Mr. Cooper Group Benefits Marketplace FAQs

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

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The Aon Benefit Experience

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 all 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 annual benefits needs and budget.

2. What are the advantages of BenX?

The Marketplace (or, as we call it, the Mr. Cooper Group Benefits Marketplace) ensures that we offer a consistent benefit experience for all team members, regardless of location or income. Through a company credit program, we contribute varying dollar amounts to team members based on location, income, family size, etc. Medical care and coverage can vary from state to state and across regions within each state.

The Marketplace ensures that team members can choose a plan that best meets their needs in their region or state. The medical and prescription drug, dental, and vision benefits available through the Marketplace offer you:

- **Lots of choices.** Traditionally, you only got to choose from the health plan options offered by the company. Through BenX, you're able to 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, Mr. Cooper Group will provide a company credit to use toward the cost of your medical and dental coverage.

In addition, you have the option to enroll in other valuable benefits—including critical illness insurance, hospital indemnity insurance, accident insurance, and legal services (which includes identity theft protection)—through the Benefits Marketplace. You can also get discounted rates for pet insurance.

See question #3 for details.

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3. Where can I get more information?

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

Before and during enrollment:

- **Make It Yours website**—Visit www.mrcoopergroupbenefits.com (click the **Make It Yours** tile) to learn how the Benefits Marketplace works and what coverage options you may have—and get tips for choosing the right coverage for you and your family. You can also watch videos and access the insurance carrier preview sites here.
- **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. And you can contact **insurance carriers** directly with specific questions.
- **Mr. Cooper Group Benefits Marketplace and Alight Mobile app**—When it's time to enroll, log on to the Mr. Cooper Group Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile) or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options, get helpful decision support, and enroll. You'll also see the company credit amount from Mr. Cooper Group and prices by option.
- **Mr. Cooper Group HR Service Center**—You can reach a customer service representative through online chat or by scheduling an appointment through the Benefits Marketplace. You can also call the Mr. Cooper Group HR Service Center at **1-844-MRCOOPER (672-6673)** Monday through Friday, from 9:00 a.m. to 6:00 p.m. CT. 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 when a representative is available.

Managing your benefits year round:

- **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. (contact information is available on the Make It Yours website).
- **Mr. Cooper Group Benefits Marketplace 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.

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Enrollment

4. What will I need to do?

You must enroll or you will **not** have medical, dental, or vision coverage through Mr. Cooper Group. Keep in mind, if you do not select medical coverage, you will not have prescription drug coverage either.

Note: To contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account (FSA), you must make an active election during the enrollment period.

To make your elections during enrollment, log on to the Mr. Cooper Group Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile) or the Alight Mobile app. Over the course of the enrollment process, you'll need to:

- Add eligible dependents you want to cover.
- Choose the **insurance carriers** and coverage levels you want for your medical, dental, and vision benefits.
- Select your additional benefits coverage.

You can get information about enrollment on the Make It Yours website through **www.mrcoopergroupbenefits.com** (click the **Make It Yours** tile).

5. Are benefits effective on my first day with Mr. Cooper Group?

Yes. Mr. Cooper Group benefits become effective on your first day as a Cooper.

6. How do I create my user ID and password for the Mr. Cooper Group Benefits Marketplace outside of the Mr. Cooper Group network?

- 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 Mr. Cooper Group Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile) 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.

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7. How do I reset my password for the Mr. Cooper Group Benefits Marketplace?

To reset your password, go to the Mr. Cooper Group Benefits Marketplace at www.mrcoopergroupbenefits.com (click the **Team Members** tile), 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).

8. I have recently been hired/rehired. What do I need to do to enroll for coverage?

As a new hire, you have 31 days from your date of hire to enroll in coverage. Carefully review your enrollment and make active elections to ensure you have the coverage you want. To confirm your elections, review the Benefits Summary at the end of enrollment. You will also receive a Benefits Confirmation Statement mailed to your home address after enrollment.

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

You have five coverage levels to choose from, ranked by metallic colors: 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.

10. What happens if I enroll in a Bronze Plus medical option, which may have a high deductible, and I have expenses early after my coverage begins?

If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible—in case you have significant medical expenses shortly after the plan year begins (or shortly after the effective date of your coverage). Even if you start contributing to an HSA right away, your HSA may not have enough money to cover costly services early on. 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. Find out more about how you can benefit from contributing to an HSA on the **Make It Yours** website.

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11. 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-network and out-of-network benefits (e.g., a PPO) **or** as an option that offers in-network benefits only (e.g., an HMO).

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

The Gold option is offered by Aetna, Blue Cross and Blue Shield, Cigna, and UnitedHealthcare. The Gold II option is offered by Health Net, and Kaiser Permanente.

Learn more about your California coverage options **here**.

12. Will I be able to use the same doctors 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 them in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes doctors critical to your care.

Do not rely on your doctor'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 Mr. Cooper Group Benefits Marketplace. 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—and only the office location(s) you are willing to visit. Further, when searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in network.

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

13. Why should I use in-network providers?

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

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14. 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. (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 doctor's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network.

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 is not a reference to the network—many offer coverage nationally.

15. 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 through **www.mrcoopergroupbenefits.com**. Click the **Make It Yours** tile to access videos, details about your options, comparison charts, and more.

When you enroll, you'll be able to see the company credit amount from Mr. Cooper Group and your price options on the Mr. Cooper Group Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile) 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 during enrollment, you can reach a customer service representative by web chat or by scheduling an appointment through the Mr. Cooper Group Benefits Marketplace website. You can also call the Mr. Cooper Group HR Service Center at **1-844-MRCOOPER (672-6673)** from 9:00 a.m. to 6:00 p.m. CT, Monday through Friday. If you do not connect with a representative right away, you will be given the option to save your place in line and be called back when a representative is available. You can also call the **insurance carriers** with specific questions about the options they offer.

16. Will pre-existing conditions be covered?

Yes. When you enroll in medical coverage through the Benefits Marketplace, coverage is guaranteed, regardless of whether you and/or your eligible dependents have pre-existing conditions.

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17. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your medical insurance carrier's pharmacy benefit manager—which may be a separate prescription drug company. 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. For a **list of questions** to ask, visit the Make It Yours website. During enrollment, you can enter your prescriptions into the **Help Me Choose** tool on the Mr. Cooper Group Benefits Marketplace (click the **Team Members** tile) to see how your prescriptions will be covered.

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

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting "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 pre-approved, 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. Once coverage begins with your selected carrier, you may also want to contact their advocacy service to confirm coverage of the health care services you need.

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19. Will I receive a new ID card for medical and prescription drug coverage?

It depends. You'll only receive a new ID card when you enroll for the first time or change insurance carriers or coverage levels. You'll use your ID card for medical and prescription drug needs.

If issued, you should receive ID cards before your benefits take effect. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

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

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

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

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the Mr. Cooper Group Benefits Marketplace.

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

Each vision insurance carrier has its own provider networks. 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 eye doctor's office to know the carriers' network(s). To see whether your eye doctor or retail store is in network:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the Mr. Cooper Group Benefits Marketplace.

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22. What other benefit options 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, like a heart attack or stroke, or diagnosed with a critical illness, like 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.

Supplemental Life and AD&D insurance is available, as well. Mr. Cooper Group provides Basic Life and AD&D at no cost to you. If you wish to elect supplemental coverage, you can do so during enrollment.

You can also choose to enroll in **legal services coverage**. This covers attorney fees for things like wills, real estate matters, and more. Legal services also include identity theft protection, which monitors your personal information and takes steps to protect you from fraud.

We also offer **pet insurance**, which can help pay veterinary expenses for your sick or injured dog or cat.

Mr. Cooper Group's **commuter benefit** allows you to set aside money from your pay on a before-tax basis to pay for eligible costs associated with commuting to and from work, like public transit and parking expenses. Mr. Cooper Group will contribute up to $30 per month to your commuter account.

You can get more details on the Make It Yours website through **www.mrcoopergroupbenefits.com** (click the **Make It Yours** tile).

23. What is Universal Life with Long Term Care coverage?

Universal Life Insurance is portable life insurance in which premiums never increase because of your age. This life insurance also includes a benefit for long term care needs in the event you require extended care. The benefit can be used to help pay for licensed care at home, in a facility, or even if you're confined to a hospital or other care facility for specialized treatment. Your only opportunity to enroll in Universal Life with Long Term Care coverage is as a new hire. If you do not elect coverage during your new hire enrollment period, you will not have another opportunity to enroll.

24. Can I make changes to my Universal Life with Long Term Care coverage once I enroll?

Once you enroll in Universal Life with Long Term Care, you cannot make any changes to your elections, as you are locked into the coverage level selected at your initial enrollment. Your coverage will automatically continue at your selected coverage level. If you no longer wish to have this coverage, you can cancel it at any time by contacting the HR Service Center at **1-844-MRCOOPER (672-6673)**. If you cancel your coverage, you will not be given another opportunity to re-enroll.

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25. Is coverage available for married children of a team member?

Under current law, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old. Children can join or remain on a parent's plan even if they are:

- Married
- Not living with their parents
- Attending school
- Not financially dependent on their parents
- Eligible to enroll in their employer's plan

26. Are dependent elderly adults eligible for coverage?

Over-age dependents are covered upon approval from the carrier. Typically, carriers will provide a form that needs to be completed by the doctor, and then the carrier's medical director will determine disabled status.

27. I have a child I am covering on my insurance who will turn 26. What happens to coverage when they turn 26? Does HR automatically change the health insurance premium since they are no longer covered at age 26?

Coverage for medical, dental and vision automatically terminates at the end of the birth month in which the dependent turns 26. All other coverage ends on the date of birth. The dependent will be removed from coverage, and premiums will be adjusted accordingly, if applicable. Changes in premiums can take one to two pay periods to be reflected as a result of processing and when the change occurs during a given pay period.

Paying for Coverage

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

During the enrollment window, you'll be able to see the company credit amount from Mr. Cooper Group and your price options when you enroll on the Mr. Cooper Group Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile) or the Alight Mobile app. The Company Credit is applied to your premiums and is based on your geographic region, your family tier and how much you make in total pay (base + variable compensation) (see question #30). You can also earn Wellness and Non-Tobacco Credits to lower your premium even more each month (see question #31).

29. Do I get to keep the Mr. Cooper Group credit if I don't enroll in coverage?

No. The credit you get from Mr. Cooper Group is for the medical/prescription drug and dental coverage you purchase through the Marketplace. A cash refund or credit for other benefits is not available.

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30. Why is my company credit different from my manager's credit and my teammate's credit?

The company credit is a dollar amount that Mr. Cooper Group will apply to the total annual cost of your benefits. To ensure Mr. Cooper Group offers a consistent benefit experience, including premium costs, for all team members, the company credit will vary based on a few factors:

- *Your geographic region:* Health care costs vary across the country, so team members in higher-cost areas will receive a higher credit.
- *The number of dependents you cover*: The more dependents on your plan, the higher your costs, so your company credit will increase to compensate.
- *Your annual compensation:* The company credit for team members in lower-salary tiers will be higher to help team members afford the coverage they need.

31. What are the Wellness and Non-Tobacco Credits?

Mr. Cooper Group provides wellness incentive credits to our medical plan participants to offset medical plan premiums. The Wellness Credit is earned by participating in our voluntary Wellbeing360 program, and our Non-Tobacco Credit is earned by attesting as a non-smoker during the enrollment process. Total amounts of credits available are shown below.

- Team members with Total Earnings up to $65k can earn credits of up to $135/month or $1,620/year and
- Team members with Total Earnings $65k and above can earn credits of up to $90/month, or $1,080/year.

32. As a new team member, how can I earn the 2025 Wellness Credit toward my medical premium?

New team members in 2025 must complete the Wellbeing Assessment within Wellbeing360 (accessible online at **https://mrcoopergroup.limeade.com** or by downloading the Limeade ONE app) to earn the 2025 Wellness Credit. You can confirm completion of the Wellbeing Assessment by viewing your Completed Rewards within the My Points section of Wellbeing360. Wellness Credits will be applied within one to two pay periods after successful completion of the Wellbeing Assessment.

For questions, contact Limeade Support by clicking **here**. Please be ready to verify your account by providing your Employee ID (found in Workday).

If you are a non-smoker, you will attest to that during enrollment to earn the Non-Tobacco Credit.

33. How can we reset our account for Wellbeing360?

Please contact Limeade Support by clicking **here**. Please be ready to verify your account by providing your Employee ID (found in Workday).

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34. Is there a spousal/domestic partner surcharge?

Mr. Cooper Group is focused on providing the most affordable plans for our team members. As medical costs continue to rise, we look for opportunities to continue to provide affordable options while also offering choice.

Team members who have working spouses/domestic partners with access to other coverage and opt to cover their spouse/domestic partner on the Mr. Cooper medical plan will have a spousal surcharge. The surcharge will be based on your salary tier as outlined below:

- < $65K = $50/month or $25/pay period
- $65K to $100K = $75/month or $37.50/pay period
- $100K to $150K = $100/month or $50/pay period
- $150K to $200K = $125/month or $62.50/pay period
- $200K+ = $150/month or $75/pay period

If you enroll in the **Employee + Spouse** or **Employee + Family coverage tier**, you will be prompted to complete an attestation confirming your spouse does not have access to coverage elsewhere.

Should your spouse/domestic partner gain or lose coverage during the year, you can initiate a qualifying life event on the Benefits Marketplace within 31 days to update the response to your attestation.

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

An HSA is a special bank account that you can use when you enroll in a 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 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 use it for 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.

Learn more about your savings account on the Make It Yours website.

36. Does Mr. Cooper Group provide a company match to the HSA?

No. Employer matching contributions to the HSA are not permitted due to Aon Benefit Experience underwriting guidelines.

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37. 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 use it for 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.
- You can even invest your HSA dollars once your account balance reaches $1,000, allowing it to grow for future medical expenses.

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

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).

Learn more about your spending accounts on the Make It Yours website.

39. 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.

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

No. If you enroll in the Bronze Plus coverage level, you can contribute to an HSA but you cannot participate in a Health Care FSA. However, you can contribute to an HSA and participate in a Limited Purpose FSA that covers qualified dental and vision expenses. A Limited Purpose FSA can also be used to cover medical expenses but only after you have met the deductible.

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41. 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.

42. Are there any limitations for choosing a dental and/or vision plan when I have an HSA?

No. There is no limitation for choosing a dental or vision plan under an HSA. The medical plan is the only limitation when choosing an HSA—you must enroll in a Bronze Plus Medical Plan to enroll in an HSA.

43. Can I keep my current HSA?

Yes. If you currently have an HSA (regardless of whether it's with Alight Smart-Choice Accounts or another administrator) 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.

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 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, which is not a high-deductible option.

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).

44. Who administers the Mr. Cooper Group HSA?

HSAs are administered by Alight Smart-Choice Accounts. If your medical option offers an HSA and this is your first time contributing to an HSA through Alight Smart-Choice Accounts, you'll be provided with directions for opening your new account and for transferring any other HSA funds after you enroll. (There are no tax penalties for transferring money from one HSA to another.)

45. Who is the administrator for the FSAs and HSAs?

In addition to the Health Savings Accounts, Alight Smart-Choice Accounts administers our flexible spending accounts.

46. What are eligible expenses under the Health Care Flexible Spending Account (FSA)?

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

47. What are eligible expenses under a Health Savings Account (HSA)?

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

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Plan Questions/Enrollment

48. Are eye surgeries covered under the vision plan or medical plan?

If you have a medical condition that requires surgery on your eyes, the medical plan would review the claim. Laser eye correction surgery is an elective service, which is not covered. However, you may be eligible for a discount depending on your provider, just by being a member of a medical carrier. As with any surgery, please ensure you contact your plan for any pre-authorizations which may be required.

49. Does the coverage for a surgery vary based on the plan chosen?

Deductibles, copays, and coinsurance are the same across carriers within the same metallic (e.g., Bronze, Silver, Gold, etc.) option. However, deductibles, copays, and coinsurance do vary across the metallics.

50. Can I change my benefits coverage if I have a qualified life event?

Yes. As a result of a qualified life event (such as birth of a child, loss of coverage elsewhere, etc.), you will be able to change your benefits, including carriers, metallic options, and tier of coverage. For a list of qualified life events, log on to the Benefits Marketplace at **www.mrcoopergroupbenefits.com** (click the **Team Members** tile), and click the "Life Events" tab on the top rail of the site.

51. Is there an advocacy service available through the Marketplace?

Yes. You have access to Alight Advocacy Services, where you may contact a Health Pro to understand your benefits, verify care coverage, resolve billing errors, schedule appointments, and more. Just call **1-866-300-6530** and ask to be connected with a Health Pro. For more in-depth advocacy service, such as cost estimates or quality-based provider recommendations, contact your carrier.

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

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

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, Gold, and Platinum medical coverage levels have a "traditional deductible."** However, the Platinum coverage level does **not** have an **in-network** deductible. (As a trade-off, the Platinum coverage level is usually the most expensive coverage level per paycheck.) With 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 these coverage levels when you have family coverage.
    - To clarify, if you choose a Bronze Plus coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, you must satisfy the family deductible before coinsurance will kick in, 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.

53. If it says "not applicable" next to an annual deductible, does that mean there is no deductible with the plan, or that it is just not listed at this time?

In the instance where "N/A," or not applicable, is listed as the annual deductible for a plan, this means there is no deductible under that plan. This is typically seen on our Platinum Plan.

Disclaimer: Your medical, dental, and vision coverage will be fully insured in 2025. That means the insurance carrier will have the final authority on all claims, billing disputes, appeals, etc. So, if you have any questions about your coverage after January 1, 2025, contact your health insurance carrier.

54. 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 does not 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 Bronze, 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.

55. Are the deductibles and out-of-pocket maximums (in-network/out-of-network) consistent across all providers?

Yes. The plan designs are the same across all carriers within the same metallic option.

56. Do copayments count toward the deductible?

Copayments do not typically count toward the deductible. See question #52 for more details about deductibles.

57. Does the deductible count toward the total out-of-pocket maximum?

Yes. The deductible is included in the total out-of-pocket costs. See question #54 for more details about out-of-pocket maximums.

58. I am a rehire: Do the totals of my medical and dental costs reset with my new elections?

If you were rehired within the same plan year as you terminated employment AND if you elect the same carrier you had prior to being rehired, any costs previously accrued toward your medical deductible, out-of-pocket maximum, etc.—as well as toward your dental annual maximums—still apply toward the plan year's totals.

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59. If I contact one of the carriers prior to enrollment and tell them I work with Mr. Cooper Group and I chose the Gold medical plan, will the carrier know what plan that is?

Yes. The carriers can be contacted prior to enrollment, and they're equipped to answer questions specific to the Mr. Cooper Group benefit options. You can find the carriers' contact information via the **carrier preview sites** on Make It Yours.

60. Where can I find cost information for the medical, dental, and vision plans?

Premium amounts—specific to YOU—for the coverage options (by carrier) that you're interested in will show on the Mr. Cooper Group Benefits Marketplace during the enrollment period. You can see your costs for each option as an annual amount or a per-paycheck amount. If you use the **Help Me Choose** tool, you may also get an idea of what your *estimated* **total** costs could be. For more information about **Help Me Choose**, see questions #65–68.

61. Is fertility treatment covered?

Yes. Fertility drugs, infertility treatment, and fertility services are covered by all plans on the Benefits Marketplace.

62. Is gender reassignment surgery covered?

Yes. All plans cover gender reassignment surgery.

63. While adding a family member, it says that some additional documents are needed to verify the coverage. Can I submit those documents online or via email instead of fax/postal mail?

Yes. You will have access to an online portal for Dependent Verification for which you can upload required documentation. The Dependent Verification online portal can be accessed directly from your Benefits Marketplace page.

64. How can I verify whether my enrollment was completed?

You will receive a confirmation email after your enrollment is completed. You can also click on **Benefit Summary under Quick Actions** on your Benefits Marketplace home page, then click the applicable tab ("Current" or "Future") to see your benefit elections.

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65. What can the Help Me Choose tool do for me?

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

66. Is the information from the Help Me Choose tool confidential?

Yes. Your individual answers are confidential and will never be shared with Mr. Cooper Group. Your responses will only be shared with your health plan if you agree. The information you provide does not affect the price you're quoted for a health plan.

67. What does the Estimated Annual Cost include?

The Estimated Annual Cost on the **Help Me Choose** tool includes your estimated cost (plan premium and your predicted costs) under likely health scenarios. It takes into account millions of people in similar medical situations, and your family's health care claims, if available.

68. Will the Help Me Choose tool tell me what tier my prescription falls into?

Yes. After entering your prescriptions, the **Help Me Choose** tool will tell you which prescriptions are covered and which tier they fall under for each plan. However, it is strongly recommended that you contact the **insurance carrier** before you enroll to see how your medication will be covered.

69. Are my choices on the Benefits Marketplace saved as I'm enrolling through the process flow in case I need to leave?

Yes. Each time you make an election and move to the next screen, your election will be captured and saved. It is important that you confirm your enrollment when you're finished to ensure you did not save any unwanted elections.

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Prescriptions

70. Can the prescription tier levels change mid-year? Will they be consistent for the whole plan year?

Drugs can change within the formulary during the year. Pharmacy benefit managers will contact impacted members in writing if this happens and will provide alternative medications. Most often, you will see medications move to generic once their patent expires.

71. Will I need to have my medications pre-approved again with the new carrier?

Each carrier handles prescriptions differently. You will want to do your homework and contact the carrier before you enroll to better understand how your medications will be covered. Visit the Make It Yours website to download the **Prescription Drug Transition Worksheet** for a list of questions to ask the carriers.

72. Are medications covered the same on all plans?

Medication coverage can vary by medical carrier. When considering changing your medical carrier it is important to contact the carrier to verify if your specific medications are covered. Although formulary updates can be made at any time, the carriers typically only update quarterly. If your medication is no longer covered due to a formulary update, you should receive a communication from the carrier. You can work with your doctor to transition to a covered medication that will work for you. If your doctor feels there is not an equivalent drug suitable for you they may file an appeal at that time.

73. Is it mandatory that I use mail order for my maintenance medications?

No. Mail order is not mandatory, however many Team Members utilize mail order for the convenience of having these medications delivered on a scheduled basis. Also, mail order is less expensive than picking up directly at the pharmacy. Please see your plan details for more information on the specific copay differences.

74. Is it accurate that certain medications are only covered on the Bronze Plus (HSA) plan?

No. Medication coverage between the plan metallic levels is the same, some differences will exist by carrier (e.g. BCBS, UHC, Cigna, Aetna). If you are using your HSA to help cover the cost of your medications, this is not the only option you have if you would like to consider another plan level. Utilizing a Flexible Spending Account (FSA) will allow you to contribute pre-tax dollars that can be used to cover a wide range of expenses including prescription drugs. It is important to note that FSA funds do not carry over year to year.

Other

75. Can I elect family coverage for Legal Services?

MetLife Legal Plans covers you, your spouse, and your dependents.

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76. Does the pet insurance price on their website include the Mr. Cooper Group discount? Does it only cover cats and dogs?

You will see the Mr. Cooper Group group discount when accessing Healthy Paws from the Benefits Marketplace. Healthy Paws coverage includes dogs and cats.

77. What is the $50 wellness benefit that is offered by the voluntary group hospital indemnity, critical illness, and accident insurance plans?

This is an annual benefit you and everyone covered on your certificate can earn by completing an eligible health screening test.

- For team members, the annual benefit amount is $50 for completing a health screening test.
- Your spouse's benefit amount is $50.
- The benefit for child coverage is $50, with no annual maximum.

78. Does hospital indemnity apply for a maternity stay?

Yes.

79. Can I elect voluntary plans if I do not enroll in medical?

Yes.

80. Does hospital indemnity cover ER visits?

No. Hospital indemnity covers confinement to a hospital, critical care unit, or rehabilitation facility. Accident insurance, however, does cover emergency room visits.

81. Does hospital indemnity cover multiple stays in a calendar year?

Yes. The hospital indemnity plan provides benefit payments up to 30 days per confinement.

82. Is COVID-19 a critical illness under the Voluntary Coverages with Voya?

COVID-19 is a covered benefit under the Voya critical illness plan.

83. Does the Voluntary Coverage follow me if I leave the company?

Yes. The Voluntary Coverages through Voya are portable, allowing you to take the coverage with you if you leave or retire.

84. How do I update my mailing address on the Benefits Marketplace?

All personal information on the Benefits Marketplace is updated from Workday. To update your mailing address in Workday, click on **Personal Information**, **Change Contact Information**, and click the **Edit** button to update your home contact information. Workday updates are sent weekly on Thursdays to the Benefits Marketplace and will be updated automatically after the changes are processed.

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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.

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