FAQs

If you have a specific question, see if it's here 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.

The Aon Benefit Experience 2

1. What is the Aon Benefit Experience (BenX)? 2
2. What are the advantages of BenX? 2
3. Where can I get more information? 3

Open Enrollment 3

4. When is Open Enrollment? 3
5. What will I need to do? 3
6. Who's eligible for benefits? 4

My Options 4

9. What are my options for health coverage? 4
10. What happens if I enroll in a Bronze Plus health option and have expenses early in the plan year? 4
11. Is one coverage level better than another? 4
12. What's the difference between a traditional PPO and a high-deductible PPO? 5
13. Can each family member choose a different health coverage level or insurance carrier? 5
14. Which health insurance carriers will I be able to choose from? 5
15. Will I be able to use the same providers as I do today? 5
16. Why should I use in-network providers? 6
17. How should I choose a health insurance carrier if my dependents and I live in different states? 6
18. How do I decide which health option is right for me? 6
19. Will pre-existing conditions be covered? 7
20. How will my prescription drugs be covered? 7
21. What is "prior review" and when is it required? 7
22. Do I have to enroll in group discount options during Open Enrollment for 2024? 7
23. Will I receive a new ID card for health coverage? 8

Paying for Coverage 8

24. When will I find out the cost of coverage? 8
25. Do I get to keep the White Castle employer contribution if I don't enroll in coverage? 8
26. What will I have to pay when I need health care? 8
27. What's a deductible and how does it work? 8
28. What's an out-of-pocket maximum and how does it work? 8
29. What's a Health Savings Account (HSA)? 9
30. Why would I want to use an HSA? 9
31. Can I contribute to an HSA if I am covered under my spouse's general purpose Health Care FSA? 9
32. Can I contribute to an HSA? 10

The Aon Benefit Experience

1. What is the Aon Benefit Experience (BenX)?

The Aon Benefit Experience (BenX) is a way for you to get health insurance coverage. It is an online insurance marketplace where buyers like you can shop for coverage from multiple health insurance carriers who are competing for your business. BenX merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

BenX is America's first national large employer multi-insurance carrier marketplace. Its website is easy to navigate and, just like other online stores, you'll 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've selected the right coverage options for your circumstances and budget.

2. What are the advantages of BenX?

The medical and prescription drug benefits available through BenX offer you:

- **Lots of choices.** Traditionally, you got to choose from the health plan options offered by your company. Through BenX, you can choose from several coverage levels, a variety of insurance carriers, and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business. So, it's in their best interest to offer their best prices. Plus, White Castle will provide an employer contribution to use toward the cost of health coverage.

In addition, you have the option to elect other valuable benefits.

You can also elect discounted coverage for auto and home insurance, pet insurance, and international vacation medical coverage.

Plus, you have help when you need it. There are great tools and resources to help you be a better consumer every step of the way. See question #3 for details about tools and resources.

3. Where can I get more information?

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

Before and during enrollment:

- **Make It Yours website** (first available with 2025 information on September 30)—Visit **whitecastle.makeityoursource.com** to learn about 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 carrier resources.
- **The enrollment website and Alight Mobile app**—When it's time to enroll, log on to the enrollment website or the Alight Mobile app (available through the Apple App Store or Google Play) to compare your options and prices, get helpful decision support, and enroll.
- **Corporate Health Exchange Call Center for White Castle**—You can reach a customer service representative by web chat through the enrollment website. You can also call the Corporate Health Exchange Call Center for White Castle at **1.855.564.6151** from 8:00 a.m. to 5:00 p.m. ET, 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 beginning January 1:

- **Make It Yours website**—Visit year-round for practical tips that help you and your family get the most out of your benefits. Get "The Inside Scoop" on how to work the 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 enrollment website and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help with more complex coverage issues, call **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.

Open Enrollment

4. When is Open Enrollment?

Open Enrollment for your 2025 benefits will take place from October 14 through November 1, 2024.

5. What will I need to do?

Between October 14 and November 1, you must enroll or you will **not** have health coverage for 2025. Keep in mind, if you don't select a health plan, you won't have prescription drug coverage either. And, to contribute to a Health Savings Account (HSA) for 2025 (if eligible), you must make an active election.

To enroll, log on to the enrollment website at **whitecastle.benefitsnow.com** or the Alight Mobile app during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2025.
- Choose the insurance carrier and coverage level you want for your health benefits.
- Enroll in the rest of your benefits.

6. Who's eligible for benefits?

Team members who work an average of 30 hours or more per week are eligible for White Castle's health care benefits.

Eligible dependents include:

- Your legally married spouse; and
- Your eligible children under age 26; and
- Your eligible children of any age who became handicapped or totally disabled before age 26.

7. How do I create my user ID and password for the enrollment website?

If you are a new user, you will need to set up your user ID and password, which are needed to access your account through the Alight Mobile app (available through the Apple App Store or Google Play).

- Go to **the enrollment website** and select **New User**;
- Enter the last four digits of your Social Security number and your date of birth to authenticate your account;
- Create your user ID and password; and
- Create answers to security questions to verify your identity if you forget your user ID or password in the future.

8. How do I reset my password for the enrollment website?

To reset your password, go to the enrollment website, click **Forgot User ID or Password**, and follow the prompts to reset your password. You will need your user ID and password to access your account on the Alight Mobile app (available through the Apple App Store or Google Play).

My Options

9. What are my options for health 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'll be able to compare benefits and features across your health options.

10. What happens if I enroll in a Bronze Plus health option and have expenses early in the plan year?

If you enroll in a high-deductible health option, you should be prepared to pay up to the cost of your deductible—in case you have significant health 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 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're saving enough in an HSA.

11. Is one coverage level better than another?

No. Don't let the names of the coverage levels fool you—one option isn't better than another. They're designed to give you choices so that you can find the option that makes sense for your situation. Remember to take your total costs into consideration, which includes what you pay out of your paycheck (before-tax premiums) *and* what you pay out of your pocket (deductibles, coinsurance, copays) when you get health care.

For example, the Gold and Platinum coverage levels will cost you more each paycheck, but less when you receive care. These coverage levels may have copays for some services and lower deductibles and coinsurance compared to the Bronze Plus and Silver coverage levels.

The Bronze Plus and Silver coverage levels come with lower paycheck deductions (before-tax premiums) and higher deductibles. If you don't need a lot of health care services, you'll spend less on your total health care costs because you're not paying premiums for coverage you don't need.

12. What's the difference between a traditional PPO and a high-deductible PPO?

A PPO is a type of health 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 lower deductible before the insurance carrier starts paying a percentage of the costs. For example, the Gold option deductible is $800 for Team Member Only coverage and $1,600 for Family coverage. In exchange for a lower deductible, you will pay more each paycheck.

A high-deductible PPO operates the same, but as the name suggests, 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 each paycheck. The high-deductible PPO also makes you eligible for an HSA. See question #s 29–32 for more details about the advantages of an HSA. Once you meet your deductible, you get the protection of a traditional PPO and pay a percentage of your ongoing expenses, up to the out-of-pocket maximum. See question #27 for more details about the deductible.

13. Can each family member choose a different health coverage level or insurance carrier?

No. All family members must be enrolled in the same coverage level with the same insurance carrier.

14. Which health insurance carriers will I be able to choose from?

Most of the largest insurance carriers are participating in BenX. Keep in mind that carriers may vary by region. For health, the insurance carriers offering coverage include Aetna, Anthem, Cigna, Geisinger, UPMC, UnitedHealthcare, Dean/Prevea360, Health Net, Medical Mutual of Ohio, Priority Health, and Kaiser Permanente. Your specific options are based on where you live. You'll be able to see the options available to you when you enroll.

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks, and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. You can get to the carrier preview sites through the Make It Yours website at **whitecastle.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through the enrollment website at **whitecastle.benefitsnow.com**.

15. 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, 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, the provider network could be different and can change, so *always* check the provider directories before making a decision.

Do **not** rely on your provider's office to know the carriers' 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 enrollment website. For 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.

16. 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.

17. How should I choose a health 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 that your dependents have access to in-network providers in most locations. Regional network 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 must 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, 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 isn't a reference to the network—many offer coverage nationally.

18. How do I decide which health option is right for me?

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

Then, when you enroll, you'll be able to see the employer contribution amount from White Castle and your price options on the enrollment website at **whitecastle.benefitsnow.com** or the Alight Mobile app. You'll 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 need additional help, you can reach a customer service representative by web chat through the enrollment website. You can also call the Corporate Health Exchange Call Center for White Castle at **1.855.564.6151** from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available. You can also call the insurance carriers with specific questions about the options they offer.

19. Will pre-existing conditions be covered?

Yes. When you enroll in health coverage through White Castle, coverage is guaranteed, regardless of whether you and your eligible dependents have pre-existing conditions.

20. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your health 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 health 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.

21. 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 "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 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 don't get preapproved, you could get stuck paying most or all of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor if you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

22. Do I have to enroll in group discount options during Open Enrollment for 2024?

As part of our participation in BenX, we are able to take advantage of group negotiated discounts. You can obtain discounted coverage for:

- **Auto and home insurance:** Offers you special group rates and policy discounts on auto and home insurance
- **Bill negotiation services:** Offers assistance reviewing out-of-network medical bills, negotiating medical bill costs with doctors and hospitals, and creating a payment plan for medical-related expenses
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured pet
- **International vacation medical coverage:** Covers any medical needs that arise during travel outside the United States

You can enroll in or drop auto and home insurance, pet insurance, and international vacation medical coverage at any time. Please note that pet insurance is offered to both full-time and part-time team members.

You can get more details on the Make It Yours website at **whitecastle.makeityoursource.com**.

23. Will I receive a new ID card for health coverage?

It depends. You will receive a new ID card if:

- You enroll under a new insurance carrier; or
- You stay with the same insurance carrier but there's a change to the information on the card.

If you are issued a new card, you should receive it before January 1. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Paying for Coverage

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

During enrollment you'll be able to see the employer contribution amount from White Castle and your price options on the enrollment website at **whitecastle.benefitsnow.com** or the Alight Mobile app.

25. Do I get to keep the White Castle employer contribution if I don't enroll in coverage?

No. The employer contribution you get from White Castle is for the medical/prescription drug coverage you purchase. A cash refund or credit for other benefits is not available.

26. What will I have to pay when I need health care?

Other than in-network preventive care, which is paid 100%, how much you have to pay when you need health care primarily depends on your coverage level. Find the details for all coverage levels on the Make It Yours website at **whitecastle.makeityoursource.com**.

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

The deductible is what you pay out of your own pocket before your insurance 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 health deductible works depends on your coverage level:

- **The Silver, Gold, and Platinum health 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.
- If you're covering yourself only under the **Bronze Plus** option, benefits don't begin until the individual deductible ($2,500) has been paid. If you're covering yourself and others under the **Bronze Plus** option, benefits don't begin for any member of the family until the entire family deductible ($5,000) has been paid.

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.

28. 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 health 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."** 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 this option 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.

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

An HSA is a special bank account that you can use when you enroll in the Bronze Plus coverage level. It allows you to set aside tax-free money to pay for qualified health care expenses, like your medical copays, deductibles, and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze Plus coverage level, 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 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. 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.

30. 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 that they are deducted from your paycheck before taxes are taken out.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on the HSA dollars when you use them to pay eligible expenses.

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 health 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 plan at the Bronze Plus coverage level, which is the only high-deductible health plan available to White Castle team members;
- You cannot be enrolled in Medicare or a veteran's health plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return; and
- You cannot be covered by any other health insurance plan, such as a spouse's plan that is not a high-deductible option.

Although you can enroll your children up to age 26 in your health 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.

All product and company names are trademarks™ or registered® trademarks of their respective owners. Use of them does not imply any affiliation with or endorsement by them.

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