Medical & Prescription Drug

You have control when you enroll — you get to choose the medical coverage level, cost, and insurance carrier that are right for you and your family. Make sure to take action so you don't miss out!

Medical Coverage

Don't let the names of the coverage levels fool you.

One option isn't better than another. The best coverage level for you depends on your and your family's needs and preferences. If you want AECOM medical coverage in 2024, you must enroll.

Choose Your Coverage Level

You have several coverage levels to choose from, including:

- **Bronze:** A high-deductible option that lets eligible participants contribute to an HSA
- **Bronze Plus:** A buy-up to the Bronze option — a high-deductible option that lets eligible participants contribute to an HSA
- **Silver:** A preferred provider organization (PPO) option
- **Gold:** A PPO option with a higher level of coverage than the Silver PPO option
- **Platinum:** A PPO option that covers in-network care and offers limited benefits for out-of-network care

For all coverage levels, some insurance carriers in CA, CO, DC, GA, MD, OR, VA and WA offer an HMO option that covers in-network care only. Each coverage level is available from different insurance carriers at different costs.

Do you live in California? Your options will be different, depending on the insurance carrier you choose. See page 6 for details.

Do you live in Hawaii? See the **2024 Hawaii Benefits Guide**.

Do you live in Puerto Rico? See the **2024 Puerto Rico Benefits Guide**.

Are you on an international assignment? See the **2024 Benefits Guide for Employees on an International Assignment**.

Do You Live Outside the Service Area?

Your specific options are based on your home zip code as reflected in the Workday system. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier.

Check This Out!

Certain regional insurance carriers will only offer certain coverage levels. Just remember that only the options available to you will appear when you enroll.

Is a Primary Care Physician Required?

You must designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier.
- Live in Northern California and choose Health Net as your insurance carrier.
- Live in Southern California and choose Health Net as your insurance carrier and Gold II or Platinum as your coverage level.
- Enroll in any other HMO plan.

Medical Plan Extras

Most medical plans include "extras" to support you in being well, including fitness and health discounts, help quitting tobacco, nutrition and weight management services, healthy moms and babies support, care programs to help you with conditions such as heart disease and more. Check with your insurance carrier to learn about what your plan offers.

Annual Deductible

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs. It doesn't include amounts taken out of your paycheck for health coverage.

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.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Annual Deductible (individual/family)	**In-network**: $4,900/$9,800	**In-network**: $3,200/$6,400	**In-network**: $1,000/$2,000	**In-network:** $800/$1,600	**In-network:** None
	Out-of-network: $4,900/$9,800	**Out-of-network:** $3,200/$6,400	**Out-of-network:** $2,000/$4,000	**Out-of-network:** $1,600/$3,200	**Out-of-network:** $5,000/$10,000

The charts within this guide may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information.

Know the Networks

Keep in mind that carrier networks can change at any time. Just because your provider was in a carrier's network one year doesn't necessarily mean they will be the next year. Use the enrollment website tools (including *Help Me Choose*) to confirm that your providers are in the carrier's network.

To ensure your medical provider is in the network of the carrier you select, call your medical provider's office directly. Indicate the carrier and network name you intend to enroll in and confirm they will accept that plan. See **tips on finding network providers**. If you can't find a carrier network that includes all of your health care providers, you might want to consider the one with the providers you see most often.

If you go out-of-network, know that:

- Out-of-network charges will **not** count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges — they will **not** count toward your out-of-network annual deductible or out-of-pocket maximum.
- Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

For more information, see page 16.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs.

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.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Annual Out-of-Pocket Maximum (individual/family)	**In-network**: $6,400/$12,800	**In-network:** $4,300/$8,600	**In-network:** $5,300/$10,600	**In-network:** $3,600/$7,200	**In-network:** $1,600/$3,200
	Out-of-network: $12,800/$25,600	**Out-of-network:** $11,500/$23,000	**Out-of-network:** $10,600/$21,200	**Out-of-network:** $7,200/$14,400	**Out-of-network:** $11,500/$23,000

The charts within this guide may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information.

What's Included?

The annual out-of-pocket maximum **includes** amounts paid toward your deductible under the Bronze, Bronze Plus, Silver, and Gold options.

It **doesn't include** amounts taken out of your paycheck for health coverage. Also, if you choose coverage under Kaiser Permanente, Bronze Plus, Silver, Gold or Platinum, copays from certain medical benefits may not apply toward the annual out-of-pocket maximum.

In-Network Benefits

When you enroll, you'll be able to see additional coverage details, and any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, call the carrier directly.

	BRONZE, BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive Care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%
Doctor's Office Visit	You pay 25% after deductible	• You pay $30 for PCP visit with no deductible • You pay $50 for specialist visit with no deductible	• You pay $25 for PCP visit with no deductible • You pay $40 for specialist visit with no deductible	• You pay $25 for PCP visit • You pay $40 for specialist visit
Emergency Room	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay $150, then 25% after deductible	You pay $200
Urgent Care	You pay 25% after deductible	You pay $50, no deductible	You pay $40, no deductible	You pay $25, no deductible
Inpatient Care	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay $350
Outpatient Care	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, covered 100%[1]

[1] There is a $100 copay for outpatient surgery at a hospital or free-standing facility.

The chart(s) above is a high-level listing of commonly covered benefits across carriers and coverage levels. This chart is intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Just for Californians!

Your options will be different, depending on the medical 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** an option that offers in-network benefits only (e.g., an HMO).

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering:

	BRONZE, BRONZE PLUS, SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	Not available	In- and out-of-network
Anthem	In-network only	In-network only	Not available	In-network only
Cigna	In- and out-of-network	In- and out-of-network	Not available	In- and out-of-network
Health Net	In- and out-of-network	Not available	In-network only	In-network only
Kaiser Permanente	In-network only	Not available	In-network only	In-network only
UnitedHealthcare	In- and out-of-network	In- and out-of-network	Not available	In- and out-of-network

Gold or Gold II?

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, Anthem, Cigna and UnitedHealthcare. The Gold II option is offered by Health Net and Kaiser Permanente.

Annual Deductible and Out-of-Pocket Maximum (California Residents)

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Annual Deductible (individual/ family)	**In-network:** $4,900/$9,800	**In-network:** $3,200/$6,400	**In-network:** $1,000/$2,000	**In-network:** $800/$1,600	**In-network:** None	**In-network:** None
	Out-of-network: $4,900/$9,800	**Out-of-network:** $3,200/$6,400	**Out-of-network:** $2,000/$4,000	**Out-of-network:** $1,600/$3,200	**Out-of-network:** Not covered	**Out-of-network:** $5,000/$10,000
Annual Out-of-Pocket Maximum (individual/ family)	**In-network:** $6,400/$12,800	**In-network:** $4,300/$8,600	**In-network:** $5,300/$10,600	**In-network:** $3,600/$7,200	**In-network:** $5,400/$10,800	**In-network:** $1,600/$3,200
	Out-of-network: $12,800/$25,600	**Out-of-network:** $11,500/$23,000	**Out-of-network:** $10,600/$21,200	**Out-of-network:** $7,200/$14,400	**Out-of-network:** Not covered	**Out-of-network:** $11,500/$23,000

Going Out-of-Network?

Out-of-network charges will **not** count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges — they will **not** count toward your out-of-network annual deductible or out-of-pocket maximum.

In-Network Benefits (California Residents)

When you enroll, you'll be able to see additional coverage details, and any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, call the carrier directly.

	BRONZE, BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive Care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%
Doctor's Office Visit	You pay 25% after deductible	• You pay $30 for PCP visit with no deductible • You pay $50 for specialist visit with no deductible	• You pay $25 for PCP visit with no deductible • You pay $40 for specialist visit with no deductible	• You pay $25 for PCP visit • You pay $40 for specialist visit	• You pay $25 for PCP visit • You pay $40 for specialist visit
Emergency Room	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay $150, then 25% after deductible	You pay $150, then 30% after deductible%	You pay $200
Urgent Care	You pay 25% after deductible	You pay $50, no deductible	You pay $40, no deductible	You pay $40, no deductible	You pay $25, no deductible
Inpatient Care	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%	You pay $350
Outpatient Care	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 30%	If not an office visit, covered 100%[1]

[1] There is a $100 copay for outpatient surgery at a hospital or free-standing facility.

The chart(s) above is a high-level listing of commonly covered benefits across carriers and coverage levels. This chart is intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Prescription Drug Coverage

Do you or a family member take medications?

Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

Your prescription drug coverage depends on the medical coverage level you choose **and** your medical insurance carrier. Below is an overview of the in-network coverage for each coverage level. See page 10 to find out why your carrier matters too.

	BRONZE, BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive Drugs (determined by the insurance carrier, as required by the Affordable Care Act)	You pay $0 You must have a doctor's prescription for the medication — even for products sold over the counter (OTC) — and you must use an in-network retail pharmacy or mail-order service.			
30-day retail supply				
Tier 1: Generally lowest cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $8
Tier 2: Generally medium cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $30
Tier 3: Generally highest cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $50
90-day mail-order supply				
Tier 1: Generally lowest cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $20
Tier 2: Generally medium cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $75
Tier 3: Generally highest cost options	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $125

If you live in California and you're eligible for coverage under Gold II, note that prescription drug coverage is the same as for the Gold coverage level shown above.

Prescription Drug Coverage: Your Medical Insurance Carrier Matters

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 a medical insurance carrier.

Things to Consider

If you or a covered family member regularly takes medication, it is strongly recommended that you call the medical insurance carrier before you enroll. **Just tell the carrier you're considering medical coverage offered through the Aon Active Health Exchange* and ask the following questions.**

- **Is my drug on the formulary?**

  A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't on a carrier's formulary, you'll pay more for it.

- **How much will my drug cost?**

  The cost of your prescription depends on how your medication is classified by your insurance carrier — either Tier 1, Tier 2, or Tier 3. The higher the tier, the more you'll pay.

  While generics typically cost less than brand name drugs, insurance carriers can classify higher-cost generics as Tier 2 or Tier 3 drugs, which means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can also find this information on the carrier preview sites, or use the prescription drug search tool when you enroll.

- **Will I have to pay a penalty if I choose a brand name drug?**

  Because many brand name drugs are so expensive, some medical insurance carriers will require you to pay the copay or coinsurance of a higher tier — plus the cost difference between brand and generic drugs — if you choose a brand when a generic is available.

- **Is my drug considered "preventive" (covered 100%)?**

  The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in-network — but, each insurance carrier determines which drugs it considers "preventive." If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

See the Prescription Drug Transition Worksheet

It can help you track your answers to these questions. Have the **worksheet** on hand when you contact the medical insurance carriers for assistance.

What's a Pharmacy Benefit Manager?

Each medical carrier uses a pharmacy benefit manager to handle its prescription drug coverage. It's like how car manufacturers rely on other companies to build certain parts of the car, like the radio or tires. Depending on your pharmacy benefit manager, you might receive a separate prescription drug card to present to the pharmacy when filling a prescription.

* The medical plan options are offered through the Aon Active Health Exchange™, which is America's first national, large-employer, multi-insurance carrier exchange. It is unrelated to the government-run state and federal health insurance exchanges or marketplaces.

Will my doctor have to provide more information before my prescription can be approved?

Many carriers require approval, or prior authorization, of certain medications before covering them. This may apply for costly medications that have lower-cost alternatives or aren't considered medically necessary.

Will I have a step therapy program?

If this applies to one of your medications, you'll need to try using the most cost-effective version first — usually the generic. A more expensive version will only be covered if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?

Certain drugs have quantity limits — for example, a 30-day supply — to reduce costs and encourage proper use.

How do I take advantage of mail-order service?

You'll likely need a new 90-day prescription from your doctor. And, because mail order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

How Much Will It Cost?

It's up to you.

You can choose the coverage level and insurance carrier that offer the right balance.

You get to decide how much you want to pay for coverage. You can choose the coverage level you want from the insurance carrier offering it at the best price.

There are other factors that impact how much you pay, too, including your contribution amount from AECOM, how many family members you cover, your (and, if applicable, your spouse/domestic partner's) commitment to well-being, and the working spouse/domestic partner surcharge (if applicable). The end result is that you could end up paying more — or less — for coverage than you do today.

Keep in mind, you'll pay the cost of medical (and dental and vision) coverage with pre-tax dollars.

Price Shopping

You'll be able to see the contribution amount from AECOM and your price options for coverage when you enroll

Pay Now or Pay Later?

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care. You determine which coverage level gives you the best deal on your total health care costs.

If you miss a paycheck deduction

If you miss one or more paycheck deductions for your benefits, due to the timing of your benefits elections or status change, Alight (our benefits administration partner) will notify Payroll to collect one extra deduction per paycheck until your arrears balance has been paid.

Pay LESS now and MORE when you need care

The Bronze and Bronze Plus coverage levels cost less per paycheck, but the deductibles are higher. Make sure you know how the deductible works, and that the deductible amount is something you can afford in the event you need a lot of health care.

Keep in mind, you can enroll in an HSA when you enroll in a Bronze or Bronze Plus coverage level. See how an HSA could save you money on page 13.

or

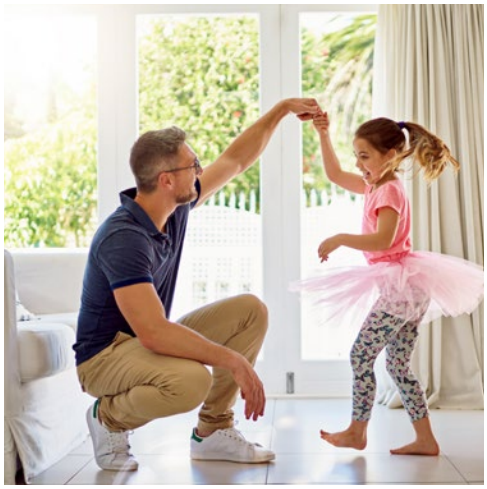
Pay MORE now and LESS when you need care

The Silver, Gold, and Platinum coverage levels generally cost more per paycheck, but the Silver and Gold deductibles are lower. The Platinum coverage level does not have a deductible. If you don't expect to have a lot of health care needs next year, you could be spending money for benefits you don't use.

Health Savings Account

Save the smart way.

A Health Savings Account (HSA) is a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up later. Plus, it's tax-free, so you're actually getting a better deal.



Use an HSA and Save

The Bronze and Bronze Plus coverage levels give you access to an HSA administered by Bank of America Merrill Lynch. This is a personal bank account that works with your medical plan if you're eligible.

The 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.

You can decide whether to enroll in an HSA and how much (if any) money you want to save when you enroll. You can change the amount you save at any time throughout the year.

What's Great About the HSA?

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside money in an HSA.

☑ It's tax-free when it goes in.

You can put money into your HSA on a pre-tax basis through convenient paycheck contributions. Not only do you save money on qualified health care expenses, but your taxable income is also lowered. For 2024, you can save up to $4,150* if you're covering just yourself, or $8,300* if you're covering yourself and your family.

If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000*.

☑ It's tax-free as it grows.

You earn tax-free interest on your money. The interest you earn even earns interest!

☑ It's tax-free when you spend it.

When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on things like your medical, dental, and vision coinsurance and deductibles. Of course, you'll want to make sure you have sufficient funds in your HSA before paying for these expenses. See more about how to use your HSA on the next page.

☑ It's always your money.

Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical plans, leave the company, or retire.

* Limits subject to mid-year changes per **IRS regulations**.

After-Tax Is an Option Too

If you want to, you can elect to contribute after-tax dollars to your HSA by transferring money from your bank account or writing a check. After-tax contributions cannot be made through payroll deductions.

The annual limit is the sum of both your pre-tax and after-tax contributions.

Back Up Your HSA

Consider how critical illness, hospital indemnity, and accident insurance coverage can provide additional medical protection and lower your out-of-pocket medical costs. That way, you can save your HSA for when you really need it.

Use Your HSA Easily

It's your money, so it **should** be easy to access — and it is! In addition to being able to manage your account online, there are three ways to use your HSA to pay for expenses. You can use your HSA debit card, pay for your expenses up front and pay yourself back from your HSA, or pay your provider directly through Bank of America Merrill Lynch.

See a complete **list of qualified expenses**.

Your **HSA User's Guide** includes details about how to grow your HSA, access your funds online, and more.

Rules About Eligibility

- To be eligible to contribute to an HSA, you must be enrolled in a Bronze or Bronze Plus medical coverage level. If you're covered by a second medical plan, it must also be a high-deductible option for you to be eligible for an HSA. For example, if you're also enrolled in your spouse's coverage, that plan must be a high-deductible option too.
- You can't contribute to an HSA if:
  - You're enrolled in Medicare or a veteran's medical plan (TRICARE).
  - You're claimed as a dependent on someone else's federal tax return.
  - You or your spouse currently participates (or previously participated within the current plan year) in a **general purpose** Health Care Flexible Spending Account (Health Care FSA).
- 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).
- In general, you can't contribute to an HSA if you use a Health Care FSA for **medical** expenses. If you have an HSA and a Health Care FSA:
  - In order to contribute to an HSA, your Health Care FSA must be "limited purpose" and can only be used to pay for qualified **dental** and **vision** expenses. However, once you meet the medical deductible, then it can be used toward qualified medical expenses as well.
  - Your HSA can be used for qualified medical, dental, and vision expenses.

  If you currently have money in a Health Care FSA and you want to contribute to an HSA in the next plan year, use the Health Care FSA money by December 31.

Also Have an FSA?

If you're wondering …

- How is an HSA different from a Health Care FSA?
- Would I want to use both an HSA and a Health Care FSA?

You can get answers in the **ABCs of HSAs and FSAs**.

Choose Your Insurance Carrier

This is how our health care approach saves you money — by making insurance companies compete for your business. Instead of AECOM choosing one or two carriers to do business with, you have several carriers to choose from.

No matter which coverage level you select, you may be able to choose from the following national and regional carriers.*

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. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

National Carriers

- **Aetna**
  Before you're a member (preview site): **https://www.aetna.com/aon/fi**
  Once you're a member (website): **https://www.aetna.com**
  Phone number: **855.496.6289**
- **Anthem**
  Before you're a member (preview site):
  https://www.anthem.com/ca/learnmore
  Once you're a member (website): **https://www.anthem.com/ca**
  Phone number: **844.424.8089**
- **Cigna**
  Before you're a member (preview site):
  https://connections.cigna.com/aonactivehealth-2024
  Once you're a member (website): **https://my.cigna.com**
  Phone number: **855.694.9638**
- **UnitedHealthcare**
  Before you're a member (preview site): **https://www.whyuhc.com/aon9**
  Once you're a member (website): **http://myuhc.com**
  Phone number: **888.297.0878**

Regional Carriers

- **Dean/Prevea 360 (generally available in WI)**
  Before you're a member (preview site): **http://aon.deanhealthplan.com**
  Once you're a member (website): **http://aon.deanhealthplan.com**
  Phone number: **877.232.9375**
- **Geisinger (generally available in PA)**
  Before you're a member (preview site): **https://geisinger.org/aon**
  Once you're a member (website):
  https://www.geisinger.org/member-portal
  Phone number: **844.390.8332**

Which Carriers Are Available to Me?

Your specific options are based on where you live (so it's important to make sure your home address on record in Workday is correct before you enroll). You'll be able to see the options available to you when you enroll.

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.

* If you live outside the service areas of all the insurance carriers, an out-of-area option through Aetna at the Silver coverage level will be your only choice. See page 2 for details.

- **Health Net (generally available in CA)**
  Before you're a member (preview site): **https://www.healthnet.com/myaon**
  Once you're a member (website): **https://www.healthnet.com/myaon**
  Phone number: **888.926.1692**
- **Kaiser Permanente (generally available in CA, CO, DC, GA, MD, VA, OR, WA)**
  Before you're a member (preview site): **https://www.kp.org/aon**
  Once you're a member (website): **https://www.kp.org**
  Pre-enrollment phone number: **877.580.6125**
  CA post-enrollment phone number: **800.464.4000**
  CO post-enrollment phone number: **800.632.9700**
  DC, MD, VA post-enrollment phone number: **800.777.7902**
  GA post-enrollment phone number: **888.865.5813**
  OR, southwest WA post-enrollment phone number: **800.813.2000**
  WA pre-enrollment **and** post-enrollment phone number: **855.407.0900**
- **Medical Mutual (generally available in OH)**
  Before you're a member (preview site): **https://medmutual.com/aon**
  Once you're a member (website): **https://member.medmutual.com**
  Pre-enrollment phone number: **800.677.8028**
  Post-enrollment phone number: **800.541.2770**
- **Priority Health (generally available in the lower peninsula of MI)**
  Before you're a member (preview site): **https://www.priorityhealth.com/aon**
  Once you're a member (website): **https://member.priorityhealth.com/login**
  Phone number: **833.207.3211**
- **UPMC Health Plan (generally available in PA)**
  Before you're a member (preview site):
  https://www.upmchealthplan.com/aon
  Once you're a member (website):
  https://www.upmchealthplan.com/members
  Pre-enrollment phone number: **844.252.0690**

Do You Live in California?

Remember, the insurance carrier you choose may also affect your coverage level choices. See page 6 for details.

What Are People Saying About Their Experiences With Health Carriers?

Sometimes it really helps to see what other people think about consumer products and services. See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available when you enroll online and throughout the year at **myAECOMbenefits.com**. Taking a look may help you with your choices.

Other people want to hear about your experiences too. Once you're a member, join in the dialogue and share your own ratings and opinions with others.

Why Stay In-Network?

Seeing out-of-network providers may cost you substantially more than seeing in-network providers. For example, you will pay more through a higher out-of-network 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.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare- based calculation to determine the maximum allowed amount.

If you use out-of-network providers, call the insurance carriers beforehand to confirm the maximum allowed amounts for the type of services you need. It could make a big difference. For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 45% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 45% of $2,000 **and** 100% of the remaining $3,000, for a total of $3,900.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 45% of $3,000 **and** 100% of the remaining $2,000, for a total of $3,350.