



Quality health insurance coverage is a big concern for you and your family. *We're here to help!*

BENEFITS GUIDE 2018

Effective 11/1/2018-10/31/2019

FAES@NIH
Foundation for Advanced
Education in the Sciences

Introduction

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MEMBER RESOURCES

We make it easy to enroll in our health plan.

You never know where life is going to take you, but with our health plans you can count on the support you need to live a healthier life. From preventive services to our extensive network of providers and resources, FAES and our health care partners are there when you need us. We will work together to help you get well and stay well...so for a few minutes of your time at no cost to you, enroll today. Here's how:

1. Determine if you're eligible. Participation in the plan is available to NIH paid trainees who work at least 30 hours per week or any entity that directly supports NIH stipend-paid trainees at NIH facilities AND has at least 80% of the voting members of their board occupied by current NIH employees.
2. Determine if it's the right time to enroll. You have 30 days from the date you're hired to enroll in our health insurance plan. Coverage will begin on the day you sign and submit your paperwork to FAES. If you do not enroll during this time, you may do so during the Open Enrollment period, usually held during the month of September. Coverage for those who enroll during the Open Enrollment period will begin on November 1st of the same year.
3. Determine which (if any) family members you want to include on your plan. Spouses, dependent children (through their 26th birthday), and disabled dependent children over the age of 26 are all eligible to be included on your plan.
4. Provide FAES with NIH Fellowship Activation Forms obtained from your Administrative Officer (AO). The forms must be signed by your sponsor. FAES requires pages 1, 2 and 3 of the 6 pages of the NIH Fellowship Activation forms.
5. Complete the FAES Election Form. The form can be downloaded [here](#).
6. Email, fax, or deliver the completed NIH Fellowship Activation Form and completed FAES Election Form to FAES Insurance Location: Building 10 (South Side,) Room 1N241
E-mail: FAESinsurance@mail.nih.gov
Secure Fax: 301- 480-3585
7. Enjoy your coverage! If you have any questions or need help completing these steps, please contact us.

Your one-stop shop for insurance forms and information

FAES Claims Secure Fax Line 877-247-0022

This line is to be used when members are asked for additional documentation for pending or denied claims – **it goes right to the CoreSource claims department.**

Insurance Team Website:

<https://faes.org/content/health-insurance-services>
<https://faes.org/content/member-resources>
<https://faes.org/content/frequently-asked-questions>

Medical Coverage



| Services | In-Network | Out-of-Network |
|---|---|---|
| ANNUAL DEDUCTIBLE | | |
| Individual | \$250 | \$400 |
| Family | \$500 | \$800 |
| ANNUAL OUT-OF-POCKET MAXIMUM | | |
| Individual | \$2,500 | \$5,000 |
| Family | \$5,000 | \$10,000 |
| LIFETIME MAXIMUM BENEFIT | | |
| | None | None |
| MEMBER COINSURANCE | | |
| | 5% | 30% |
| PREVENTIVE SERVICES | | |
| Well-Child Care | No charge | Deductible, then 30% of Allowed Benefit |
| Adult Physical Examination | No charge | Deductible, then 30% of Allowed Benefit |
| Routine GYN Visits | No charge | Deductible, then 30% of Allowed Benefit |
| Breast Cancer Screening/Mammograms | No charge | Deductible, then 30% of Allowed Benefit |
| Cancer Screening (Pap Test, Prostate and Colorectal) | No charge | Deductible, then 30% of Allowed Benefit |
| Preventive Diagnostics and Labs | No charge | Deductible, then 30% of Allowed Benefit |
| OFFICE VISITS, LABS AND TESTING | | |
| Office Visits for Illness | PCP - \$15 Copay Specialist - \$25 Copay | Deductible, then 30% of Allowed Benefit |
| Diagnostic Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| X-ray and Lab Tests (Outpatient Only) | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Allergy Testing | \$25 copay | Deductible, then 30% of Allowed Benefit |
| Allergy Injections | \$25 copay | Deductible, then 30% of Allowed Benefit |
| Outpatient Physical, Speech and Occupational Therapy (limited to 30 visits/injury/benefit period) | \$15 copay | Deductible, then 30% of Allowed Benefit |
| Outpatient Chiropractic (limited to 20 visits/benefit period) | \$15 copay | Deductible, then 30% of Allowed Benefit |
| EMERGENCY CARE AND URGENT CARE | | |
| Urgent Care Center | \$25 per visit | Paid as in-network benefits |
| Hospital Emergency Room (limited to emergency services) | \$125 per visit (copay waived if admitted) | Paid as in-network benefits |
| Ambulance (if medically necessary) | \$125 Copay per event | Paid as in-network benefits |
| HOSPITALIZATION | | |
| Inpatient Facility Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Outpatient Facility Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Inpatient Physician Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Outpatient Physician Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |

Note: The information provided is only a partial, general description of plan benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.

Medical Coverage *continued*



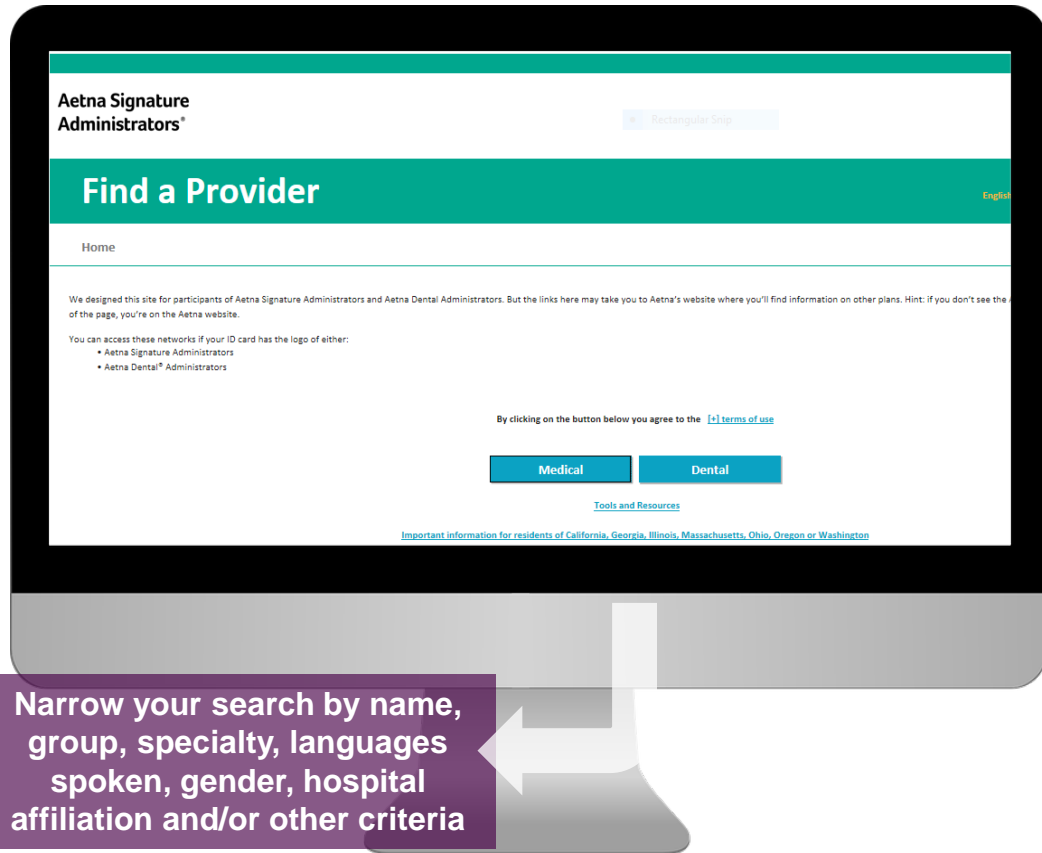
| Services | In-Network | Out-of-Network |
|--|--|---|
| HOSPITAL ALTERNATIVES | | |
| Home Health Care | No charge | Deductible, then 30% of Allowed Benefit |
| Hospice (Maximum 180 day Hospice eligibility period) | No charge | Deductible, then 30% of Allowed Benefit |
| Skilled Nursing Facility (limited to 100 days per benefit period) | No charge | Deductible, then 30% of Allowed Benefit |
| MATERNITY | | |
| Prenatal and Postnatal Office Visits | No charge | Deductible, then 30% of Allowed Benefit |
| Delivery and Facility Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Nursery Care of Newborn | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Initial Office Consultation(s) for Infertility Services/Procedures | \$25 copay | Not covered |
| Artificial and Intrauterine Insemination (limited to 3 attempts per live birth up to \$30,000 lifetime maximum) | Not covered | Not covered |
| In Vitro Fertilization Procedures (limited to 3 attempts per live birth up to \$30,000 lifetime maximum) | Not covered | Not covered |
| Breast Pump Benefit (once per lifetime) | Member can purchase any breast pump (including online) and submit receipt for reimbursement up to \$500. | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | |
| Inpatient Facility Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Inpatient Physician Services | Deductible, then 5% | Deductible, then 30% of Allowed Benefit |
| Outpatient Facility Services | Deductible, then 5% | Deductible, then 5% of Allowed Benefit |
| Outpatient Physician Services | Deductible, then 5% | Deductible, then 5% of Allowed Benefit |
| Office Visits | \$15 copay | \$15 copay |
| Medication Management/Methadone Maintenance | \$15 copay | \$15 copay |
| MISCELLANEOUS | | |
| Durable Medical Equipment | 25% of Allowed Benefit | Paid as in-Network benefits |
| Acupuncture | \$15 copay | Not covered |
| Transplants | Member is responsible for obtaining authorization for services in-network and out-of-network | |
| Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years) | No charge | Paid as in-network benefits |

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Find a Provider or a Behavioral Health Practitioner

Aetna Signature Administrators® PPO By **aetna**™

Aetna Signature Administrator's (ASA) DocFind® online provider directory lets you search for doctors and behavioral health practitioners. Search by name, gender, specialty, languages spoken, hospital and medical group affiliation and location.



www.aetna.com/ASA

HOW TO NARROW YOUR SEARCH

Name: In the "Search by Name" tab, type the name of the doctor or behavioral health practitioner you want.

Group/IPA name: In the "Advanced Search" tab, select "Medical Group/IPA California" under "Search for." Type in the name of the group or IPA.

Specialty: In the "Search by Location" tab, select "Medical Specialists" under "Search for," then select the specialty type under "Type." You can find other specialties under "More Specialties"

Behavioral Health Practitioners: select "Behavioral Health Professionals" under "Search for." Use the drop-down list under "Type" to select the provider type or discipline.

Languages the doctor or behavioral health practitioner speaks: On the "Advanced Search" tab, select one of the languages from the "Language" drop-down box.

Gender: On the "Advanced Search" tab, under the "Gender" drop-down box, select "Female," "Male" or "All Genders."

Hospital affiliation: On the "Advanced Search" tab, select the hospital you want the provider to be affiliated with under the "Hospital Affiliation" drop-down box.

Filing a Claim

Notice of Claim

A claim for benefits should be submitted to the **claims processor** within ninety (90) calendar days after the occurrence or commencement of any services by the **provider**, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a **covered person** or his beneficiary, if any, to the **plan administrator** or to any authorized agent of the **Plan**, with information sufficient to identify the **covered person**, shall be deemed notice of claim.

For non-urgent care, the **covered person** (or their authorized representative) must call the **Health Care Management Organization** at least fifteen (15) calendar days prior to initiation of services. If the **Health Care Management Organization** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For **urgent care**, the **covered person** (or their authorized representative) must call the **Health Care Management Organization** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services

Please note that if the **covered person** needs medical care that would be considered as **urgent care**, then there is no requirement that the **Plan** be contacted for prior approval.

Covered persons shall contact the
Health Care Management Organization by calling:
1-866-884-6819

Pre-Service Claim Procedure

Health Care Management

Health care management is the process of evaluating whether proposed services, supplies or treatments are **medically necessary** and appropriate to help ensure quality, cost-effective care.

Certification of **medical necessity** and appropriateness by the **Health Care Management Organization** does not establish eligibility under the **Plan** nor guarantee benefits.

Filing A Pre-certification Claim

This pre-certification provision will be waived by the **Health Care Management Organization** if the **covered expense** is rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

All **inpatient** admissions, partial hospitalizations, **home health care** (excluding supplies and **durable medical equipment**), and **hospice** care are to be certified by the **Health Care Management Organization**.

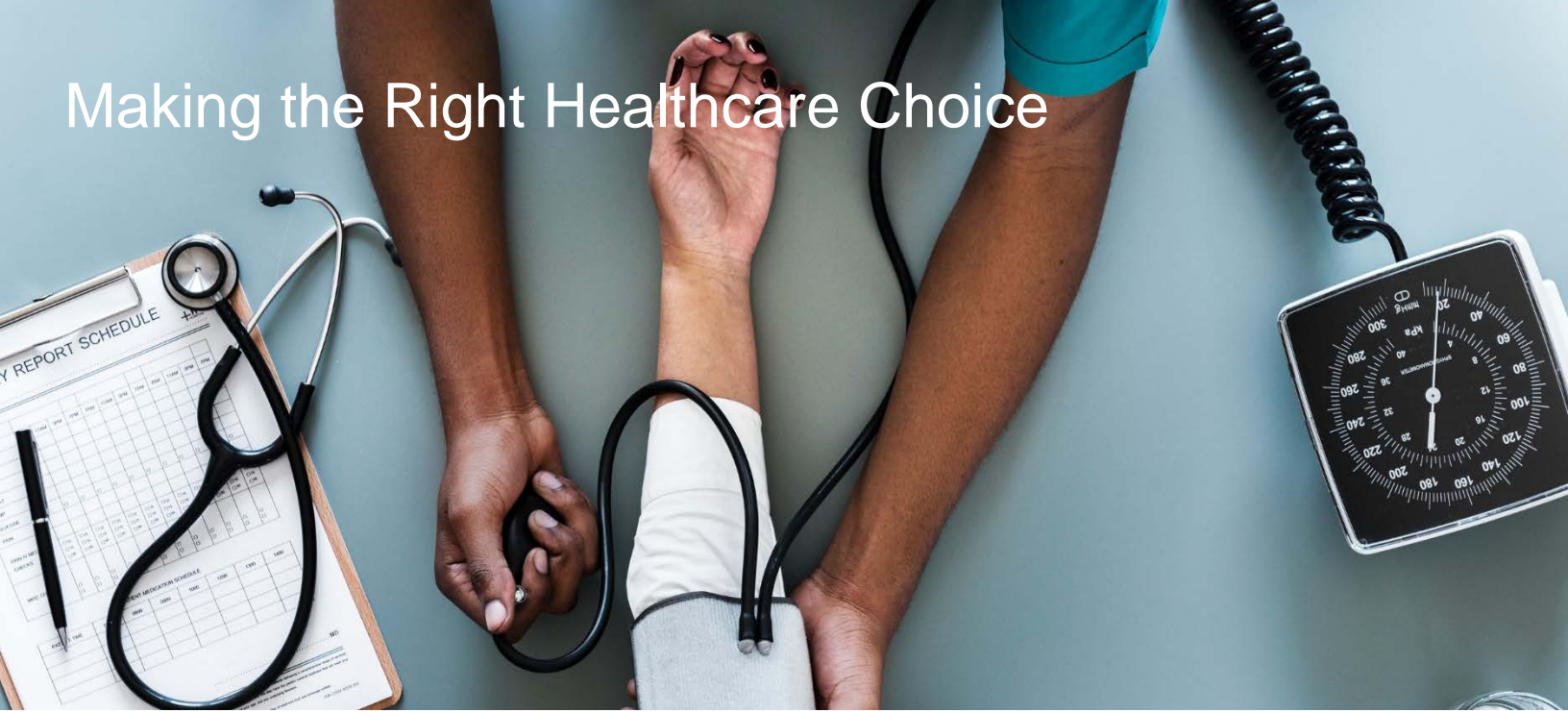
Review Of A Denied Claim

You may request a review of a denied claim by making a written request to the Named Fiduciary within 180 calendar days from receipt of a notice of denial, include the reasons you feel the claim should not have been denied along with any additional information and comments relevant to the claim You are entitled to receive, upon request and free of charge, copies of all documents relevant to the denial including: any internal guideline or similar criterion that was relied on in making the determination; and an explanation of any scientific or clinical judgment on which any medical necessity conducted by individuals who made the original determination or their subordinates. You will be notified of the decision within a reasonable period of time but not later than 60 days after the plan receives your request for review. If your claim is denied on appeal, you have the right to bring a civil action for benefits under Section 502(a) of ERISA. Please see your Plan Document/Summary Plan Description for further details.

Stop Health Care Fraud: If you suspect fraud.

Call our Fraud Hotline 877-45-FRAUD

Making the Right Healthcare Choice



Choosing the right setting for your care (from allergies to X-rays) is key to getting the best treatment with the lowest out-of-pocket costs to you and your family. It is important to understand your options so you can make the best decisions when you or your family member need care.

Primary Care Provider (PCP)

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide advice over the phone or for you in for a first visit right away.

Convenience Care Centers (Retail Health Clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms, ear infections, minor scrapes or bruises.

Urgent Care Centers

Urgent Care Centers (such as Patient First or ExpressCare) have a doctor on staff and are another option when you need care on weekends or after hours. They are a great resource for routine illnesses but also for broken bones, stitches, and other more serious concerns that your PCP and Convenience Care cannot assist with.

Emergency Room (ER)

An emergency room provides treatment for acute illnesses and trauma. You should call 911 or go straight to the ER if you have a life-threatening injury, illness, or emergency. This service is best for heart attacks, major broken bones, severe bleeding, etc.

| Site | Average Cost | Your Cost | Services |
|------------------|--------------|-------------|--|
| PCP | \$105 | \$15 copay | Main point of contact for all issues. Use them as the first resort except in life-threatening emergencies. |
| Convenience Care | \$73 | \$25 copay | Coughs, colds, pink eye, ear infection, immunizations. Extended hours from Dr. office. |
| Urgent Care | \$175 | \$25 copay | Sprains, strains, minor broken bones, x-rays, stitches, burns, etc. Open nights and weekends. |
| Emergency Room | \$1,233 | \$125 copay | Chest pain, difficulty breathing, major bleeding. |

Pharmacy Benefits



| Plan Feature | Amount | Description |
|---|---|---|
| Deductible | None | Your benefit does not have a deductible. |
| Annual Out-of-Pocket Maximum | Individual: \$2,000 Individual & Child(ren): \$4,000 Individual & Adult: \$4,000 Family: \$4,000 | |
| Preferred Preventive Drugs <i>(up to a 34-day supply)</i> | \$0 | A Preferred Preventive Drug (<i>not subject to any copay and deductible</i>) is a medication or item on Caremark's Preferred Preventive Drug List that is prescribed under certain medical criteria by a provider under a written prescription for – Aspirin, Folic Acid, Fluoride, Iron Supplements, Smoking Cessation Products, and FDA approved contraceptives for women. This list is subject to change. |
| (Tier 1) - Generic Drugs except Preferred Preventive Drugs <i>(up to a 34-day supply)</i> | \$10 | All generic drugs are covered at this copay level. |
| (Tier 2) Preferred Brand Name Drugs <i>(up to a 34-day supply)</i> | \$15 | All preferred brand name drugs are covered at this copay level. |
| (Tier 3) Non-Preferred Brand Name Drugs <i>(up to a 34-day supply)</i> | 45% of Costs Specialty – 10% of costs up to maximum of \$150 Infertility Rx – Not covered | All non-preferred brand name drugs are covered at this copay level. These drugs are not on the preferred drug list. Check the online preferred drug list to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist. |
| Maintenance Copays <i>(up to a 90-day supply)</i> | Generic: \$20 Preferred: \$30 | Maintenance drugs of up to a 90-day supply are available for twice the copay only through the Rx Delivered or retail pharmacy. |
| Restricted Generic Substitution | Yes | If you choose a non-preferred brand name drug (Tier 3) instead of its generic equivalent, you will pay the highest copay plus, the difference in cost between the non-preferred brand name drug and the generic. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for a brand name drug and DAW (dispense as written) is noted on the prescription, you will only pay the copay plus the difference between the non-preferred brand name drug and the generic. |
| Prior Authorization | Yes | Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. |

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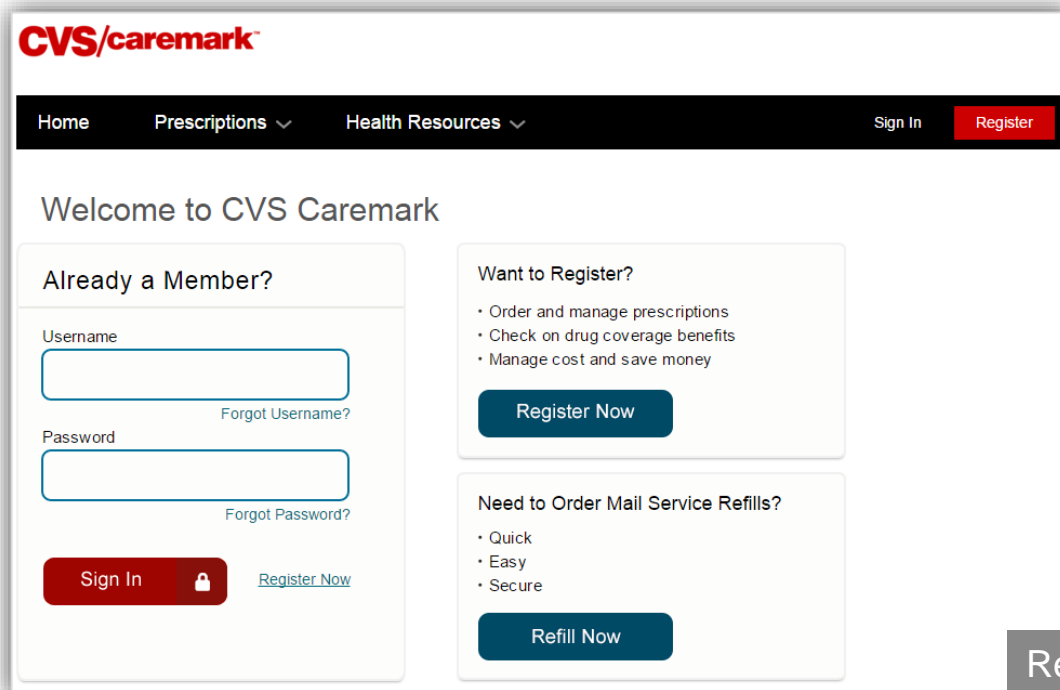
Pharmacy



Go to caremark.com for complete and up-to-date drug information

Since the prescription drug list (PDL) may change, we encourage you to visit our website, caremark.com. This website is the best source for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons.

| Drug Tier | | Includes | Helpful Tips |
|-----------|----------------------------------|--|---|
| \$ | Tier 1 Lowest Cost | Lower-cost, commonly used generic drugs. Some low-cost brands may be included. | Use Tier 1 drugs for the lowest out-of-pocket costs. |
| \$\$ | Tier 2 Mid-range Cost | Many common brand name drugs, called preferred brands. | Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs. |
| \$\$\$ | Tier 3 Highest Cost | Mostly higher-cost brand drugs, also known as non-preferred brands. | Many Tier 3 drugs have lower-cost options in Tier 1 or 2. Ask your doctor if they could work for you. |



Register at caremark.com for mail order options and much more...

Caremark makes it easy to order prescription refills, get drug cost estimates and find ways to save on your medications.

Specialty Pharmacy



PERSONALIZED CARE FOR YOUR COMPLEX CONDITION

What To Look For In A Specialty Pharmacy Provider

Specialty drugs can help you stay healthier but getting the most from them requires extra care. We help make it easier for you to manage your condition and enjoy better quality of life with the experienced support of our clinician-led teams.

We have over 30 years' experience helping people with their specialty pharmacy needs. Many of our specialty pharmacies are accredited by two independent health care review groups – The Joint Commission and URAC. The Joint Commission is the nation's major standards-setting and accrediting organization in health care. URAC establishes quality standards for the health care industry.

Their accreditation reflects our high standards for quality and safety in health care.

Helping You Stay Healthier

Personalized Attention

When you choose CVS Caremark to provide your specialty drugs, you'll get personalized support from a team of clinical experts trained in your condition. Your team will be led by a pharmacist or nurse and can help you with:

- Coordinating delivery of your refills
- Understanding and managing your condition
- Taking your medicine correctly
- Troubleshooting side effects
- Proper medicine storage

We'll help with your specialty pharmacy needs.
Call us toll-free: **1-800-237-2767**

Find more information about your condition
and medication at www.cvscaremarkspecialtyrx.com



Ready to go mobile?

Start managing your prescriptions on the go today. Caremark.com site features are now available from your Smartphone or tablet through our mobile site and apps.



Whether you log in through our mobile site at www.caremark.com or through our Apple® or Android™ mobile apps, you will have real-time, secure access to your prescriptions and pharmacy information:

- Request mail service prescriptions
- Request a new prescription with FastStart®
- Check your order status
- Check your drug coverage and cost
- Find pharmacies in your network
- View your prescription history

Download CVS Caremark apps from the App Store or Android Market or simply visit Caremark.com on your Smartphone or tablet today.

Frequently Asked Questions

Q: Do I use the same log in information I use on Caremark.com?

A: Yes, simply enter your username and password.

Q: If I am not registered on Caremark.com yet, can I register from my mobile device?

A: Yes, you can set up your Caremark.com account from the mobile site or the mobile apps. Just make sure to have your prescription ID card or a recent prescription handy.

Vision (included in your plan)

VSP CHOICE EXAM PLUS PLAN®



The VSP Choice Exam Plus Plan includes a full eye exam for \$10 and discounts on eyewear through a VSP Choice Preferred Provider¹, or a set exam allowance through any other provider

| Provider Choices | <p>VSP Choice Preferred Providers</p> <ul style="list-style-type: none"> 46,000 access points nationwide. VSP preferred providers are located in retail, neighborhood, medical and professional settings. <p>Other Providers</p> <ul style="list-style-type: none"> We also have a direct pay or assignment of benefits arrangement with Walmart Vision Center and Sam's Club Optical Center. Members have the freedom to choose any provider, national retailer, or local retail chain. |
|--|---|
| Benefits through a VSP Choice Preferred Provider | |
| Plan Feature | Description |
| Exam Services | Comprehensive WellVision Exam |
| Exam Copay | \$10 |
| Discounts on Glasses | <ul style="list-style-type: none"> 20% off complete pairs of prescription glasses 20% off all lens options 20% off unlimited non-prescription sunglasses³ |
| Contact Lenses | <ul style="list-style-type: none"> 15% off contact lens exam, excluding materials Exclusive offers for VSP members include: Mail-in rebate savings⁴ up to \$110 on eligible Bausch & Lomb contacts and up to \$125 on eligible ACUVUE Brand Contact Lenses⁴ |
| VSP Laser VisionCareSM Program | Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, and Custom Lasik ⁵ |
| Eye Health Management Program® | <ul style="list-style-type: none"> VSP collects HIPAA-compliant patient condition data and shares it with your health plan or disease management vendor ICD-9 code-based reporting of certain chronic conditions supports your disease management efforts Exam reminder letters sent to VSP members with certain conditions who have not had an eye exam in 14 months |
| Open Access Schedule | Reimbursement schedule for services from other providers: Exam - \$45 |
| Exclusions | <p>The following items are excluded under this plan: two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing.</p> <p>Items not covered under the contact lens coverage: insurance policies or service agreements; artistically painted or non-prescription lenses; additional office visits for contact lens pathology; contact lens modification; polishing or cleaning.</p> |

¹ Plan available through various provider networks including the VSP Network, Choice Network, and Advantage Network.

² Less any applicable copay.

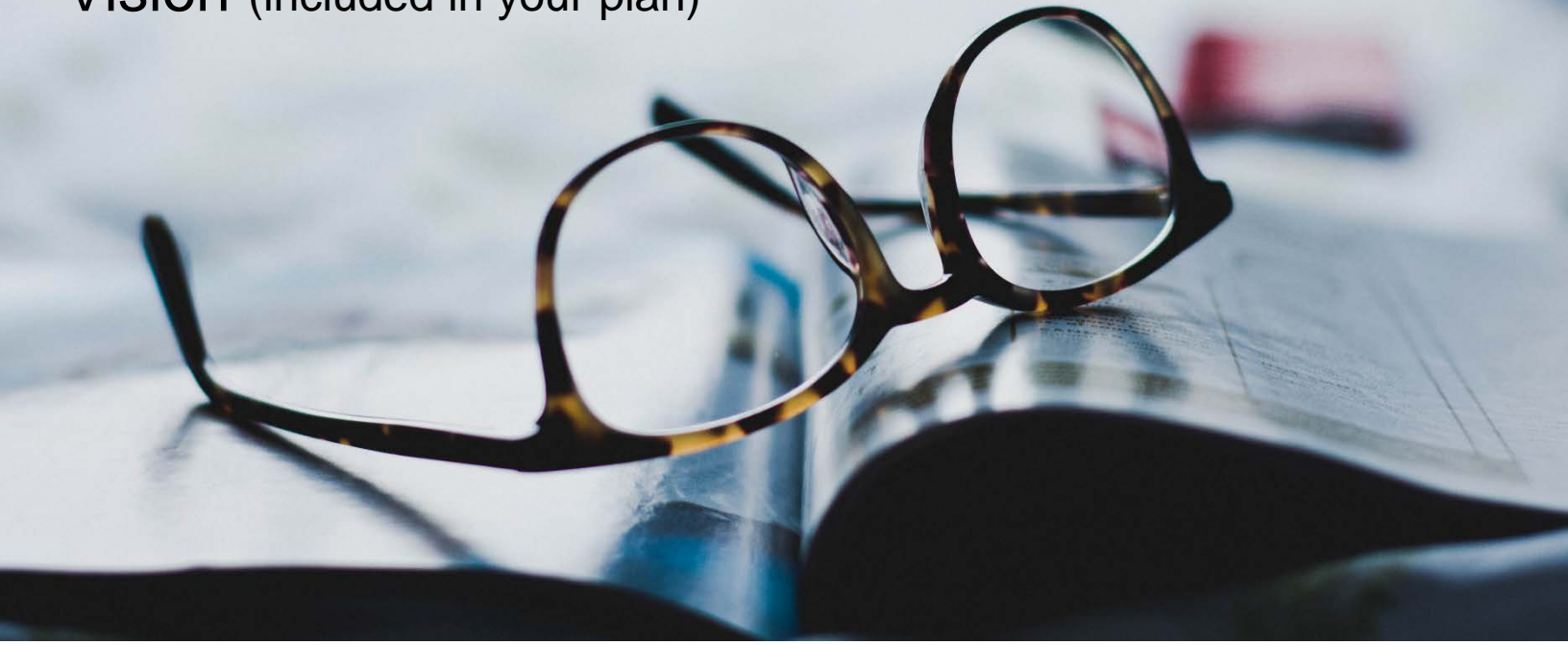
³ Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

⁴ Rebates subject to change.

⁵ Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVision Care discounts are only available from VSP-contracted facilities.

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Vision (included in your plan)



VSP.com
at your
Fingertips

VSP vision care is dedicated to offering a benefit that's simple to use and worry free.

Members can take advantage of a variety of communication tools designed to increase awareness and understanding of the VSP benefit.

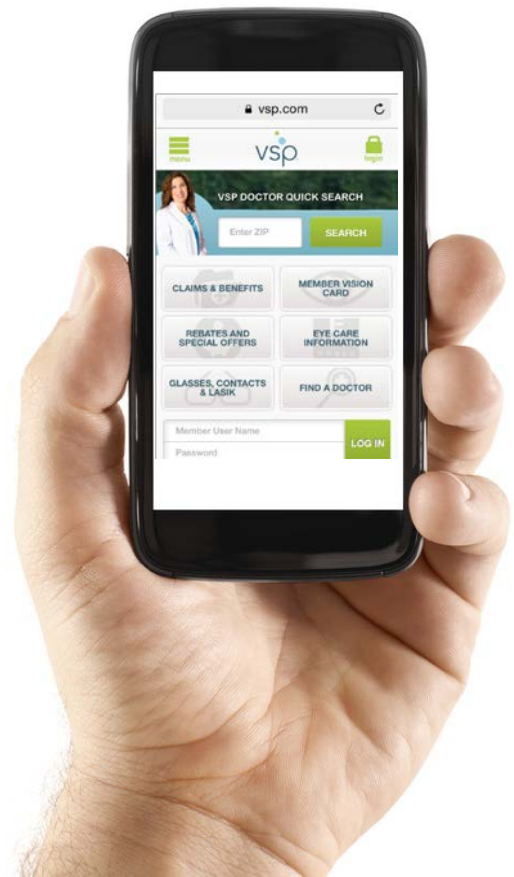
Contact VSP Member Services at **800.877.7195** for more information or to order the tools you need.

An ID Card, or Member Vision Card, isn't required for members to receive services or care.

Members simply call a VSP provider to schedule an appointment, and tell them that they're a VSP Member. The provider and VSP handle the rest. If a member wishes to have an ID Card, they can register an log on to VSP.com to print one.

VSP Member Services **800.877.7195**

- Find a doctor by name or location, and get directions to your appointment.
- Access your Member Vision Card and personal benefit information.
- View Exclusive Member Extras, like rebates, special offers, and promotions.
- Get eye care information on a variety of topics to maintain optimal eye health.



Dental (optional)

METLIFE TAKEALONG DENTAL



This plan is being made available to Fellow members of FAES on a voluntary, Employee pay-all basis. The premiums for the dental will be billed to the member on a monthly basis directly by MetLife when you enroll.

| | High Option Benefit | Medium Option Benefit | Low Option Benefit |
|---|---|---|--|
| Preventive & Diagnostic Services | In-network: 100% Out-of-network: 100% | In-network: 100% Out-of-network: 100% | In-network: 100% Out-of-network: 100% |
| Basic Restorative Services | In-network: 80% Out-of-network: 80% | In-network: 70% Out-of-network: 70% | In-network: 70% Out-of-network: 70% |
| Major Restorative Services | In-network: 50% Out-of-network: 50% | In-network: 50% Out-of-network: 50% | In-network: 50% Out-of-network: 50% |
| Child Orthodontia Covered Services | In-network: 50% Out-of-network: 50% | Orthodontia not covered | Orthodontia not covered |
| <i>Calendar year deductible - applies to basic and major restorative services</i> | | | |
| Individual | \$25 | \$50 | \$75 |
| Family | \$75 | \$150 | \$225 |
| Waiting Period | 6 months for Basic Restorative 12 months for Major Restorative & Child Orthodontia | 6 months for Basic Restorative 12 months for Major Restorative | |
| Calendar Year Maximum Benefit | \$2,000 per person | \$1,500 per person | \$1,000 per person |
| Child Orthodontia Lifetime Maximum | \$1,000 per person | Orthodontia not covered | Orthodontia not covered |
| Dependent Age | A dependent child is eligible for benefits up to his/her 26th birthday. | | |

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In-network refers to the benefits provided under this program for covered dental services that are provided by a participating dentist. Out-of-network benefits refer to benefits provided under this program for covered dental services that are not provided by a participating dentist.

MEMBER COST

To view the cost for each option, go to metlifetakealongdental.com and type in your ZIP code to find the cost in your area.

A PERSONAL ONLINE GATEWAY TO YOUR HEALTH PLAN

These days, people do their banking, pay utility bills and shop for just about anything online. It's secure, fast, easy and convenient. At CoreSource, we believe accessing information about your health plan, and managing your accounts should be no different. That's why we provide **myCoreSource.com**, a personal online portal to detailed claims data, out-of-pocket expense tracking, dedicated customer service with speedy responses to your important questions, and much more. Better yet, you can visit the portal to your health plan when it fits your busy schedule – at any time of the day or night.

Take advantage of all that myCoreSource.com has to offer:

View claim detail

- Use a variety of filtering and sorting capabilities to help you find specific claims faster, including the ability to sort by patient status, type or service date.

Site Security and Login

- Intense security protects members' information.
- Create separate logins for family members, and have the ability to block certain information from other members of the household.

Online Message Center

- Quick, direct access to Customer Service.
- Immediately send questions about a specific claim while viewing it.
- Select certain topics so that your important questions are delivered to the appropriate department and answered as quickly as possible

View Custom Content

- Tailored messages from your employer when needed.
- Informational articles on website functions, health and wellness and healthcare consumer advice.
- View links and resources personalized to be relevant to your coverage.

Electronic Explanation of Benefits (EOB)

- View information on medical claims and payments made by CoreSource with secure electronic EOB.
- Receive a secure e-mail automatically when electronic EOBs become available.
- Update the e-mail address receiving secure electronic EOBs at any time.

Receive E-mail Alerts

- When electronic EOBs are available to view.
- Replies to your Message Center questions.



CoreSource solutions

Continuation of Health Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

You must notify Human Resources within 30 days of the following COBRA events:

- divorce or legal separation
- death of an employee
- dependent child's loss of dependent status

Individual election rights to continuation of coverage

Loss of Coverage due to:

Voluntary or Involuntary loss of employment

Max Continuation for covered individuals:

| | |
|--------|-----------|
| You | 18 Months |
| Spouse | 18 Months |
| Child | 18 Months |

Loss of Coverage due to:

Disability (at the time of event)

Max Continuation for covered individuals:

| | |
|--------|-----------|
| You | 29 Months |
| Spouse | 29 Months |
| Child | 29 Months |

Loss of Coverage due to:

Your Death

Max Continuation for covered individuals:

| | |
|--------|-----------|
| You | n/a |
| Spouse | 36 Months |
| Child | 36 Months |

Loss of Coverage due to:

Your Divorce or Legal Separation

Max Continuation for covered individuals:

| | |
|--------|-----------|
| You | n/a |
| Spouse | 36 Months |
| Child | 36 Months |

Loss of Coverage due to:

You become entitled to Medicare

Max Continuation for covered individuals:

| | |
|--------|-----------|
| You | n/a |
| Spouse | 36 Months |
| Child | 36 Months |

When any covered member loses health insurance coverage based on a termination of employment or the occurrence of other qualifying events, the member will be eligible to elect continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Once your termination of health insurance coverage is processed you will receive a COBRA packet in mail from CoreSource. You will have 60 days to elect COBRA. Once COBRA is elected your coverage is retroactive to the date you lost coverage. There will be no lapse in coverage. Please contact a FAES insurance representative for additional information on pricing regarding COBRA coverage.

Each individual who is covered by the health plan immediately preceding the member's COBRA event has independent election rights to continue his or her medical or vision coverage. The right to continuation of coverage ends at the earliest of when:

- you, your spouse or dependents become covered under another group health plan: or,
- you become entitled to Medicare: or,
- you fail to pay the cost of coverage: or,
- your COBRA Continuation Period expires.

For more information visit:
www.dol.gov/ebsa/cobra.html

Commonly Used Terms

Allowable charge – sometimes known as the "allowed amount," or network negotiated amount, this is the dollar amount considered by a health insurance company to be a reasonable charge for services or supplies based on the rates in your area.

Benefit — the amount payable by the insurance company to a plan member for medical costs.

Coinsurance — the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.

Coordination of benefits — a system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

Copayment — one of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., \$15 for every visit to the doctor), while your insurance company pays the rest.

Deductible — the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Dependent — any individual, spouse or child, which is covered by the primary insured member's plan.

Exclusion or limitation — any specific situation, condition, or treatment that a health insurance plan does not cover.

In-network provider — a health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers due to negotiated discounts for services in exchange for the insurance company sending more patients their way.

Medicare — the federal health insurance program that provides health benefits to Americans age 65 and older. Signed into law on July 30, 1965, the program was first available to beneficiaries on July 1, 1966 and later expanded to include disabled people under 65 and people with certain medical conditions. Medicare has two parts; Part A, which covers hospital services, and Part B, which covers doctor services.

Network — the group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.

Out-of-network provider — a health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

Out-of-pocket maximum — the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all eligible expenses for the remainder of the year.

Preferred provider organization (PPO) — a health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.

Provider — any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that is licensed to provide medical care.

Waiting period — the period of time that an employer makes a new Employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions

For a complete glossary of healthcare terms visit

HealthCare.gov

www.healthcare.gov/glossary

Annual Notices

Right to Rescind Coverage PPACA requires group health plans to provide notice 30 days prior of group health plan termination. The rules prohibit rescissions except in very limited situations such as employees who commit fraud or make intentional misrepresentations. For example, if plan documents require employees enrolling family members to assert that these individuals meet plan eligibility requirements and to immediately notify the employer if their status changes, rescission might be possible for an employee who intentionally misrepresented marital status to obtain coverage for a friend. Prospective terminations of coverage and retroactive terminations for failure to pay premiums or contributions are not rescissions.

FAES Group Health Plan the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Group Health Plan (the “Plan”) to periodically send a reminder to participants about the availability of the Plan’s Privacy Notice and how to obtain a copy of this notice. The Privacy Notice explains participants’ rights and the Plan’s legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI.

Mothers’ and Newborns’ Act Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Information *Attention Members who are Medicare eligible or who have Medicare eligible dependents*—(or those who will soon be eligible). Coordination of benefits between the group plan and Medicare Parts A & B depends on specific criteria and reason for election of Medicare. Please contact the FAES Insurance Team for more information in regards to these criteria and how the coordination of benefits would be determined.

Uniformed Services Employment and Reemployment Rights Act (USERRA) Health Insurance Protection if you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Women’s Health and Cancer Rights Act of 1998 If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- *All stages or reconstruction of the breast on which the mastectomy was performed;*
- *Surgery and reconstruction of the other breast to produce a symmetrical appearance;*
- *Prostheses; and*
- *Treatment of physical complications of the mastectomy, including lymphedemas.*

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

COBRA Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to award termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former fellows and any other beneficiary will receive COBRA enrollment information.

Medicare Part D Notice

Important Notice from the employer about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. The employer has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your group coverage will not be affected. You and your dependents can keep this coverage if part D is elected and the plan will coordinate with Part D. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back but you/they may have to wait until the next open enrollment plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current group coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage. Contact your HR Manager for further information. It is always best to discuss your personal situation with a Medicare expert when you are considering your options. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this group coverage changes. You also may request a copy of this notice at any time. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1- 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

New Health Insurance Marketplace Coverage Options

PART A: General Information

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2015 for coverage starting as early as January 1, 2016.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your HR department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | | |
|---|--------------|---|--|
| <u>Employer Name</u> | | <u>Employer Identification Number (EIN)</u> | |
| <u>Employer Address</u> | | <u>Employer Phone Number</u> | |
| <u>City</u> | <u>State</u> | <u>Zip Code</u> | |
| <u>Who can we contact about employee health coverage at this job?</u> | | | |
| <u>Phone number (if different from above)</u> | | <u>Email Address</u> | |

- Eligible members regularly scheduled to work more than 30 hours each week.
- Dependent coverage - eligible dependents are spouses/domestic partners and children (biological, adopted and step-children)
- Coverage meets minimum value standards, and the cost of this coverage to you is intended to be affordable, based on employee wages.

*** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. ****

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Prescription Reimbursement Claim Form

Important!



- Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name (Last Name)

(First Name)

(MI)

Address

Address 2

City

State

Zip

Country

Patient Information—Use a separate claim form for each patient.

Name (Last Name)

(First Name)

(MI)

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member

Spouse

Child

Other _____

Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? Yes No

Is the medicine covered under any other group insurance? Yes No

If yes, is other coverage: Primary Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company _____ ID # _____

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X

Signature of Member

Date

STEP 2**Submission Requirements:**

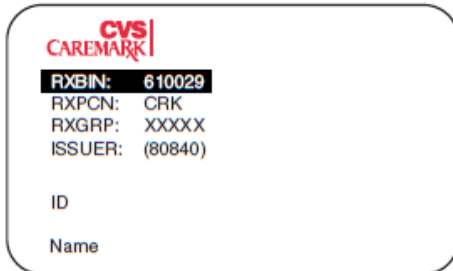
You **MUST** include all original receipts in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Days Supply
- Total Charge
- Pharmacy Name and Address or Pharmacy NABP Number

If Foreign Claim: Country: _____ Currency: _____ Amount: _____

Pharmacist's Signature: _____

Comment Section

STEP 3**Mailing Instructions:**

The RXBIN # is located on front of your CVS Caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.

RXBIN # 610415 mail to:

CVS Caremark
 P.O. Box 52116
 Phoenix, Arizona 85072-2116

RXBIN # 004336 , 012114 mail to:

CVS Caremark
 P.O. Box 52136
 Phoenix, Arizona 85072-2136

RXBIN # 610029 mail to:

CVS Caremark
 P.O. Box 52196
 Phoenix, Arizona 85072-2196

RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

CVS Caremark
 P.O. Box 52010
 Phoenix, Arizona 85072-2010

RXBIN # 610473 , 610475 mail to:

CVS Caremark
 P.O. Box 53992
 Phoenix, Arizona 85072-3992

IMPORTANT REMINDER

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.



FAES HEALTH CLAIM FORM

INSTRUCTIONS: THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill or if the bills are for a major illness, accident, or hospitalization the reverse side of this form must be completed by the attending physician.
AVOID DELAY - ANSWER ALL QUESTIONS

| | | | |
|--|--|---|--|
| EMPLOYEE INFORMATION: | | Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Laid Off <input type="checkbox"/> Disability Leave <input type="checkbox"/> Other | |
| Employee Name (Please print first name, middle initial, last name) | | I.D. Number: | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated |
| Street Address: (street, city, state, zip code) | | | Date of Birth: Month/Day/Year |
| Employer's Name: FAES | | Group Number: FA | |

DEPENDENT'S INFORMATION: (complete only if patient is a dependent)

| | |
|-------------------------------------|--|
| Name of Dependent: | Relationship: <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Spouse <input type="checkbox"/> Child _____ |
| Marital Status (other than spouse): | Date of Birth: Month/Day/Year |

AT TIME CHARGES WERE INCURRED: (If answer to either is yes, give employer's name and address)

Was spouse employed? Yes No If claim was for child, was child employed? Yes No

COMPLETE FOR ALL PATIENTS:

| | |
|--|---|
| Diagnosis or nature of injury: | |
| When were you first treated for this condition? (month/day/year) | Name and address of physician who first treated you: |
| Is patient also covered for benefits by: a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Group prepayment arrangement providing for medical care and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No d. No fault automobile insurance as a result of injuries sustained in an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency. | |
| Was illness or injury due in any way: a. To the patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. To an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c. To any other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If any of above are answered "Yes" give details under "Accident." | |
| Remarks: | |
| Accident: | |
| Date: _____ (Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.) | (Place of accident: <input type="checkbox"/> Work <input type="checkbox"/> Other) |
| How did accident happen? | Name and address where accident occurred: |

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.

SIGNED (PATIENT, OR PARENT IF MINOR)

► _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

SIGNED (PATIENT, OR PARENT IF MINOR)

► _____ Date _____

STOP — If attaching an itemized statement, do not complete this side.

Itemized statements must show Physician's name and address, dates and types of services, charges, patient's name and diagnosis.

| | | |
|--------------------------------|----------------------------------|-------------------------|
| Patient's Name (First/MI/Last) | Patient's Birth Date (Mo/Day/Yr) | Employee's I.D. Number: |
|--------------------------------|----------------------------------|-------------------------|

VERIFICATION OF SERVICES

In order to process your bill for services as part of your patient's claim for healthcare expense reimbursement, we require the following data. **Your cooperation is appreciated.**

PHYSICIAN OR SUPPLIER INFORMATION

| | | | |
|----------|--|---|--|
| Date of: | ILLNESS (first symptoms), or INJURY (Accident), or PREGNANCY (LMP) | Date patient first consulted you for this condition? | Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|----------|--|---|--|

| | |
|---|---|
| Provider of care: (Please check) <input type="checkbox"/> Attending <input type="checkbox"/> Surgeon <input type="checkbox"/> Consulting | If other than attending, give name of referring physician |
|---|---|

| | |
|--|--|
| Name & address of facility where services rendered (if other than home or office) | For services related to hospitalization, give hospitalization dates. ADMITTED DISCHARGED |
|--|--|

DIAGNOSIS Please indicate ICD9-CM or DSM III codes.

| | |
|----------------|------------------|
| PRIMARY | SECONDARY |
|----------------|------------------|

| Date of Service | Place of Service* | CPT Procedure (identify) | Fully describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session) | Charges | Amount Paid | Balance Due |
|-----------------|-------------------|--------------------------|--|---------|-------------|-------------|
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| | | | |
|-------------------------------|----------------------|--|-------------|
| Signature of Provider | Total Charge | Amount Paid | Balance Due |
| Date | Signed | Degree | |
| Your patient's account number | Provider I.D. number | Provider's name, address, zip code, and telephone number | |

If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician.

Therapy performed by _____ was conducted at my direction and under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below.

| | |
|--------------------------------------|---------------------------------------|
| Name of Attending Physician _____ | Date of Examination _____ |
| Address of Attending Physician _____ | Attending Physician's Signature _____ |
| | Professional Status _____ |

- *Place of service codes**
- | | | | |
|------------------------------|-------------------------------|------------------------------------|-------------------------------------|
| 1 - (IH) Inpatient Hospital | 4 - (H) Patient's Home | 7 - (NH) Nursing Home | 0 - (OL) Other Location |
| 2 - (OH) Outpatient Hospital | 5 - Day Care Facility (Psy) | 8 - (SNF) Skilled Nursing Facility | A - (IL) Independent Laboratory |
| 3 - (O) Doctor's Office | 6 - Night Care Facility (PSY) | 9 - Ambulance | B - Other Medical Surgical Facility |



EMPLOYEEONE
BENEFIT SOLUTIONS

921 E. Fort Ave, Suite 325
Baltimore, MD 21230
employee1.net