not only your home zip code.

16. What out-of-state coverage considerations should I factor in?

If you are a frequent traveler who travels outside your state: You may want to consider one of the national insurance carriers that offer national provider networks outside your state. Urgent and emergent situations are covered as in-network by regional health plans for domestic and international travel. In some cases, coverage is available through a carrier's service area network through other partners. Carrier preview sites will state the expansions as part of provider search tools. Visit the Make It Yours site (click on "Your Carrier Connection" on the home page) to access carrier "Before You're a Member" preview sites.

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

If you travel internationally: You may want to consider one of the national insurance carriers that offer national provider networks and review how they cover international travel. Individuals who go on international assignment through the firm's GEMS program will be enrolled in an International Expatriate coverage option while on assignment. If you are planning international vacation travel, you might want to consider enrolling in the International Vacation Insurance to supplement your medical coverage needs.

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

If your insurance carrier name includes a state (e.g., Blue Cross Blue Shield of Illinois), this refers to the location the carrier operates from (i.e., which state has primary jurisdiction over the laws, rules, and regulations the carrier follows). In general, it is not a reference to the network—many offer coverage nationally.

Just think—when in doubt, check it out!

17. What if my dependents include children attending school out of state? Will they have in-network coverage under the Exchange?

We recommend you consider a national carrier since their networks are the broadest and typically have in-network providers across the country. Through the carrier provider search tools, you can enter a dependent's address to search for in-network providers/facilities based on their zip code. We also encourage you to contact the carrier service centers to ensure your specific questions and concerns are answered.

18. If we are traveling out of the country for a GT engagement, are we covered? Or do we need to add the international coverage at our expense?

The four national carriers will typically cover urgent and emergent medical situations while out of the country as "in-network" coverage. If you travel internationally for business, you will want to research the carriers to understand how they handle emergency medical needs while out of the country on routine business.

In addition to your medical plan coverage, when you book your travel on your firm's Diners card, Travel Services Medical Protection is also provided through Diners Club International. Diners' Travel Services Medical Protection provides assistance if you have a medical emergency away from home (this is a pay-per-use service). This includes access to a global referral network of local physicians, dentists, hospitals and pharmacies, and provides emergency treatment by a physician or dentist for covered expenses of up to $2,500 (a $50 deductible is applicable per person per trip). Check with Diners for more details on this benefit.

Grant Thornton also offers the services of International SOS (ISOS). While ISOS is not a medical plan, it does provide employees access to a medical and security *advisor* for emergency assistance when traveling outside the United States. ISOS is a network of medical and professional service teams that operates 24x7/365, all over the world. Information on the ISOS program is available on Canvas.

For international assignments through our GEMS program, GT offers an Expatriate Medical plan which secondees will be enrolled in while on international assignment.

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

You will have access to a number of resources to help you make smart decisions. You should start by visiting the Make It Yours website at grantthornton.makeityoursource.com to access videos, details about your options, comparison charts, and more.

Then, when you enroll you will be able to see your price options, including the amount you pay and what Grant Thornton pays on your behalf, on the Grant Thornton Benefits Center website at digital.alight.com/grantthornton (available through single-sign-on from your Grant Thornton computer). You will also be able to access tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings, and more.

If you still have questions, you can reach a customer service representative by web chat through the Grant Thornton Benefits Center website. You can also call the Grant Thornton Benefits Center at **+1 833 476 2341** from Monday through Friday, from 8 a.m. to 5 p.m. CT. 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. You can also call the insurance carriers with specific questions about the options they offer.

20. Can you explain how the Traditional vs. True Family deductible works?

For the traditional deductible, each person has an individual deductible and out-of-pocket maximum. As soon as one family member reaches the individual deductible, that person's expenses will have coinsurance applied up to their out-of-pocket maximum. In addition, claims incurred by the family will continue to accumulate towards the family deductible. Once the family deductible is met, coinsurance is applied for everyone until the family reaches the family out-of-pocket maximum.

With the true family deductible, all claims for a family will aggregate towards the family deductible. There is no limit to the amount one member can pay toward the family deductible. Once the deductible is met, coinsurance will be applied to future claims up to the family out-of-pocket maximum.

21. Will pre-existing conditions be covered?

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

22. When utilizing multiple providers (i.e., surgeon and anesthesiologist) what is the best way to ensure they are both in-network to avoid finding out after a procedure that one is considered out-of-network?

The first step is to confirm if the facility where a planned procedure will occur is in-network. After you have done that, you can use the tools available during enrollment to help identify the providers and their locations which are in-network with the specific carrier. Please be sure to include all locations where a provider is listed to cover all the possible locations as providers may service from various locations. You can also contact your carrier to see what information they might have or contact the facility to get a list of on-site specialists who might be working on your procedure.

23. Besides the cost of the premiums, a main cost consideration and benefit in choosing a provider is their ability to negotiate favorable cost of service and procedures with health care providers for the portion that comes out of our pockets. Is there a way to compare how each insurance provider succeeds in that area? Can we see the cost comparisons for a core set of services, like cost for an Urgent Care Visit, an X-Ray, Blood Test, and other most common items?

This information is proprietary to the carriers and their contract providers. As such, carriers do not share their negotiated rates. Employees should feel free to contact the carrier with specific questions about coverage and cost. Additionally, the Exchange Broker (Aon) does not track/collect information based on supplied carrier cost. That is specific to the contracted carrier/provider.

24. 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.

Coverage with the national carriers (BCBSIL, UnitedHealthcare, Aetna, Cigna) will offer prescription drug benefit coverage from CVS Caremark. Regional carriers maintain their own prescription drug network, so there could be variances in how prescription drugs are covered.

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That is why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication, it is strongly recommended that you use available resources before you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website for a list of questions to ask and also check out the "Your Carrier Connection" section to link to carrier preview sites and reach to carriers if needed.

Paying for coverage

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

You will be able to see the amount you will pay and the amount paid by Grant Thornton (if applicable) when you enroll on the Grant Thornton Benefits Center website available through single-sign-on from Canvas, via the Alight Mobile app or directly at digital.alight.com/grantthornton.

26. Is a Healthy Lifestyle Credit available?

Grant Thornton will offer an opportunity to earn a Healthy Lifestyle Credit of up to $600 per year. You will need to answer one simple question during enrollment and attest that you will follow your physician's guidance with respect to getting an annual periodic physical for yourself and any covered dependents. Once we have confirmation you have completed the attestation, your credit will begin the later of Jan. 1, 2022 or the pay cycle following confirmation of completion.

Health Savings Accounts and Health Care Flexible Spending Accounts

27. What is a Health Savings Account (HSA)?

An HSA is a special bank account that you can put money in when you enroll in a Bronze Plus or Silver High Deductible Health Plan (HDHP) coverage level. Unlike a medical FSA, this is not a "use it or lose it" account. HSA accounts are more like personal savings accounts with balances that carry over from year to year. They earn interest on a tax free basis, and if you make contributions via payroll deduction, you also avoid federal income tax and federal payroll tax.

HSAs allow you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. Because you will be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze Plus or Silver coverage levels, an HSA is a great way to pay less for those out-of-pocket expenses because you are using tax-free money. And if you change coverage levels to move out of a HDHP in the future, you can still use funds to pay qualified health care expenses—you just cannot put more money in.

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

As long as you are enrolled in the Bronze Plus or Silver High Deductible coverage level, you can decide whether to enroll in an HSA and how much (if any) money you want to contribute at any point in time during the year. You can also fund your account with after tax dollars and take a deduction on your federal tax return. And if you do not have a lot of health care expenses, 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 specific situation, you should consult a tax professional.

28. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. You decide how much money you want to contribute, and you can change your contribution election at any time. If you do not have a lot of health care expenses, your money can stay in your account year to year. And, as long as you save your receipts for qualified medical expenses, you can reimburse yourself from your account in any year—not just the year the expense is incurred.

The HSA has the following tax advantages:

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

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

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

30. What is the difference between a general purpose Flexible Spending Account (FSA) and a Limited Purpose Flexible Spending Account (LP FSA)

A general-purpose FSA will cover all eligible medical, dental, vision, and pharmacy expenses while a Limited Purpose FSA (LP FSA) will only cover eligible dental and vision expenses.

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

If you enroll in the Bronze Plus or Silver HDHP coverage level, you can use an HSA, a Health Care FSA, or both an HSA **and** a Health Care FSA. If you have an HSA and a Health Care FSA, in order to contribute to an HSA, your Health Care FSA must be "limited purpose" and can only be used to pay for eligible dental and vision expenses. However, once you meet the medical deductible, then it can be used toward eligible medical and prescription drug expenses as well. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses.

32. Why would I want to use both an HSA and a limited purpose Health Care FSA?

Both accounts allow you to pay for eligible expenses with tax-free dollars. The biggest difference between the accounts is that your HSA balance rolls over from year to year, even if you change medical plans, leave the company, or retire. With the Health Care FSA (whether limited purpose or not), any unused balance is forfeited at the end of the year.

It may not be advantageous to enroll in both, except in unique situations. For example, if you expect to have higher expenses than your HSA balance can cover (based on the maximum you can contribute each year), you may also want to contribute to the limited purpose Health Care FSA to pay for those expenses with tax-free money once the medical deductible is reached. Or you may want to fund the HSA and have the balance carry over and grow from year to year to grow and invest towards retirement and use the FSA to pay for current medical expenses.

33. Can I contribute to an HSA if I am covered under my spouse's general purpose Health Care FSA?

No. If your spouse's general purpose Health Care FSA covers your medical expenses, it would be considered other health coverage and you would not be eligible to contribute to an HSA.

34. Can I contribute to an HSA?

In order to contribute to any HSA, you need to meet the following criteria:

- You must be enrolled in a high-deductible option at the Bronze Plus or Silver coverage level;
- You cannot be enrolled in Medicare or a veteran's medical plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return;
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option; and
- You cannot be enrolled in a general purpose Health Care FSA, but you may be enrolled in a limited purpose Health Care FSA.

You can use money from your HSA to pay your dependents' health care expenses as long as you claim them as dependents on your federal income taxes (generally children up to age 19 or under age 24 if they are full-time students).

After you enroll

35. Where can I find summary plan descriptions (SPDs) or more information on my plan?

SPDs and benefit details will be available through the Grant Thornton Benefits Center website year-round.

36. Will the Advocacy Services (provided by Health Pros) be able to assist with the claims appeal process when a carrier denies a claim/procedure?

Yes, Health Pros (which the firm pays for on your behalf) can provide assistance with general support with in-network claims issues, general questions related to understanding your EOB, and any support you might need interacting with your medical carriers and their providers on your behalf.

37. Who completes the process depends on where you get care?

When you stay in network, your doctor usually completes the process on your behalf when it is required. But you should always confirm with your doctor to be sure he or she is handling it.

If you go out of network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you do not get preapproved, you could get stuck paying most or all of the bill or 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.

38. Will we receive a Total Rewards statement to see how much GT contributes for health care premiums on behalf of its employees?

While we had to discontinue the Total Rewards statements due to changes in technology, you can still see the amount of employer contribution on your W-2 as well as on the GT Benefit Center portal.