2025 Veritiv Annual Enrollment: Frequently Asked Questions

GENERAL

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

The Aon Benefit Experience (BenX) is a way for you to get medical, dental, vision, and other 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.

2. What does this mean for me?

The medical and prescription drug, dental, and vision benefits available for 2025 offer you:

- **Lots of choices.** 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 interests to offer their best prices. Plus, Veritiv will provide a subsidy to use toward the cost of your coverage.

In addition, you have the option to enroll in other valuable benefits including supplemental life insurance for you and your family, supplemental accidental death and dismemberment (AD&D) coverage, disability coverage, group legal, group accident, critical illness insurance, hospital indemnity insurance, and identity theft protection. Also, you can get discounted rates for auto and home insurance, pet insurance, and international vacation medical coverage.

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

3. My child lives in another state. Do I need to do anything special?

If you and one or more of your family members live in different areas, you probably don't want to choose an HMO option. Be sure to check the plans and carrier networks. If you have questions, you can call the Veritiv Benefits Center at **1.855.278.4981**. Customer service representatives are available from 9:00 a.m. to 6:00 p.m. ET, Monday through Friday. The insurance carriers can also answer specific questions about their provider networks.

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** (first available with 2025 information on October 1)—Visit **veritiv.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 other carrier resources.
- **Pricing Tool** (available through the Make It Yours website)—Use this interactive pricing tool before you enroll to compare the costs of your health care options. To access the pricing tool beginning October 1, visit the Make It Yours website and click **Compare Your Costs**. You'll need to enter the access code provided in your enrollment postcard and other enrollment communications.
- **My-HR and Alight Mobile app**—When it's time to enroll, log on to My-HR (**digital.alight.com/veritiv)** and click **Enroll Now** (or visit **digital.alight.com/myhrveritiv**) or use 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.
- **Veritiv Benefits Center**—You can reach a customer service representative by web chat or by scheduling an appointment through My-HR. You can also call the Veritiv Benefits Center at **1.855.278.4981** from 9:00 a.m. to 6:00 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.
- **My-HR and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.
- **Alight Advocacy Services**—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 Services**—Get assistance reviewing out-of-network medical bills, negotiating medical bill costs with doctors and hospitals, and creating a payment plan for medical-related expenses. Call **1.844.891.8981** for more information.

ENROLLMENT

5. What will I need to do?

Between October 21 and November 1, 2024, you need to make an active enrollment to get the coverage you want next year!

To enroll, log on to My-HR (**digital.alight.com/veritiv**) and click **Enroll Now** (or visit **digital.alight.com/myhrveritiv**) or use 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 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 **veritiv.makeityoursource.com**.

6. What happens if I don't enroll?

If you don't enroll:

- **You will default to employee-only medical coverage under the lowest cost Bronze medical option, effective January 1. Corresponding deductions will be taken from your 2025 paychecks, and you will not be able to change your benefit elections until the next Annual Enrollment period unless you experience a qualified life event.**
- You will also default to paying the $100 monthly employee tobacco surcharge.
- You will not have dental or vision coverage through Veritiv next year.
- If eligible, you will default to $0 contributions to your Health Savings Account (HSA) or flexible spending account(s).
- You will default to your 2024 coverage for supplemental life insurance and/or supplemental AD&D coverage for you and/or your family, group legal, hospital indemnity, group accident, critical illness, or identity theft protection through Veritiv next year.

7. What family members can I enroll in coverage?

Eligible dependents may include:

- Your lawful spouse as defined by the plan's Summary Plan Description including same-sex domestic partners and common law spouses where application for consideration has been submitted and approved.
- Natural children, stepchildren, adopted children, disabled children, children placed in your home for adoption, and children for whom you are the legal guardian. A dependent child must be under the age of 26, unmarried, and rely on you for primary support and maintenance. For all plans, dependent children may be covered until the last day of the month in which the child turns 26.
- Unmarried children of any age who are incapable of self-support due to a physical or mental handicap and who are fully dependent on you for support, are also eligible.

Things to consider when electing coverage for a family member:

- If you choose to elect coverage for your spouse or partner in the Veritiv Medical plan, and he or she has access to subsidized medical coverage through his or her own employer, a monthly surcharge of $150 will be added to your paycheck deduction cost.
- If you elect to cover new dependents in 2025 for Medical, Dental, Vision, or Life benefits, you will be asked to provide documentation and certify that those family members meet the criteria of an eligible dependent under Veritiv's Benefits Plan. Prepare now by making sure you have access to marriage licenses, birth certificates, etc. Any dependents previously certified will not need to be re-certified.
- If you elect to cover a new family member during 2025 (i.e., due to a marriage or birth), you will be asked to provide documentation in order to add him or her to the Veritiv Benefits Plan. Don't forget that all family status changes must be made within 31 days of the date of change!

8. How do I create my user ID and password for My-HR?

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 My-HR 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.

9. How do I reset my password for My-HR?

To reset your password, go to My-HR, 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 CHOICES

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

You have several coverage levels to choose from, including Bronze, 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 medical options.

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

If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible in the event 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 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.

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

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

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

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

Learn more about your California coverage options and insurance carriers.

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

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, 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.

Do not rely on your provider's office to know the carriers' network(s). Be sure to check each carrier's provider network. 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 My-HR. 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 and confirm whether the specialty of the facility is covered in-network.

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

14. Why should I use in-network providers?

Seeing out-of-network providers will very likely cost you substantially more than seeing in-network providers. For example, you will pay more through a higher deductible and higher coinsurance. You'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. Certain Platinum options won't cover out-of-network services at all, so check your options carefully during enrollment if you think you or your family will see out-of-network providers.

15. 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 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). See question #13 for information on how to search for providers.

If you have questions during enrollment, you can call the Veritiv Benefits Center at **1.855.278.4981**. Customer service representatives are available from 9:00 a.m. to 6:00 p.m. ET, Monday through Friday. The insurance carriers can also answer specific questions about their provider networks.

16. How do I decide which medical 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 **veritiv.makeityoursource.com** to access videos, details about your options, comparison charts, and more.

Before you enroll, take advantage of an interactive pricing tool that helps you compare the costs of your medical options based on your situation. You can even see how your costs stack up against other coverage options available to your family. To access the pricing tool beginning October 1, visit the Make It Yours website and click **Compare Your Costs**. You'll need to enter the access code in your enrollment postcard and other enrollment communications.

Then, when you enroll, you'll be able to see the subsidy amount from Veritiv and your price options on My-HR (**digital.alight.com/veritiv**) by clicking **Enroll Now** (or visit **digital.alight.com/myhrveritiv**), or use 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 or by scheduling an appointment through My-HR. You can also call the Veritiv Benefits Center at **1.855.278.4981** from 9:00 a.m. to 6:00 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 receive a call back once a representative is available. You can also call the insurance carriers with specific questions about the options they offer.

17. Will pre-existing conditions be covered?

Yes.

18. 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.

19. 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 whether you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

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

Just like the medical insurance carriers, each dental carrier has its own provider network 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 My-HR.

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 DHMO 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.

21. 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' networks. 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 My-HR.

22. What other benefits are available to me?

You can choose to supplement your medical coverage with:

- **Critical illness insurance:** Pays a benefit if you or a covered family member is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage kidney disease).
- **Hospital indemnity insurance:** Pays a benefit in the event you or a family member covered under this plan is hospitalized.
- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan is in an accident.

You can also choose to enroll in:

- **Supplemental life insurance:** Protects your family financially in the event of a death.
- **Supplemental accidental death and dismemberment coverage:** Protects your family financially in the event of a tragic accident.
- **Long Term Disability Buy-Up:** Purchase additional long term disability coverage to supplement the disability benefits provided to you by Veritiv.
- **Group legal services:** Provides access to a network of attorneys who can help with legal issues such as creating or updating a will, real estate matters, tax audits, document preparation, and more.
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud.

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

23. What else is available to me?

We are able to take advantage of group negotiated discounts for:

- **Auto and home insurance:** Offers you special group rates and policy discounts on auto and home insurance and convenient payroll deductions.
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured pet.
- **International vacation medical:** Covers any medical needs that arise during travel outside the United States.

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

PAYING FOR COVERAGE

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

You'll be able to see the subsidy amount from Veritiv and your price options when you enroll. Log on to My-HR (**digital.alight.com/veritiv)** and click **Enroll Now** (or visit **digital.alight.com/myhrveritiv**) or use the Alight Mobile app.

25. Do I get to keep the Veritiv subsidy if I don't enroll in coverage?

No. The subsidy you get from Veritiv is for the medical/prescription drug and dental coverage you purchase.

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

An HSA is a special bank account that you can use when you enroll in a Bronze or Bronze Plus coverage level. It 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. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or 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.

27. 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.

28. 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.

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

Yes, but if you do, the money you contribute to the FSA can only be used for dental and vision expenses. Your HSA must be used for medical and prescription drug expenses.

30. 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.

31. 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 high-deductible option at the Bronze or 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; and
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option.

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

32. What happens to my HSA if I don't enroll in the Bronze or Bronze Plus plan for 2025?
You can keep your HSA and use the funds in the account for qualified health care expenses, but you can no longer make pre-tax contributions to the account.