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FAQs

If you have a specific question, see if it's in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, feel free to browse and scan the FAQs at your own pace.

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The Aon Active Health Exchange™

1. What is an exchange?

An exchange is a way for you to get medical, dental, vision, and other coverages. It is an online marketplace where buyers like you can shop for coverage from multiple health insurance carriers who are competing for your business. An exchange merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

The Aon Active Health Exchange ("Exchange") is a virtual, employer-sponsored marketplace where team members can review, compare, and select a range of benefit programs and services that meet their needs. The Exchange's website enables you to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you will feel confident that you've selected the right coverage options for your circumstances and budget.

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

No. The Aon Active Health Exchange is a **private** exchange. It is unrelated to the government-run federal and state 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, dental, and vision benefits available through the Exchange offer you:

- **Lots of choices.** Through the Exchange, you're able to choose from several coverage levels, a variety of insurance carriers, and a range of costs.
- **Personalization.** One size does not fit all when it comes to benefits. By selecting from a variety of benefit options, you can build a total benefits package that is most relevant and meaningful to **you**.
- **Competitive pricing.** The insurance carriers are competing for your business as an individual. So, it's in their best interests to offer you their best prices. Plus, Slalom Consulting will provide a credit/subsidy to use toward the cost of your medical and dental coverage.

In addition, you have the opportunity to enroll in other valuable benefits through the Exchange—including hospital indemnity insurance, accident insurance, and legal services. You can also get discounted rates for auto and home insurance and pet insurance.

You have help when you need it. There are great tools and resources to help you every step of the way. See question #4 for details about tools and resources.

4. Where can I get more information?

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

Before and during enrollment:

- **Make It Yours website**—Visit **https://makeityours.us.slalom.com** to learn about the Exchange, your coverage options, and choosing the right coverage for you and your family.
- **Your Carrier Connection** (available through the Make It Yours website)—Visit each carrier's preview site to get up to speed on provider networks, prescription drug information, and other carrier resources.
- **The Thrive Benefits Portal**—When it's time to enroll, log on to the Thrive Benefits Portal at **https://benefits.us.slalom.com** to compare your options and prices, get helpful decision support, and enroll.
- **Slalom Benefits Support Center**—You can reach a customer service representative by web chat or by scheduling an appointment through the Thrive Benefits Portal. You can also call the Slalom Benefits Support Center at **1.844.962.0173** from 8:00 a.m. to 6:00 p.m. PT, 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.

Managing your benefits:

- **Make It Yours website**—Visit year-round for practical tips that help you and your family get the most out of your benefits. Get the "**The Inside Scoop**" on how to work the health care system, be a savvy shopper, and save money.
- **Your Carrier Connection** (available through the Make It Yours website)—Take advantage of the tools, resources, and information offered through your insurance carrier. For questions about your coverage, always start with your carrier. They know their plans best and have the final authority on all claims, billing disputes, etc.
- **The Thrive Benefits Portal**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help with more complex coverage issues, call **1.866.300.6530** and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues. Bill negotiation representatives can help review and negotiate out-of-network medical bills.

Enrollment

5. What will I need to do?

You must enroll before your deadline or you will not have medical, dental, vision, or voluntary benefits coverage through Slalom. Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either. And, to contribute to a Health Savings Account (HSA) or to a flexible spending account, you must make an active election. To enroll, log on to the Thrive Benefits Portal at **https://benefits.us.slalom.com** during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2023.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits.

You can get information about enrollment on the Make It Yours website at **https://makeityours.us.slalom.com**.

6. What else should I do during enrollment?

During your enrollment process, you will need to update or add your beneficiary information for all coverages that require a beneficiary (e.g., life insurance and disability insurance benefits). If you enroll any dependents, your confirmation page may prompt you to take any further action, with directions for providing additional information where needed to complete the process.

7. Who qualifies as a dependent and able to be added to my coverage?

- In order for any eligible dependent to be enrolled under coverage, the employee must be eligible and enrolled under coverage.
- Eligible spouses or domestic partners, including marriage, civil unions, common-law couples of opposite- and same-sex that are recognized at the municipal, state, or federal level through an affidavit or certification for domestic partnership.
- Children under the age of 26, including biological, adopted, or under legal guardianship of the eligible employee.

My Options

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

The medical coverage options (i.e., plan designs) available through the Exchange include familiar types of plans such as high-deductible health plan coverage, PPOs, and HMOs. The options are named **Bronze**, **Bronze Plus**, **Silver**, **Gold**, and **Platinum**. As always, you will decide whether you want to pay more from each paycheck and less when you receive care, or less from each paycheck and more when you receive care. Please note that the:

- Bronze, Bronze Plus, and Silver plan designs are qualified High Deductible Health Plans (HDHPs) that allow you to open and use a Health Savings Account (HSA) to pay for your out-of-pocket health care expenses or to save for future needs as money you put into an HSA is yours to keep; and
- Gold and Platinum plan designs are traditional plans that offer lower deductibles and copays, but usually higher premiums with copays, and cannot be used with an HSA.

  Note: Please note that if your spouse or partner is enrolled in a non-HDHP plan at another employer and you are also covered by that plan, you are not allowed to use an HSA in accordance with IRS rules.

While the plan designs are the same across each region and each carrier, both the price (i.e., premium) and the network of health care providers that are available to you are different by carrier and by location—the latter of which is based on your home address, not work address. Please note that your health care provider will not know what the terms Bronze, Silver, Gold, and Platinum mean. To determine if your health care provider or facility is in-network under the plan or plans that you are considering, visit each carrier's preview site from the Your Carrier Connection page on the Make It Yours website.

When you enroll, you will be able to compare benefits and features across your medical options. Do not let the names of the options fool you, though. Choose the option that is best suited to your individual needs and situation so that you get the right coverage for you and your family. Specific details about the options available to you will be available on the Thrive Benefits Portal when you enroll.

While you may be most comfortable with a certain carrier you have used in the past, we strongly encourage you to evaluate all carrier options. The carriers offer identical plan designs, meaning you may be able to get equal coverage for a lower price if you switch to a new carrier. If you need help with how your current care or treatment may transition to a different carrier, check out the Transition of Care worksheet on the Make It Yours website.

9. What happens if I enroll in a Bronze, Bronze Plus, or Silver medical option and have expenses early in the plan year?

The Bronze, Bronze Plus, and Silver medical options are High Deductible Health Plans—meaning you will pay the full deductible amount required by the plan before the insurance carrier pays a portion of your costs. These plans also come with the opportunity to elect to contribute to a Health Savings Account (HSA). If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible early in the year—in case you have significant medical expenses shortly after the plan year begins. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. One option is to pay for those early expenses out of pocket and then, when your account balance grows enough to cover the qualified expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in an HSA.

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

Your options will be different, depending on the insurance carrier you choose. For starters, each insurance carrier in California can choose to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** as an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold II option **only** offers in-network benefits.

The Gold option is offered by Aetna, Blue Cross by Premera, Cigna, and UnitedHealthcare. The Gold II option is offered by Health Net and Kaiser Permanente. Learn more about your California coverage options and insurance carriers here.

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

Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). And **doctors can move in and out of carrier networks at any time**. If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care. Even if you can keep your current insurance carrier through the Exchange, the provider network maybe different and can change, so **always** check the provider directories before deciding.

To see which coverage level and carrier combination could be the best fit for you and your family, take advantage of the **Help Me Choose** tool within your enrollment process. By answering a few questions about your preferences up front, you can easily see the options that are the best match for the features and preferences you've identified. You can also add your preferred doctors, hospitals, and prescription drugs to further fine-tune your search—and compare up to three options side-by-side. The engine behind the **Help Me Choose** tool uses the answers you gave, along with other national data, to assign a score (called a "Plan Score") to each of your options and lists them starting with your best matches up top. (It's important to note that sometimes, depending on how you answered the questions when you first opened the tool, the plan with the highest plan score may not have the lowest expected cost.)

Important: 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're considering on the Thrive Benefits Portal. For the best results:
  - Search for your provider by name—not medical practice.
  - Check only the office location(s) you are willing to visit. Your provider may be in-network at one location and out-of-netwoirk at another location.
  - 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, you will cover out-of-area dependents) or you need the network name, you need to call the insurance carrier.

12. I'm familiar with a certain carrier from prior experience. Is that carrier the same on the Exchange?

No. While the names may be the same as you're accustomed to, each carrier on the Exchange offers different provider networks and plans for different geographies. Just because you have experience with a certain carrier does not mean that carrier's offering for Slalom team members will be the same. It is critical that you check providers and plan details for all carriers available to you, regardless of any previous experience.

13. Why should I use in-network providers?

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

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

Remember, your coverage is based on where you live, not the location of your Slalom office.

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers (Aetna, Blue Cross by Premera, Cigna, and UnitedHealthcare) that offer nationwide provider networks so that your dependents have access to in-network providers in most locations.

Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.

Do not rely on your provider's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network. When you enroll, check the networks of each insurance carrier you're considering on the Thrive Benefits Portal. For best results, follow the guidelines outlined in Question #11.

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

You'll have access to several resources to help you make smart decisions. You should start by visiting the Make It Yours website at **https://makeityours.us.slalom.com** to access videos, details about your options, comparison charts, and more.

Once enrollment begins, you will then have access to cost information and additional personalized comparison tools—and you will be able to elect your benefit options for 2023—on the Thrive Benefits Portal at **https://benefits.us.slalom.com**.

One such personalized tool is **Help Me Choose**. Take advantage of the **Help Me Choose** tool within your enrollment process to see which coverage level and carrier combination could be the best fit for you and your family. By answering a few questions about your preferences up front, you can easily see the options that are the best match for the features and preferences you've identified. You can also add your preferred doctors, hospitals, and prescription drugs to further fine-tune your search—and compare up to three options side-by-side. The engine behind the **Help Me Choose** tool uses the answers you gave, along with other national data, to assign a score (called a "Plan Score") to each of your options and lists them starting with your best matches up top. (It's important to note that sometimes, depending on how you answered the questions when you first opened the tool, the plan with the highest plan score may not have the lowest expected cost.)

If you need additional help, you can reach a customer service representative by web chat or by scheduling an appointment through the Thrive Benefits Portal. You can also call the Slalom Benefits Support Center at **1.844.962.0173,** Monday through Friday, from 8:00 a.m. to 6:00 p.m. PT, to answer questions about the Exchange and the enrollment process. 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 carrier with specific questions about the options they offer.

16. Will pre-existing conditions be covered?

In accordance with current federal law, all medical plans that Slalom offers through the Exchange guarantee coverage, regardless of whether you and/or your eligible dependents have pre-existing conditions. If you're switching carriers and you and/or a covered family member is under treatment or has a pre-existing condition, you may be able to temporarily continue care at the network rate once your new medical coverage begins. You should contact the carrier you're considering to determine their rules for transition of care. Visit the Make It Yours website for a helpful Transition of Care worksheet that provides a list of questions to ask the carrier(s) you may be considering. And, if you need further help with transition of care, you can email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530**.

17. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your medical insurance carrier's pharmacy benefit manager, which may be a separate prescription drug company, such as Express Scripts for Cigna and Optum for UnitedHealthcare. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication, it is strongly recommended that you call the medical insurance carrier before you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website for a list of questions to ask.

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

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting a "prior review" (also referred to as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition, and confirm how the bill is going to be paid.

Who completes the process depends on where you get care:

- When you stay in-network, your doctor usually completes the process on your behalf when it's required. But you should always confirm with your doctor to be sure he or she is handling it.
- If you go to an out-of-network provider, 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 a prior review is required and you don't get preapproved, you could get stuck paying most or all of the bill and/or a penalty. For that reason, it's always in your best interest to ask your doctor whether you need to do anything in advance and confirm that services you need will be covered by your insurance carrier. Emergency services do not require prior review or authorization.

If you need help with prior review, you can email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530**.

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

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

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

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the Thrive Benefits Portal.

If you are considering a Platinum dental option:

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

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

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

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

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the Thrive Benefits Portal.

21. What other optional, voluntary benefit programs and services are available to me through the Exchange during enrollment?

The following is a list of supplemental, voluntary, and employee-paid coverages, available through the Thrive Benefits Portal, that you can select when you enroll. Additional information for each benefit is located on the Make It Yours website at **https://makeityours.us.slalom.com**.

- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan is in an accident
- **Auto and home insurance:** Offers you special group rates and policy discounts on auto and home insurance, as well as coverage for condos/renters, personal property, RVs, and boats
- **Bill negotiation services:** Offers assistance reviewing out-of-network medical bills, negotiating medical bill costs with health care providers and facilities, and creating a payment plan for medical-related expenses
- **Hospital indemnity insurance:** Pays a benefit in the event you or a family member covered under this plan is hospitalized
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud
- **Legal services:** Covers attorney fees for things like wills, real estate matters, and more
- **Long-term care insurance (LTC):** Helps pay the costs of custodial and personal care of long-term stays at a health care facility or in-home care for services that are not covered by health insurance.
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured dog or cat
- **Voluntary accidental death and dismemberment coverage:** Protects your family financially in the event of a tragic accident
- **Voluntary commuter benefits:** Provides pre-tax reimbursement benefits to help pay eligible commuting expenses
- **Voluntary life insurance:** Protects your family financially in the event of a death

You can get more details on the Make It Yours website at **https://makeityours.us.slalom.com**.

22. Is infertility coverage provided through Slalom's medical coverage choices?

Through all of Slalom's health insurance plans offered on the Exchange, artificial insemination, in vitro fertilization, assisted reproduction—GIFT and ZIFT, and cryopreservation (egg freezing) in cases of iatrogenic infertility (for example, chemotherapy) are covered. There is a lifetime maximum medical benefit of $25,000 and a separate maximum pharmacy benefit of $10,000.

Insurance carriers define the clinical policies used by physicians, so it is important to connect with your insurance carrier or the available Health Pros to understand the requirements for coverage. Note that **elective** cryopreservation (egg freezing) and surrogacy services are not covered by the medical plan.

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Paying for Coverage

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

During the enrollment window, you'll be able to see the credit/subsidy amount from Slalom and your price options when you enroll on the Thrive Benefits Portal at **https://benefits.us.slalom.com**.

24. Do I get to keep the Slalom credit/subsidy if I don't enroll in coverage?

No. The credit/subsidy you get from Slalom is applied toward the cost of the medical/prescription drug and dental coverage that you purchase through the Exchange. If you enroll in a medical option that costs less than your selected option's premium and you contribute to an HSA, the excess credit will be deposited into your HSA. If you're eligible and you do not have or open an HSA, you will lose any unused credit. There is no cash refund or credit/subsidy provided for other benefits.

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

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you meet your deductible. The negotiated costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service.

How the medical deductible works depends on your coverage level:

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

  To clarify, if you choose a Bronze Plus or Silver coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, though, you must satisfy the family deductible before coinsurance will kick in, even if only one family member has expenses. The annual deductible does not include copays or amounts taken out of your paycheck for health coverage.

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

[1] If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus or Silver coverage level, you will have a traditional annual deductible. No member in the family will pay more than $3,000 toward the family deductible.

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

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage or certain copays under the Gold and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

- **The Bronze, Gold, and Platinum coverage levels have a traditional out-of-pocket maximum.** Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.
- **The Bronze Plus and Silver coverage levels have a "true family out-of-pocket maximum."**[2] 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 these options when you have family coverage.

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

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

An HSA is a special account that you can use when you enroll in a Bronze, Bronze Plus, or Silver coverage level. It allows you to set aside pre-tax money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze, Bronze Plus, and Silver coverage levels, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

The HSA has the following tax advantages:

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- You are not taxed on the HSA dollars when you use them to pay for qualified expenses.
- Interest earnings on your HSA balance are not taxed.
- You can also invest your HSA dollars in a range of investment funds to further grow your nest egg.

Just make sure you use money in your HSA only for qualified health care expenses, which are designated by the Internal Revenue Service (IRS). 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're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute up to the IRS limits. 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. Also, the money is yours to keep even after you no longer work for the company, at which time you could decide to keep your balance with Alight Smart-Choice Accounts or roll it over to another tax-qualified account, such as your new employer's HSA or even your own individual retirement account as long as you meet certain IRS eligibility requirements.

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

Please note that the IRS establishes the maximum annual contribution limits that you can make into HSAs each year. Therefore, if you have another HSA that you will contribute to in 2023 and you also plan to contribute to your Slalom HSA in 2023, be sure you add all of your contributions together, including any contributions you may have made to an HSA outside of Slalom during the same year, so that they don't exceed the IRS limits. You are responsible for knowing when you've reached the total contribution limits among your HSAs.

If you have questions about the use and appropriateness of an HSA as it applies to your specific tax situation, you should consult a tax professional.

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

While both accounts offer a tax-free benefit when you pay for eligible medical, dental, and vision expenses, they differ in several critical ways:

	HSA	HFSA
Do I need to be enrolled in a particular medical coverage level to participate?	Yes, you must be enrolled in a Bronze, Bronze Plus, or Silver coverage level.	No
Can I contribute to my account before taxes?	Yes	Yes
Do unused dollars roll over from year to year?	Yes	No
Does the money in the account earn interest?	Yes	No
Can I use a debit card to pay for expenses?	Yes	Yes
Can I use the account to pay for vision or dental expenses?	Yes	Yes
How much can I contribute to the account per year?	For 2023, the annual limits set by the IRS are $3,850 for individual coverage, and $7,750[3] 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.	$3,050

29. Can I enroll in both an HSA and a HFSA?

If you enroll in one of the HDHP plans (Bronze, Bronze Plus, and Silver), you can enroll in an HSA and a **Limited Purpose** Flexible Spending Account (LPFSA). **You cannot also enroll in an HFSA**. This is an IRS rule.

If you have an HSA and an LPFSA, in order to contribute to your HSA, your LPFSA can only be used to pay for eligible dental and vision expenses. However, once you meet the medical deductible, 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.

If you enroll in one of the traditional plans (Gold and Platinum), you can only enroll in an HFSA.

Regardless of your health plan choice, you can choose to enroll in a **Dependent Care Flexible Spending** Account (DCFSA) to assist with qualified dependent care expenses.

If you have questions regarding how the use of any of these accounts impacts your personal tax situation, please contact a qualified tax advisor, as Slalom cannot provide tax advice.

[3] Limits subject to midyear changes per IRS regulations. For more information, go to **www.irs.gov**.

30. Why would I want to use both an HSA and a Limited Purpose FSA (LPFSA)?

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 and LPFSA, you lose or forfeit any unused balance at the end of the year (i.e., "use it or lose it").

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 LPFSA to pay for those expenses with tax-free money once the medical deductible is reached.

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

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

32. Can I contribute to an HSA?

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

- You must be enrolled in a HDHP plan, which for Slalom are the Bronze, Bronze Plus, or Silver plan designs;
- 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 or a non-US health insurance scheme; and
- You cannot be enrolled in a general purpose Health Care FSA, but you may be enrolled only in an LPFSA.

Although you can enroll your children up to age 26 in your medical coverage, you can't use money from your HSA to pay their health care expenses unless 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).

Information contained herein is not intended as legal, tax or other professional advice. You should not act upon any such information without first seeking a qualified professional on your specific matter.

Terms and conditions of policies may change. Please consult policy documents to confirm availability of benefits.

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