FAQs

The information below addresses general benefits and features to help you understand your options for 2024.

Review the list and click on the link to be taken directly to the answer you're looking for. This is a great resource during enrollment and highly recommended that you review these FAQs in their entirety.

Enrollment for Your Benefits

1. What will I need to do?

New hires ***must actively enroll*** during the new hire enrollment period, or you will **not** have medical coverage through the Red Cross. An active enrollment is also required to contribute to a Health Savings Account (HSA) or either of the flexible spending accounts. Additional core and supplemental benefits (e.g., dental, vision, and employee life insurance) also require an active enrollment. Based on your eligibility, you will be automatically enrolled in some benefits (e.g., disability and basic life insurance) at no cost to you.

To view all of your available benefits and to enroll, log on to the Benefits Service Center portal during the communicated enrollment period. The **Benefits Service Center portal** is accessible via Single Sign-On from **HR Now** by selecting **My Benefits**.

You'll need to:

- Enroll the eligible dependents you want to cover.
- Go through the **Help Me Choose** tool to assist you in selecting a medical option.
    - The **Help Me Choose** tool allows you to answer questions about your health care needs, which can help save time and ensure you have the best match. You will be able to answer questions about your dependents, your doctors, your prescriptions, and more to help you choose the medical coverage that best fits your needs.
- Choose the insurance carrier and coverage level you want for your medical benefits.
- Review the ***Your Benefits Summary*** page on your enrollment flow in its entirety. Once you have completed your review, you will be asked to confirm your elections. Select **Confirm** to complete your enrollment.
- Look for and review your confirmation email. Contact the **Benefits Service Center** within two weeks if there are errors on the confirmation.

2. Where can I get more information?

Before and during enrollment:

- **Make It Yours** website (available through the **Benefits Service Center portal**)—learn about your coverage options and costs, and get tips for choosing the right coverage for you.
- The **Make It Yours** website also has a link to a pricing tool, **Compare Your Costs**. The access information for this interactive pricing tool is located within HR Now (search "MIY"). Or you can contact the **Benefits Service Center** for the access information. Use this tool before the enrollment period to compare the costs of your health care options.
- **Your Carrier Connection** (available through the **Make It Yours** website)—carrier preview websites and pre-enrollment call centers allow you to access and research provider networks, hospitals, prescription drug information, and other carrier-specific resources.
- **Benefits Service Center portal**—when it's time to enroll, log on to the **Benefits Service Center portal,** Single Sign-On accessible from **HR Now,** by selecting **My Benefits** to compare your options and prices, get helpful decision support, and enroll.
- **Help Me Choose tool** (available through the **Benefits Service Center portal**)—the **Help Me Choose** tool is available during enrollment. With the **Help Me Choose** tool, you provide some information and then the tool provides a ranking of the plans. You can see how plans compare at a high level, including premium and estimated out-of-pocket costs.

Questions? Customer service representatives are available year-round through **Help Requests** and **Chat With Us** available on the Benefits Service Center portal or by calling the **Benefits Service Center** at **1-877-860-7526** from 9:00 a.m. to 5:00 p.m. ET, Monday through Friday.

My Options

3. What are my options for medical coverage?

You will have several coverage levels to choose from, including Bronze Plus, Silver, Gold, and Platinum. The Bronze Plus plan is a high-deductible health plan, while the Silver, Gold, and Platinum plans are PPOs. Each coverage level is available from multiple insurance carriers at different costs. You can use the **Make It Yours** website and **Help Me Choose** tools to compare benefits and features across medical options.

- With a high-deductible health plan (HDHP), you have a higher deductible before your medical and prescription drug coverage kicks in. To balance the cost of the high deductible, you will pay less in premiums each paycheck. Once you meet your deductible, you get the protection of a traditional preferred provider organization (PPO) and pay a percentage of your ongoing expenses, up to the out-of-pocket maximum.
- A preferred provider organization (PPO) is a type of medical option 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**. When you enroll in a traditional PPO, like a Gold option, you have to meet a deductible for certain medical care before the insurance carrier starts paying a percentage of the costs. In exchange for a lower deductible, you will pay more in premiums each paycheck.

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

You'll have access to several resources to help you make decisions. You should start by visiting the **Benefits Service Center portal** where you can access the **Make It Yours** website. You can access videos, details about your options, and more. The **Make It Yours** website has helpful comparison charts, like the one below, to help you make a decision.

	BRONZE PLUS	SILVER	GOLD[1]	PLATINUM
Plan Type	HDHP	PPO	PPO	PPO
Deductible (Individual/Family)	$2,450/$4,900	$1,000/$2,000	$800/$1,600	$250/$500
Coinsurance	25%	30%	25%	15%
Out-of-Pocket Maximum	$3,900/$7,800	$5,300/$10,600	$3,600/$7,200	$2,300/$4,600
Family Deductible/ Out-of-Pocket Maximum Type	True Family	Traditional	Traditional	Traditional
Primary Care/Specialist	25%	$30/$50 copay	$25/$40 copay	$25/$40 copay
Emergency Room	25%	$150 copay + 30%	$150 copay + 25%	$150 copay + 15%
Urgent Care	25%	$50 copay	$40 copay	$25 copay
Hospital per Admission	25%	30%	25%	15%
Retail (Mail Order, Tier 1/2/3)	25%	$12/$50/$70 copays	$10/$40/$60 copays	$8/$30/$50 copays

[1] Carriers in California can choose to offer standard Gold coverage (shown) or a Gold II option, which offers only in-network benefits.

The Red Cross will help employees pay for health care coverage by providing a significant credit. When you enroll, you'll be able to see the credit amount from the Red Cross and your options on the **Benefits Service Center portal.** You'll also be able to access the **Help Me Choose** tool that gives you a personalized suggestion, helps compare the details of your options, lets you see insurance carrier ratings, and more by answering a few questions.

If you need additional help, you can reach a customer service representative through the **Benefits Service Center portal** by utilizing the **Chat With Us** and **Help Requests** features.

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

If you enroll in a high-deductible health plan (Bronze Plus), you should be prepared to pay up to the cost of your deductible—in case you have significant medical expenses shortly after your coverage begins.

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

You may have additional options depending on the insurance carrier you choose.

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.

Learn more about your California coverage options and insurance carriers on the **Make It Yours** website and your **Benefits Service Center portal**.

7. I live in Hawaii. How are my medical options different?

Learn more about your Hawaii coverage options and insurance carriers on the **Make It Yours** website and your **Benefits Service Center portal**. Note, premiums are only available on the Benefits Service Center portal.

8. How can I find providers?

Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers, and you should confirm they are in-network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Do not rely on your provider's office to know the carriers' network(s) because carriers offer multiple networks, and your provider may not participate in all of a carrier's networks. To see whether a doctor is in-network:

- Check out the **insurance carrier** preview sites on the **Make It Yours** website, where you can find information on how to contact each of the insurance carriers.
- When you enroll, use the **Benefits Service Center portal** to check the networks of each insurance carrier you're considering. You can access this information by clicking **Find Doctors** when you're selecting your medical plan. For the best results:
  - Search for your provider by name—not medical practice.
  - Check only the office location(s) you are willing to visit.
  - When searching for a facility, use the complete facility name.

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. Participating doctors may change throughout the year and it's always best to confirm their in-network status before each visit.

9. Why should I use in-network providers?

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

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

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offer national provider networks, so 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.

National carriers have a wider network across regions. This offers more coverage under the same carrier across different locations. Regional carriers are location-specific and may not be offered in your ZIP code. **You will need to call the insurance carrier you are considering to confirm they provide national coverage and whether an out-of-area provider is in the carrier's network.**

11. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your medical insurance carrier's pharmacy benefit manager—which could be a separate prescription drug company. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. 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.

Paying for Coverage

12. What will I pay for medical coverage?

The Red Cross will pay a significant amount toward the cost of coverage. You will see this credit on the Benefits Service Center portal.

There are several pricing regions around the country, and the insurance companies give us premium rates specific to each area.

We strongly encourage you to review your options using the **Make It Yours** website accessible from the **Benefits Service Center portal***. This website allows you to determine the best option that suits your needs.

Keep in mind: You'll pay the cost of medical coverage with pre-tax dollars.

*Note, residents of Hawaii do not have access to the Cost Comparison tool on Make It Yours. Premium details can be found on the Benefits Service Center portal.

13. When will I find out the cost of other benefits?

During the enrollment period, you'll be able to review the premiums for all benefits you are eligible for on the **Benefits Service Center portal**.

14. How can I earn wellbeing incentives for my spending accounts?

The Be Well@Red Cross wellbeing program is designed to help improve your overall wellbeing—physically, emotionally, financially, and socially. The Be Well@Red Cross program is open to benefit-eligible employees located outside of the European Union. Employees covered by Collective Bargaining Agreements should consult their contract or contact their union representative for eligibility details. Employees and their spouse/domestic partner enrolled in a Bronze Plus, Silver, Gold, or Platinum medical plan can receive incentives in their Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). Eligible employees and spouses/domestic partners must complete both a Health Screening and the Health Assessment to earn incentives.

Be Well@Red Cross offers tools and resources available to help you achieve your goals and earn incentives, including:

- Phone and virtual health coaching
- Doctor chat with a licensed physician
- Tracking goals, such as physical activity and fruit and vegetable intake
- Daily habits sessions on topics, including nutrition, stress management, and more
- Online community chat where you and your colleagues can support and motivate one another
- Workout videos and healthy recipes

Earn incentives: Through the Be Well@Red Cross wellbeing program, you can earn up to a $700 contribution from the Red Cross to your Health Savings Account (HSA) if you are covered by a Bronze Plus medical plan—or your Health Reimbursement Arrangement (HRA) if you have a Silver, Gold, or Platinum plan. Spouses/domestic partners can also earn up to $700 for participating if they are enrolled in one of the above-mentioned medical plans—giving you the potential to earn up to $1,400.

Employees must complete a Health Assessment and Health Screening before incentives are distributed.

The wellbeing program resources are available for eligible employees who do not enroll in a medical plan, but you won't be able to earn incentives.

Activities must be completed by **November 30** each year to potentially earn the full plan year incentive. Any activities completed after November 30 will be credited in the following year.

Access the Be Well@Red Cross wellbeing program site via **HR Now** by selecting **My Benefits** and/or on the **Benefits Service Center portal** by selecting the Be Well@Red Cross tab or Quick Link.

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

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

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

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

16. 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 Silver, Gold, and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

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

The Bronze Plus coverage level has a "true family out-of-pocket maximum."[1] This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in 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.

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

17. What is a flexible spending account (FSA)?

A flexible spending account is an account into which you put money that can be used to pay for certain out-of-pocket health care costs. This is a tax-advantaged account, meaning you set aside money on a pre-tax basis. You have the option to set aside funds in a Health Care FSA and a Dependent Care FSA.

Health Care FSA contributions are available in a lump sum at the start of the plan year.

For example: Patricia anticipated that she would spend $1,000 on glasses, dental work, and medication. She elects to contribute $1,000 (pre-tax) toward eligible medical expenses. The funds will be available for immediate use on the first day of the plan year. Equal payments will be deducted from the employee's pay throughout the plan year.

Dependent Care FSA contributions are available as the funds are contributed.

For example: Scott anticipated that he would spend $500 on after-school care for his children while he is at work. He elects to contribute $500 (pre-tax) toward the eligible dependent care expense. The funds are only available as they are deducted from Scott's paycheck. If the amount deducted in the pay period is $25, then only that amount is available for use. The amount accumulates each pay period and remains available for use until the end of the calendar year.

Any remaining Health Care FSA funds and all Dependent Care FSA funds that are not used at the end of the year are forfeited (the "use it or lose it" IRS rule). You have until April 30 of the next year to submit reimbursement claims for eligible expenses for the previous year.

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

An HSA is a special bank account you can use when you enroll in a Bronze Plus coverage level (e.g., a high-deductible health plan). An HSA allows you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. The money you save in an HSA rolls over from year to year and is yours to keep—even if you leave the Red Cross. This includes wellbeing incentive rewards deposited to your account.

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

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for unqualified expenses, you'll pay income taxes on that money and an additional 20% penalty if you're under age 65. 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). 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. Go to **irs.gov/publications/p502** to view a list of qualified expenses or view the Alight Smart-Choice Accounts **list of qualified expenses**.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute. And, if you don't have a lot of health care expenses, your money can stay in your account year to year and earn tax-free interest. 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.

19. Why would I want to use an HSA?

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

The HSA has the following tax advantages:

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

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

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

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

No. If you enroll in the Bronze Plus coverage level, you can participate in an HSA. You can't contribute to an HSA and participate in the Health Care FSA at the same time.

22. 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.

23. Can I contribute to an HSA?

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

- You must be enrolled in a high-deductible health plan option at the Bronze Plus coverage level.
- You cannot be enrolled in Medicare or a veteran's medical plan (TRICARE).
- You cannot be claimed as a dependent on someone else's tax return.
- You cannot be covered by any other health insurance plan, such as a spouse's plan, which is not a high-deductible option.

24. Can I keep my HSA from a previous employer even if I enroll in a non-HSA-eligible PPO health plan?

Yes. If you currently have an HSA and you have a balance, the unspent funds will remain in your HSA, earn tax-free interest, and be available for qualified health care expenses at any time in the future. Limited usage rules apply. If you do not have coverage under a Red Cross provided HSA-eligible HDHP health plan, you cannot make contributions to your HSA. Contact the **Benefits Service Center** for additional details and directions on how to transfer your balance.

25. What is a Health Reimbursement Arrangement (HRA)?

An HRA is an American Red Cross funded account that helps employees pay for qualified medical expenses not covered by health plans. If you are enrolled in the Silver, Gold, or Platinum plans (PPOs) **and** participate in the Be Well@Red Cross wellbeing program, you will have your incentive dollars earned deposited into the account. The funds roll over each year and are available to pay for eligible medical, dental, and vision expenses; however, the funds cannot be taken with you if you are no longer employed with the Red Cross. You cannot make payroll contributions into an HRA, but you can set up an FSA if you want to set aside additional dollars for medical expenses.

26. How can I obtain additional assistance understanding my health care coverage?

If you need help with understanding your benefits, call **1-866-300-6530** and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve most issues.