FAQs Quick Start Menu

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.

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, and vision coverage. It is an online insurance marketplace where buyers like you can shop for coverage from multiple health insurance carriers who are competing for your business. BenX merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

BenX is America's first national, large-employer, multi-insurance carrier marketplace. Its website is easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right coverage options for your circumstances and budget.

2. What are the advantages of BenX?

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

- **Lots of choices.** Traditionally, you were able to choose from the health plan options offered by your 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, Neiman Marcus Group will provide a credit to use toward the cost of your coverage.

In addition, you have the option to enroll in other valuable benefits—including critical illness insurance, hospital indemnity insurance, accident insurance, legal services and identity theft protection. Also, you can get discounted rates for auto and home insurance and pet insurance through BenX.

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

3. Where can I get more information?

There are lots of resources available to help through December 31, 2025.

Before and during enrollment:

- **Make It Yours website** (first available with 2025 information on May 29)—Visit **NMG.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.
- **NMGbenefits.com and Alight Mobile app**—When it's time to enroll, log on to **NMGbenefits.com** or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to compare your options and prices, get helpful decision support, and enroll.

  Questions? Once logged on, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through **NMGbenefits.com**. You can also call the Neiman Marcus Group Benefit Service Center at **1.866.673.0462** from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday. English- and Spanish-speaking representatives are available.

Managing your benefits August 1 through December 31:

- **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.
- **NMGbenefits.com and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help before July 31, email a Health Pro at **NMGHealthPro@alight.com** or call **1.866.279.2719** from 9:00 a.m. to 9:00 p.m. ET, Monday through Friday and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues through July 31, 2025.

Enrollment

4. Why is my benefits plan year shortened and effective only from August 1 to December 31, 2025?

We are planning to harmonize benefit plans across Saks Global, effective January 1, 2026. More information about your new 2026 benefits plan will be communicated in the coming months.

In the meantime, your NMG benefits will still be available to you through December 31, 2025. We encourage you keep this in mind as you make your elections during Annual Enrollment (June 9 through June 27).

5. What will I need to do?

From June 9 through June 27, you should enroll to make sure you get the coverage you want from **August 1 through December 31, 2025**! Not only could your needs have changed, but other things could have changed too—including your options and prices, the network of doctors, and how your prescription drugs are covered. It's very important to double-check even if you choose exactly what you have today.

If you don't enroll, your current coverage will continue from August 1 through December 31, 2025. (You will have an additional enrollment period in the coming months for benefits effective January 1, 2026.) To contribute to a flexible spending account, you must make an active election.

To enroll, log on to **NMGbenefits.com** or the Alight Mobile app during the enrollment period. Over the course of the enrollment process, you can:

- Enroll the eligible dependents you want to cover from August 1, 2025 through December 31, 2025. You must certify whether your spouse/domestic partner has access to medical coverage elsewhere. If you don't certify, the spouse/domestic partner subsidy differential will be applied.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits, including accident insurance, critical illness, hospital indemnity, long-term disability, Accidental Death & Personal Loss, life insurance, legal services, and identity theft protection at **NMGbenefits.com** or with the vendor directly for auto and home insurance and pet insurance.

You can get information about enrollment on the Make It Yours website (available at **NMG.makeityoursource.com**).

6. How do I create my user ID and password for NMGbenefits.com?

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 **NMGbenefits.com** 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.

7. How do I reset my password for NMGbenefits.com?

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

My Options

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

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, and Gold. 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.

9. What happens if I enroll in a Bronze or Bronze Plus medical option and have expenses early in the shortened 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 case 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 new plan 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. Just remember, your HSA election amount made during Annual Enrollment will be deducted over the five months from August 1 through December 31, 2025.

10. 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.

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

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

Even if you can keep your current insurance carrier, the provider network could be different and can change, so *always* check the provider directories before making a decision.

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

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering at **NMGbenefits.com**. 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.

12. 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. Also, certain options/carriers in California won't cover out-of-network services at all.

13. 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). 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 isn't a reference to the network—many offer coverage nationally.

14. 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 (available at **NMG.makeityoursource.com**) to access videos, details about your options, comparison charts, and more.

Then, when you enroll, you'll be able to see the credit amount from NMG and your price options at **NMGbenefits.com** or the Alight Mobile app. You'll also be able to access tools that give you a personalized suggestion, help compare the details of your options, and more.

If you need additional help once logged on, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through **NMGbenefits.com** or call the Neiman Marcus Group Benefit Service Center at **1.866.673.0462** from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday. English- and Spanish-speaking representatives are available. You can also call the **insurance carriers** with specific questions about the options they offer.

15. Will pre-existing conditions be covered?

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

16. 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 Optum Rx (if you're considering coverage under Aetna, Blue Cross and Blue Shield of Texas, Cigna, and UnitedHealthcare) **or the other medical insurance carriers 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.

Note: Preventive prescription drugs will be 100% covered. 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.

17. 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.

18. 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 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 at **NMGbenefits.com**.

19. 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 at **NMGbenefits.com**.

20. 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 (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:

- **Legal services:** Covers attorney fees for things like wills, real estate matters, and more
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud

You can get more details by accessing the Make it Yours site at **NMG.makeityoursource.com**. Looking ahead, some voluntary benefits may be changing effective January 1, 2026. More information about your new 2026 benefits plan will be communicated in the coming months.

21. 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
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured dog or cat

You can get more details on the Make It Yours website at **NMG.makeityoursource.com**. Looking ahead, some voluntary benefits may be changing effective January 1, 2026. More information about your new 2026 benefits plan will be communicated in the coming months.

Paying for Coverage

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

From June 9 through June 27, log on to **NMGbenefits.com** and select **Enroll in Your Benefits**. When you do so, you'll be able to see the medical credit amount from NMG and prices for all of your benefit options.

23. How will the transition to the new Saks Global plans as of January 1, 2026 impact my deductibles, out-of-pocket maximums, and certain plan limits?

The amounts you contribute toward deductibles, out-of-pocket maximums, and certain plan limits will reset when you enroll in new benefit plans as of January 1, 2026.

24. Do I get to keep the NMG credit if I don't enroll in coverage?

No. The credit you get from NMG is for the medical coverage you purchase through BenX. A cash refund or credit for other benefits is not available.

25. How can I confirm the premium differential will be applied?

If you (and/or your covered spouse) completed a **Biometric Screening** at a Quest Diagnostic Service Center or onsite at NMG locations in 2025 and qualified for the premium differential of up to $30.77 per person, per bi-weekly pay period (or up to $15.39 per person, per weekly pay period), you will see the premium differential credit when you enroll at **NMGbenefits.com**. The premium differential will be applied on your first paycheck in August. If you (and your spouse/domestic partner, if applicable) completed a Marquee Health Coaching program, you will see premium credits applied to your paycheck beginning in September. The first credits will include additional premium differential credits due from August 1 through September 30.

26. As a new hire, am I required to complete a Biometric Screening to earn the premium differential?

Yes. If you complete your Biometric Screening within 30 days of your hire date, you will earn up to $30.77 per person, per bi-weekly pay period (or $15.39 per person, per weekly pay period) towards your medical plan premium differential, regardless of the screening results for you (and your covered spouse/domestic partner). If you do not complete the Biometric Screening, you will not qualify for the premium differential.

If you were hired on or after August 1, 2024 and took your Biometric Screening within 30 days of your hire date, you do not need to complete a Biometric Screening by April 30, 2025. You will receive the full savings towards your medical plan premium differential of $30.77 per person, per bi-weekly pay period (or $15.39 person, per weekly pay period) for the plan year beginning August 1, 2025

27. As a new hire, should I still take the Biometric Screening even if I do not enroll in an NMG medical plan?

Yes. It's recommended that you still complete a Biometric Screening within 30 days of your hire date, even if you have not enrolled in an NMG medical plan. Circumstances can change, and if you have a Qualified Life Event, you will not be able to take a Biometric Screening at that time to earn the medical premium differential.

28. As a new hire, does my covered spouse/domestic partner need to complete a Biometric Screening to earn the premium differential?

No. If you have completed your Biometric Screening within 30 days of your hire date, your covered spouse/domestic partner will automatically receive the full savings towards the medical premium differential.

29. As a new hire, will my premium differential be prorated?

Yes. As a new hire, once you complete your Biometric Screening, you will begin to receive premium differential credits beginning the first of the month following 30 days from your hire date and continuing through the end of the plan year (July 31). In the first full plan year following your hire, you will be eligible to receive the full premium differential.

30. What if I'm covering a spouse/domestic partner under a NMG medical plan?

If you choose to cover a spouse/domestic partner, you will be required to certify online at the time of enrollment and re-certify each year during Annual Enrollment, whether or not your spouse/domestic partner has access to medical coverage elsewhere. If you don't re-certify, the spouse/domestic subsidy differential will be applied.

31. 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.

32. 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.

33. How is an HSA different from a Health Care Flexible Spending Account (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.

34. Should my HSA election be based on a full calendar year?

Yes. If you choose to enroll in an HSA, you will elect a contribution amount based on a full calendar year (up to the 2025 IRS maximum contribution of **$4,300** if you're covering just yourself, or **$8,550** if you're covering yourself and family). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.

For example, if you elect an **annual amount of $4,300**, your total HSA contribution from August 1 through December 31 will be approximately:

- $165.38 per pay period for 11 pay periods for bi-weekly associates
- $82.69 per pay period for 22 pay periods for weekly associates

The total contribution will be approximately $1,820 of the $4,300 election.

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 annually (or approximately $423 prorated from August 1 through December 31).

35. Should my FSA election be based on a full calendar year?

Yes. If you choose to enroll in an FSA, you will elect an FSA contribution amount based on a full calendar year (up to the 2025 IRS maximum contribution of **$3,300** for a Health Care and Limited Purpose FSA and **$5,000** for a Dependent Care FSA). However, due to the shortened plan year, you will only receive the contributions that were made from August 1 through December 31.

For example, if you elect an **annual amount of $3,300** for a Health Care FSA, your total contribution from August 1 through December 31 will be approximately:

- $126.92 per pay period for 11 pay periods for bi-weekly associates
- $63.46 per paid pay period for 22 pay periods for weekly associates

The total contribution will be approximately $1,396 of the $3,300 election.

36. Can I enroll in both an HSA and a limited purpose Health Care FSA?

Yes. If you enroll in the Bronze or Bronze Plus coverage level, you can use an HSA or both an HSA **and** a limited purpose Health Care FSA. If you have an HSA and a limited purpose Health Care FSA, in order to contribute to an HSA, your limited purpose Health Care FSA can only be used to pay for eligible dental and vision expenses. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses.

37. Why would I want to use both an HSA and a limited purpose Health Care FSA?

Both accounts allow you to pay for eligible expenses with tax-free dollars. The biggest difference between the accounts is that your HSA balance rolls over from year to year, even if you change medical plans, leave the company, or retire. With the limited purpose Health Care FSA, any unused balance is forfeited at the end of the year.

It may not be advantageous to enroll in both, except in unique situations. For example, if you expect to have higher expenses than your HSA balance can cover (based on the maximum you can contribute each year), you may also want to contribute to the limited purpose Health Care FSA to pay for those expenses with tax-free money once the medical deductible is reached.

38. 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.

39. 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;
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option; and
- You cannot be enrolled in a general purpose Health Care FSA, but you may be enrolled only in a limited purpose Health Care FSA.

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).