FAES

FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

2021-2022 Benefits Guide

Plan Year: November 1, 2021 – October 31, 2022

Medical | Pharmacy | Dental | Vision

Your Guide to Benefits

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Welcome to Your 2021-2022 Benefits Program!

FAES strives to provide the best and most flexible plan offerings to its plan members. We consider the investment we make in our benefit offerings as an investment in the health and well-being of our plan participants and their eligible dependents. Review this guide in its entirety and consider the array of benefits available to you and your dependents.

What should I know for 2021-2022?

- Your medical and pharmacy coverage will remain the same – insured through Trustmark with Aetna's network
- Your dental and vision coverage will also remain the same – insured through MetLife

Who can I contact for insurance forms and information?

FAES Insurance Contact Information:
Main Number: 301-496-8063
Email: FAESinsurance@mail.nih.gov
Hours of Operation: M-F 9:00 AM – 4:00 PM
Or Scan the QR Code

FAES Insurance Website: https://faes.org/content/health-insurance-services

The specific terms of coverage, exclusions and limitations are contained in the Plan Documents and insurance certificates. All coverages and the costs for such coverage for all participants are subject to change at any time in the future. If you have any questions about a specific service or treatment, please contact the appropriate insurer or the FAES Insurance Department.

Eligibility and Enrollment

Who is Eligible?

Participation in the plan is available to NIH paid trainees who work at least 30 hours per week or select entities that directly support NIH stipend-paid trainees at NIH facilities.

Your dependents generally include:

- A spouse to whom you are legally married;
- A dependent child under age 26 (including children, stepchildren, and legally adopted children);
- A disabled dependent child over the age of 26

FAES requires all newly eligible participants electing spouse and/or dependent children coverage under our group insurance plans to provide proof of relationship eligibility before coverage can take effect.

Acceptable documentation to confirm spouse and dependent children eligibility includes any of the following as applicable to the dependent relationship being verified:

- Birth Certificate
- Marriage Certificate
- Adoption or legal guardianship document/proof
- Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
- Written divorce settlement, separation agreement, court or administrative process order assigning legal responsibility of the employee for the welfare of the applicable dependent

What Steps Should I Take to Enroll?

1. **It's time to enroll.** You have 30 days from the date you're hired to enroll in our health insurance plan. Coverage will begin on your award start date. If you do not enroll within 30 days of your start date, you may do so during the Open Enrollment period, which is usually held during September. Coverage for those who enroll during the Open Enrollment period will begin on November 1st of the same year.
2. **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.
3. **Provide FAES with NIH Fellowship Activation Forms** obtained from your Administrative Officer (AO). Your sponsor must sign the forms. FAES requires pages 1, 2 and 3 of the 6 pages of the NIH Fellowship Activation Forms.
4. **Complete the FAES Election Form.** The form can be downloaded here.
5. **Email or fax** the completed NIH Fellowship Activation Form and completed FAES Election Form to FAES Insurance
   Email: FAESinsurance@mail.nih.gov
   Secure Fax: 301-480-3585
6. **Enjoy your coverage!** If you have any questions or need help completing these steps, please contact us.

Please email all necessary documents for new enrollment, renewals, changes or terminations to FAESinsurance@mail.nih.gov.

Changing Your Elections

When Can I Make Changes to my Benefits?

It is very important to consider your choices carefully before you make your benefits elections. Open Enrollment occurs once each calendar year and you may change your benefit elections during the Open Enrollment period. Once you have made your selection, you may not change benefit elections until the next Open Enrollment, unless you have a Qualifying Life Event during the year.

Qualifying Life Events include:

- Marriage, divorce, or legal separation
- Adding a dependent child through birth, adoption, or court-ordered custody
- Death of a spouse or child
- Change in your work schedule affecting benefits, i.e., full-time to part-time or part-time to full-time
- Your dependent loses eligibility for coverage
- Your spouse loses health coverage through their employer

Note: *For additional information and guidelines about qualifying events, visit: www.irs.gov*

If you experience any of the above Qualifying Life Events, you have **30 days** to notify the FAES Insurance Department. Otherwise, elections you make during Open Enrollment will remain in effect for the entire plan year.

What if I am having a baby?

To change your benefit elections to include coverage upon the birth of your new child, you will need to complete a few steps.

1. First, you will need to complete the FAES change form within **30 days** of your child's birth.
2. You will need to provide proof of live birth – this can be a live birth letter or discharge paperwork stating the date of birth of your child.
    - You will need to provide your child's birth certificate and Social Security Number later since these may take more than thirty days to obtain.
    - Upon receipt of your child's birth certificate and Social Security Number, please provide to the FAES Insurance Department
3. If the arrival of your new child will be changing your coverage from individual to family coverage, FAES will need updated Fellowship Activation Forms.
    - The effective date of change will be the date of birth of your new child
    - You will need to sign the paperwork and obtain the signature of your fellowship sponsor

*Paperwork must be completed and turned into the FAES Insurance Department within **30 days** of the birth of your child.*

Medical Benefits

Services	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	$125	$400
Family	$250	$800
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual	$1,500	$3,500
Family	$3,000	$7,000
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 (Excluding Blood Draws)	$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 maximum benefit per plan year combined)	$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 Benefits *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	Deductible, then 30% of Allowed Benefit
NICU (follows in-patient hospital stay)	Deductible, then 5%	Deductible, then 30% of Allowed Benefit
Initial Office Consultation(s) & Testing for Infertility Services/Procedures	$25 copay	Not covered
Breast Pump Benefit (once per lifetime)	Member can purchase any breast pump (including online) and submit receipt for reimbursement	
MENTAL HEALTH AND SUBSTANCE ABUSE ***See page 8 for additional details on Mental Health coverage***		
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	
Medication Management/Methadone Maintenance	$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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In-Network vs. Out-of-Network

Using in-network providers will be the most cost-effective option for you and your eligible dependents. Your health care expenses will be more predictable because in-network providers have agreed to negotiated rates (referred to as allowed benefit) with the insurance company. Your health care expenses are based on copayments and coinsurance of those negotiated rates; a deductible ($125 for individual and $250 for family) will apply to certain health care services.

On the other hand, out-of-network providers have not agreed to negotiated rates (allowed benefit amount) and their costs for services can vary and be much higher than in-network costs. When you visit an out-of-network provider, you will be responsible for the out-of-network deductible ($400 for individual and $800 for family) and you will then pay a 30% coinsurance of the allowed benefit. If the provider's charge for the service is more than the allowed benefit, the provider may bill you for the remainder of the cost, known as balance bill. See the example below to help understand the impact of using in-network versus out-of-network providers.

Example of Surgery Costs	In-Network Provider	Out-of-Network Provider
Rotator Cuff Surgery Cost	$9,000 (Allowed Benefit)	$10,000
Member Deductible Responsibility (Individual Level)	$125	$400
Remaining Event Exposure	$8,875	$9,600 *($600 above Allowed Benefit)*
Member Coinsurance Responsibility (percentage of the remaining expense after Deductible, capped by the Out-of-Pocket Maximum)	$8,875 x 5% coinsurance = $443.75	$9,000* x 30% coinsurance = $2,700.00 **Allowed Benefit*
Total Member Responsibility	**$568.75**	**$3,100.00**
Important Note***	The plan covers ALL remaining expenses after the member responsibility for this specific surgery. The total member responsibility amount counts towards the annual out-of-pocket maximum.	The provider can balance bill the member for the $600 above the allowed benefit amount. The balance bill amount does not count towards the out-of-pocket maximum.

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Out-of-Network Mental Health Benefits

FAES's medical plan allows members to seek mental health care from both in and out-of-network providers for **office visits at the same copay**. Members will have the same coverage for mental health when going in or out of the network. There are no restrictions when selecting your mental health provider as you can go to any provider in the United States.

What does this mean for me?

This means that you can see an in-network mental health provider for your office visits, as well as a provider who is outside of the Aetna Signature Administrator's Provider network.

What happens when I go to an out-of-network (OON) mental health provider for my office visit?

- If you have a mental health office visit with an out-of-network provider, you will need to submit the claim to Trustmark for reimbursement by following these simple steps:
    1. Fill out a Trustmark Health Claim Form. Pay special attention to the portion pertaining to the authorization of who should be paid to ensure you are only signing one of the options – either to pay the provider or to pay the member.
    2. Include either an itemized statement or complete page 2 of the Health Claim Form.
    3. Attach proof of your payment.
    4. Submit your claim for reimbursement to one of the following:
        a. Email:
            a. HBEVClaimsubmission@trustmarkbenefits.com
            b. In the subject line, write "FAES OON Claim Submission"
        b. Portal:
            a. Sign into your www.mytrustmarkbenefits.com account
            b. Click on the link for "Messages"
            c. Select "General Inquiry"
            d. In the Subject line type "OON Claim Submission"
            e. Attach claim/itemized statement/proof of payment
        c. Mail to:
            a. Trustmark Health Benefits
            PO Box 2920
            Clinton, IA 52733-2920
    5. If you have any questions during this process, please contact Trustmark's customer service number, 1-888-270-2044, which can be found on your ID card.
- You have 1 year from the date of service to submit to Trustmark for processing. If Trustmark does not receive the claim within 365 days from the date of service, the claim will be denied as it will be considered outside of the claims filing deadline.
- Please contact FAES Insurance if you go to an out-of-network mental health provider and have questions about how to submit for reimbursement.

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 medical guidance via telehealth (i.e., phone, video) or can schedule an appointment for an in-person visit with you 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.

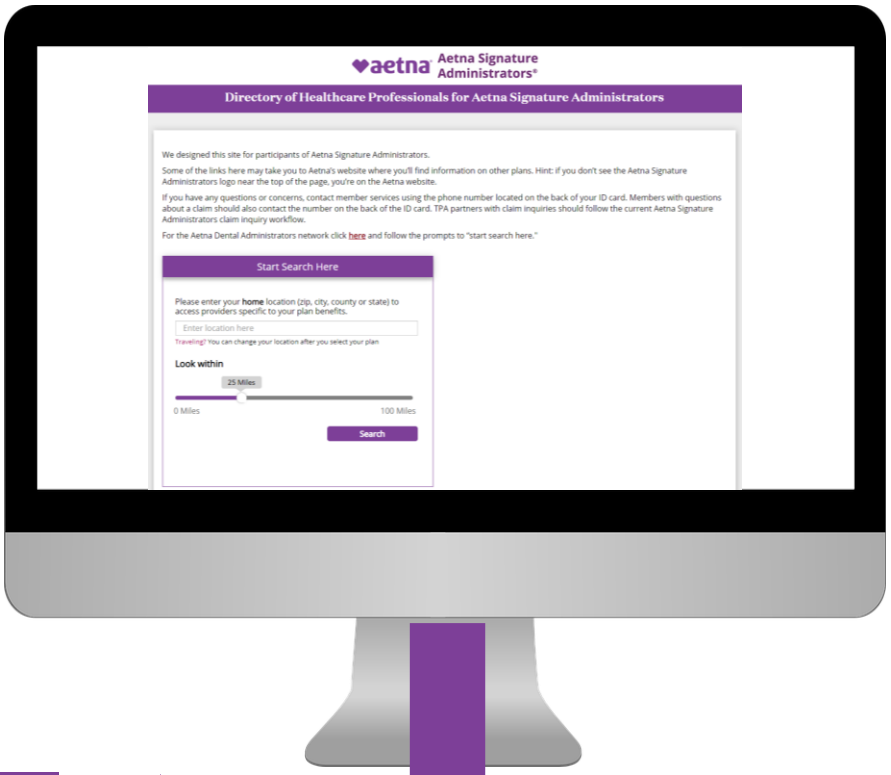
Site	Average Cost	Your Cost	Services
PCP	$105	$15 copay	Main point of contact for all issues. Use them as the first resort except in life-threatening emergencies.
Convenience Care	$73	$25 copay	Coughs, colds, pink eye, ear infection, immunizations. Extended hours from Dr. office.
Urgent Care	$175	$25 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.

How to Find a Provider

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



Narrow your search by name, group, specialty, languages spoken, gender, hospital affiliation and/or other criteria

How To Narrow Your Search

aetna™ Trustmark® benefits beyond benefits

Want to refine your search? Multiple options are available. You can easily:

- Filter by provider characteristics – such as:
  - Specialty
  - Languages spoken
  - Gender
  - Board certification
  - Hospital affiliation
  - Accepting new patients
  - Performance
- Expand or reduce the geographic radius of your results
- Sort by best matched or distance
- View a map to see the locations of results and get driving directions
- Print results

If you wish to view additional information about providers, detail pages are available on selected providers.

Filing a Claim

Notice of Claim

A claim for benefits should be submitted to the ***claims processor, Trustmark,*** 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 their 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.

How Can I Review 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 Trustmark's Fraud Hotline 877-45-FRAUD.

Documentation for pending or denied claims should be submitted via **Trustmark's Secure Fax Line 877-247-0022** ***which goes directly to the Trustmark claims department.***

How Do I Get Pre-Authorization?

Covered persons needing pre-authorization shall contact the **Trustmark Health Care Management Organization** by calling:

1-888-270-2044

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. Consult with your provider to verify if pre-authorization is needed.

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

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 approval prior to the care.

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***.

Trustmark Member Portal

Electronic communications

By opting in, you'll receive helpful info about your benefits and health via email so you can engage on-the-go. You'll also receive an email when your electronic explanation of benefits (EOB) is available, which shows your medical claims and payments made by your health benefit plan. Log on and go to the *About Me* tab to opt in so you can get your info when you need it… and save a few trees along the way!

Access your benefits and claims

You can quickly access plan benefits and claims information for you and your family to help you make smart, informed choices about your health and healthcare spending.

Review all your expenses in one place

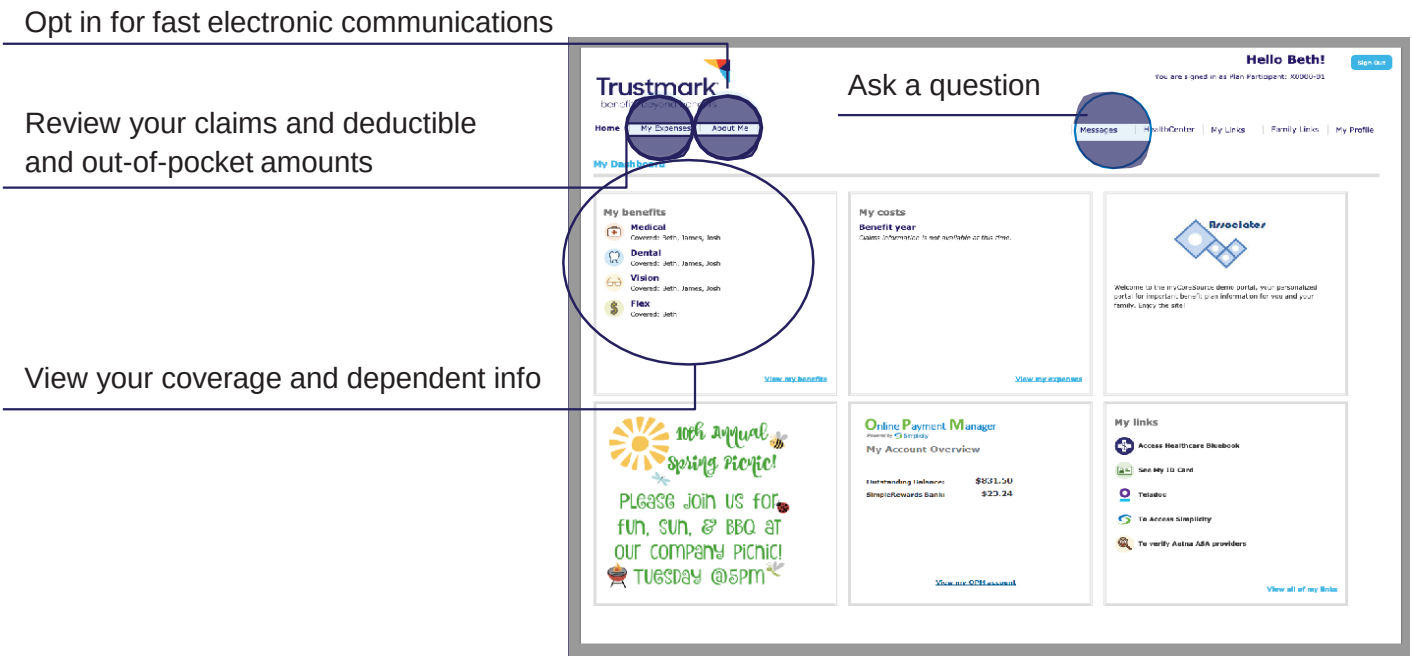
You can review all your claims, deductible, and out-of-pocket balances with just a few clicks. You can even filter your info to find exactly what you're looking for! Just log on and go to the *My Expenses* tab to see all your info.

Connect through the Message Center

Connect with customer service when you have questions, including the ability to immediately send a question about a claim while viewing its details. You can also submit claims and upload the claim form and applicable receipts via the Message Center.

Get a full look at your benefits

Click the My Benefits tile to review the details of your plan, including your coverage, your member ID, and your dependents and their information.



Expect more. *Benefit* more.

Visit myTrustmarkBenefits.com to login or register.

Self-funded plans are administered by Trustmark Health Benefits, Inc. Trustmark Health Benefits, Inc. is a subsidiary of Trustmark Mutual Holding Company.
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400 Field Drive
Lake Forest, IL 60045
800.832.3332
www.TrustmarkHB.com

Trustmark
benefits beyond benefits

Pharmacy Benefits

EXPRESS SCRIPTS®

Plan Feature	Cost	Description
Deductible	None	Your benefit does not have a deductible.
Annual Out-of-Pocket Maximum	Combined with medical out-of-pocket maximum	
Preferred Preventive Drugs *(up to a 34-day supply)*	$0	N/A
(Tier 1) - Generic Drugs except Preferred Preventive Drugs *(up to a 34-day supply)*	$10	All generic drugs are covered at this copay level.
(Tier 2) Preferred Brand Name Drugs *(up to a 34-day supply)*	$15	All preferred brand name drugs are covered at this copay level.
(Tier 3) Non-Preferred Brand Name Drugs *(up to a 34-day supply)*	45% of Costs Specialty – 10% of costs up to maximum of $150	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 *(up to a 90-day supply)*	Generic: $20 Preferred: $30 Specialty – 10% of costs up to maximum of $300	Maintenance drugs of up to a 90-day supply are available for twice the copay only through the Home Delivery or participating SMT 90 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 brand and generic. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for brand name drug and DAW (dispense as written) is noted on the prescription, you will pay the difference in cost between the brand and generic drugs. The cost difference is added to the generic copay.
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 800-922-1557 to begin the prior authorization process.

*To confirm if your pharmacy is a participating SMT 90 pharmacy, please visit express-scripts.com

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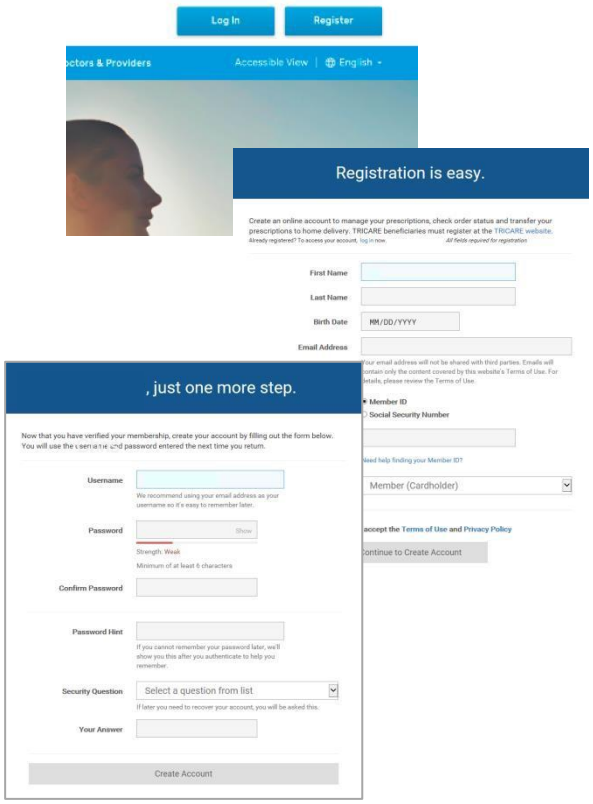
Registering with Express Scripts

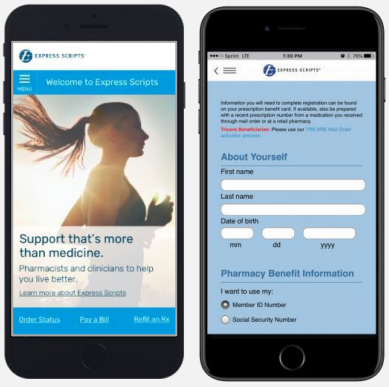
Online access to savings and convenience. Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts™ mobile app



Get Started Today! Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com, select Register or download the Express Scripts mobile app for free from your mobile device's app store and select Register
- Complete the information requested, including personal information and member ID number or Social Security Number (SSN), create your username and password, along with security information in case you ever forget your password
- Click Register now and you're registered
- To set preferences, select Communication Preferences from the menu under Account, scroll to Communication and Viewing Preferences. Click Edit preferences. Preferences can only be selected via the member website.

Members who have touch ID authentication on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.



- Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.
- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.
- The Express Scripts mobile app is available for iPhone®, AndroidTM, Windows Phone®, AmazonTM, and Blackberry® mobile devices.

Home Delivery and 90-day

Getting Started with Home Delivery from Express Scripts

Whether you are viewing the member website or using the Express Scripts™ mobile app, you can easily manage your home delivery prescription:

To access the member website …
Log-in to express-scripts.com (Register if it is your first visit. Just have your member ID or SSN handy.)

If you have a NEW prescription …

- ***Get started*** by contacting your doctor to request a 90-day prescription that he or she can ePrescribe directly to Express Scripts
- ***Or*** print a form by selecting "Forms" or "Forms & Cards" from the menu under "Benefits," print a mail order form and follow the mailing instructions.
- ***Or*** call Express Scripts and they'll contact your doctor for you.
- ***Please allow 10 to 14 days for your first prescription order to be shipped.***

If you already have a prescription …

- ***Check Order Status*** online or using Express Scripts' app to view details and track shipping.
- ***Transfer retail prescriptions to home delivery.*** Just click *Add to Cart* for eligible prescriptions and check out. Express Scripts contact your provider on your behalf and take care of the rest. Check ***Order Status*** to track your order.
- ***Refill and Renew Prescriptions*** for yourself and your family while online or while using the app. Just click Add to Cart for eligible prescriptions and check out. Express Scripts will contact your provider on your behalf, if renewals are included, and take care of the rest.

Getting Started with a 90-day Supply of your Long-Term Medicine

You can now get a three-month supply of your long-term medicine. Getting a single three-monthly supply saves you money over three, one-month supplies. Standard shipping costs are included as part of your prescription plan benefit. Plus, you'll make fewer trips to the pharmacy, and you'll be less likely to miss a dose since you won't have to refill as often.

Delivered to you
Have your medicine delivered from Express Scripts Pharmacy with:

- FREE standard shipping
- Access to a pharmacist 24/7
- Automatic refill reminders so you're less likely to miss a dose
- Extended Payment Plan available

It's easy to start! Just call **855.778.1444** or go to **express-scripts.com/3month**. Express Scripts will contact your doctor to get your new prescription.

OR At a participating pharmacy
To find a pharmacy that participates in filling three-month supplies, log in or register at express-scripts.com/3month, select "Prescriptions," and click "Find a Pharmacy".
The pharmacy can tell you how to transfer your prescription or start a new one.

855.778.1444 express-scripts.com/3month

Your Journey with Accredo

EXPRESS SCRIPTS®
accredo®

At Accredo, your specialty pharmacy, taking care of you is our focus. You might be newly diagnosed and beginning with a specialty medication, or you might just be new to Accredo. Either way, our specialty-trained pharmacists, nurses, pharmacy techs and patient care advocates understand chronic and complex conditions. We're here to help you navigate this journey.

What is a specialty medication?

A medication used to treat chronic, complex conditions like multiple sclerosis, hepatitis C and cancer. Specialty medications can include oral solids, or can be injected, infused or inhaled and may require special handling, such as refrigeration.

1 SPECIALTY CLINICIANS ARE YOUR GUIDE

- Our specialty-trained pharmacists and nurses are **available 24/7** for any questions about your therapy
- You'll receive **one-on-one clinical support** to help you administer your medication safely and effectively
- Your Accredo team helps you **manage possible side effects**
- For certain conditions, **Accredo nurses help you administer your medication** in the comfort of your home, when appropriate

2 AN EASY ROUTE FOR GETTING YOUR MEDICATION

- **Free shipping** to where you choose[1], when you choose
- **Additional supplies**, like syringes and sharps containers, included at no additional charge
- Medication is **handled with care**, including refrigeration if needed (plus information on how to properly store your medication at home)
- **Refill reminders** and shipment updates by email or text[2] to make sure you don't run out
- **Order refills** at accredo.com, on our mobile app or by calling the number on your prescription label

3 NAVIGATE INSURANCE AND FINANCIAL ASSISTANCE

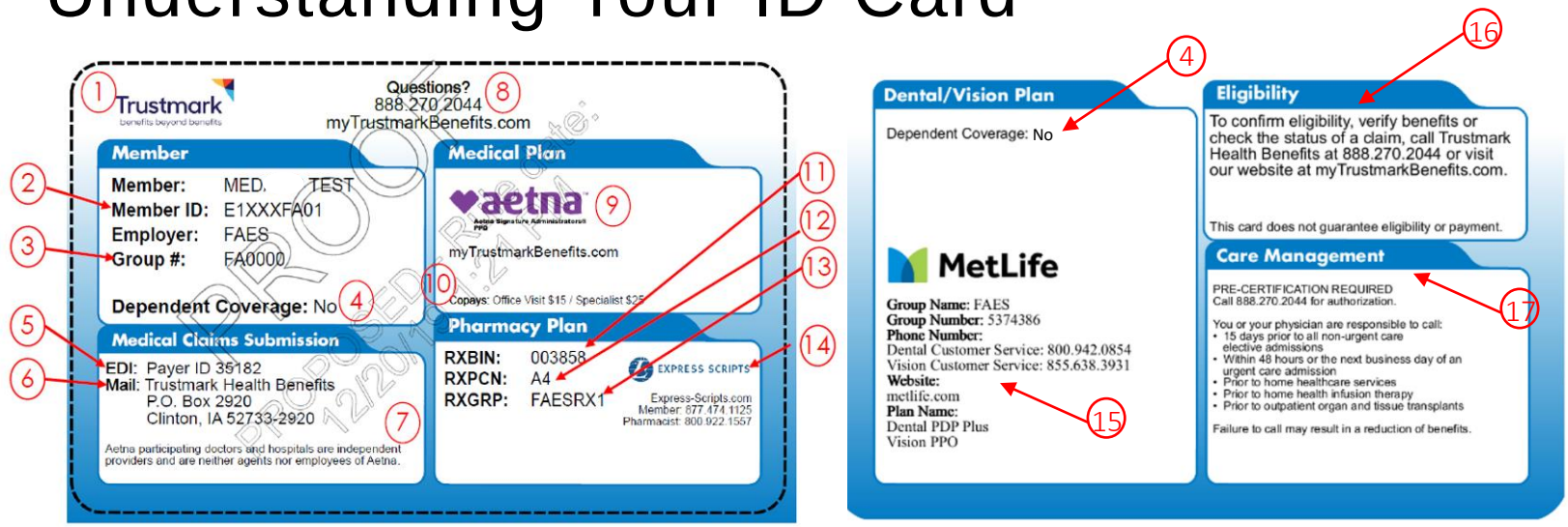
- Get help **understanding your insurance coverage** and coordinating with your health plan on approvals and eligibility
- **We'll find financial assistance** programs that may be available from drug manufacturers and community organizations
- In 2017, Accredo coordinated **$575 million in copay assistance** for qualified patients[3]

Accredo provides personalized clinical support and care for a wide range of complex conditions, *including:*

- Age-related macular degeneration
- Alpha-1 antitrypsin deficiency
- Anemia
- Severe asthma
- Cancer
- Crohn's disease
- Cystic fibrosis
- Deep vein thrombosis
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Hereditary angioedema
- Hereditary tyrosinemia
- Immune deficiency
- Infertility
- Lysosomal storage disorders
- Multiple sclerosis
- Neutropenia
- Osteoarthritis
- Osteoporosis
- Psoriasis
- Pulmonary arterial hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis
- And many more, including orphan and ultra-orphan conditions

Contact Accredo by calling
877-895-9697

Understanding Your ID Card



FRONT OF CARD:

1. **Plan Administrator – your insurance is through Trustmark and utilizes the Aetna network of providers. Trustmark processes claims and manages the day-to-day aspects of your group plan**
2. **Member ID – used by Trustmark Customer Service to verify eligibility and coverage**
3. **Group Number – helps Trustmark identify the benefits of your particular plan**
4. **Dependent Coverage: "Yes" or "No" – dependents do not get their own cards with their name listed**
5. **EDI Payer ID – the number your provider uses to submit claims information to Trustmark**
6. **Mail – mailing address for claims submissions**
7. **Aetna Notice – Aetna is your network of providers; benefits are insured by Trustmark**
8. **Questions? – Toll free and online support to get information or access care**
9. **Network of providers – to find a provider search www.aetna.com/asa**
10. **Office Visit Copays – amount you pay on the day you visit your provider**
11. **RxBin – pharmacists use this number to process your prescriptions**
12. **RxPCN – pharmacists use this number to identify plan benefits**
13. **RxGroup – pharmacists use this number to identify plan benefits**
14. **Express Scripts – prescription coverage administrator and customer service**

BACK OF CARD:

4. **Dependent Coverage: "Yes" or "No" – dependents do not get their own cards with their name listed**
15. **MetLife – the back of your ID card contains important Group Name, Group Number, and Contact Information for your Dental and Vision Plan through MetLife**
16. **Eligibility – contact Trustmark to confirm your eligibility, verify benefits, and check the status of your claim**
17. **Care Management – For authorization of certain services under your Trustmark plan, you and your provider will need to contact Care Management**

Dental PDP Plus Plan

The MetLife 2021-2022 Dental Plan offers comprehensive in-network and out-of-network benefits. 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. Please see the back of your Trustmark ID Card for your MetLife Dental PDP Plus Plan group number and contact information.

	In-Network	Out-of-Network
Preventive & Diagnostic Services	100%	100% of Allowed Benefit
Basic Restorative Services	80%	80% of Allowed Benefit
Major Restorative Services	50%	50% of Allowed Benefit
Orthodontia Covered Services	50%	50% of Allowed Benefit
Plan Year Deductible **Individual** **Family** *Plan year deductible - applies to basic and major restorative services*	$50 $150	$50 $150
Plan Year Maximum Benefit	$3,000 per person	$3,000 per person
Orthodontia Lifetime Maximum	$2,000 per person	$2,000 per person
Dependent Age	A dependent child is eligible for benefits up to their 26th birthday.	

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.

Dental Coverage Details

MetLife

Preventive Care*

for example
cleanings, x-rays and exams

*Subject to frequency limits.

TYPE A
Preventive & Diagnostic

- Oral Exams
- Prophylaxis (Cleaning)
- Bitewing X-rays
- Fluoride treatments
- Sealants
- Lab and other tests

Basic Care

for example
fillings and extractions

TYPE B
Restorative

- Space Maintainers
- Full Mouth X-Rays
- Periapical X-Rays
- Periodontal maintenance
- Resin Composite Fillings
- Palliative Care
- Oral Surgery (simple extractions)

Major Care

for example
bridges, crowns and dentures

TYPE C
Prosthodontics

- Consultations
- Root Canal
- Periodontal Surgery
- Prefabricated Crowns
- Crown Buildups (Post Core)
- Dentures
- Fixed Bridges
- Implant Services
- Periodontal Surgery
- Oral Surgery (surgical extractions)
- General Anesthesia

Orthodontics

The orthodontia benefits cover both the adult and child (up to age 26). The lifetime maximum coverage amount is $2,000. The services performed for the purpose of orthodontia benefits will be considered at the 50% coinsurance amount.

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.

Dental PDP Plus Frequencies

MetLife

How often and how many services are covered under this plan?

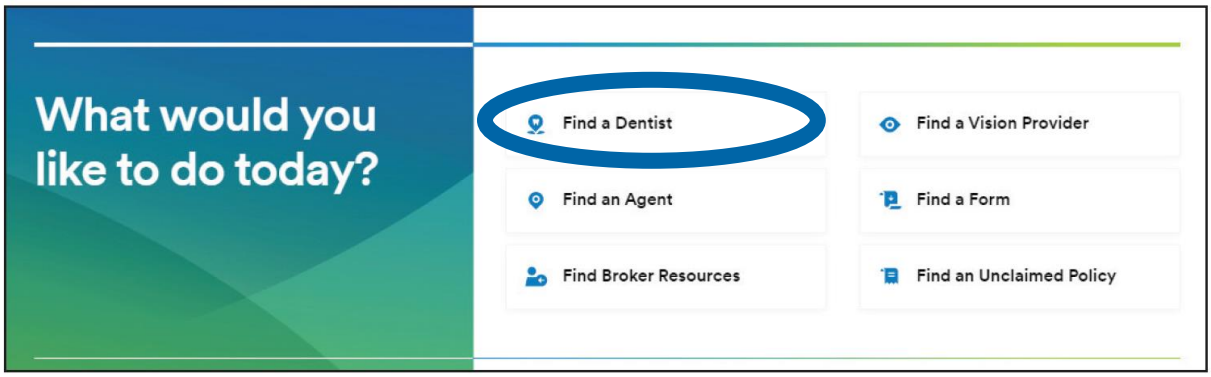
Service Category	Selected Covered Services	How Many/How Often
Type A – Preventive & Diagnostic	Oral Examinations	2 in a year
	Bitewing X-Rays (Adult/Child)	1 in 12 months
	Prophylaxis – Cleanings	2 in a year
	Topical Fluoride Applications	1 in a year – Children up to age 14
	Sealants	1 in 60 months – Children up to age 16
Type B – Restorative	Full Mouth X-Rays	1 in 60 months
	Space Maintainers	1 per lifetime per tooth area – Children up to age 14
	Amalgam and Composite Fillings	1 in 24 months – Anterior teeth only
	Periodontal Scaling & Root Planing	1 in 24 months per quadrant
	Periodontal Maintenance	2 in 1 year – includes 2 cleanings
Type C – Prosthodontics	Crowns/Inlays/Onlays	1 per tooth in 84 months
	Prefabricated Crowns	1 in 84 months
	Repairs	1 in 12 months
	Endodontics Root Canal	1 per tooth per lifetime
	Periodontal Surgery	1 in 36 months per quadrant
	Bridges	1 in 84 months
	Dentures	1 in 84 months
	Consultations	2 in 12 months
	Implant Services	1 service per tooth in 84 months – 1 repair per 12 months

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.

Finding a Dental Provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching MetLife's online **Find a Dentist** directory.

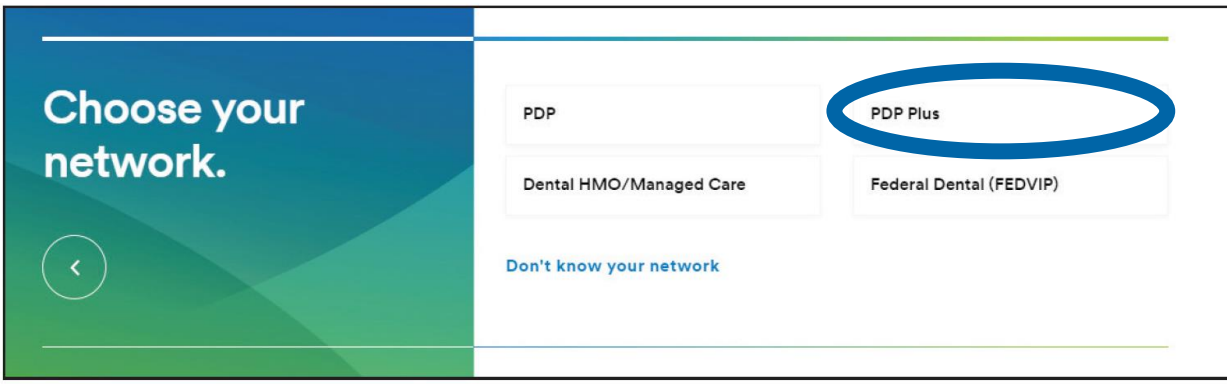
Step 1:
Go to metlife.com



Step 2:
Select "Find a Dentist" next to "What would you like to do today?"

Step 3:
Select "PDP/ PDP Plus" next to "Choose your network."

Enter your Zip, City or State and select the "Find a Dentist" button. You will then be prompted to select your plan from the list. The plan name is located in your Schedule of Benefits.



Vision PPO Plan

MetLife

The MetLife 2021-2022 Vision Plan offers comprehensive in-network and out-of-network benefits. Please see the back of your Trustmark ID Card for your MetLife Vision PPO Plan group number and contact information.

	In-Network	Out-of-Network Reimbursement	Frequency Period **
Exam(s) Copay	$10 copay	Up to $45 allowance	Once per plan year
Eyewear Copay	$20 copay	N/A	Once per plan year
Frame Allowance* (once per plan year)	$130 allowance $70 allowance at Costco, Walmart, and Sam's Club	Up to $70 allowance	Once per plan year
Eyeglass Lenses (one pair per plan year)			
Single Vision	$20 copay	Up to $30 allowance	Once per plan year
Lined Bifocal	$20 copay	Up to $50 allowance	Once per plan year
Lined Trifocal	$20 copay	Up to $65 allowance	Once per plan year
Lenticular	$20 copay	Up to $100 allowance	Once per plan year
Contact Lenses* (one pair or single purchase per plan year)			
Elective	$130 allowance	Up to $105 allowance	Once per plan year
Therapeutic	Covered 100% after eyewear copay	Up to $210 allowance	Once per plan year

*** You can choose 1 pair of frames OR contact lenses each plan year; Inquire with your in-network provider if there are additional discounts available on hardware.**
**** Your Frequency Period Begins November 1, 2021 through October 31, 2022 (Plan Year)**

Eye doctor visits can be expensive. From wellness care to significant incidents, vision insurance is a smart way to protect your eyesight and pocketbook.

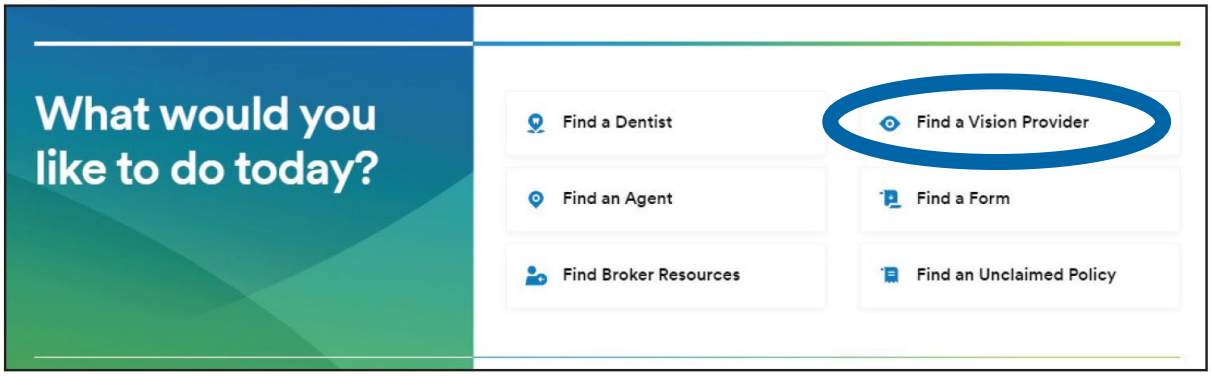
11 million Americans over the age of 12 need vision correction.[1]

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.

Finding a Vision Provider

With MetLife Vision, you can choose from thousands of ophthalmologists, optometrists and opticians at private practices or at popular retail locations like Costco® Optical, Visionworks and more. You can find the names, addresses, and phone numbers of providers by searching MetLife's online **Find a Vision Provider** directory.

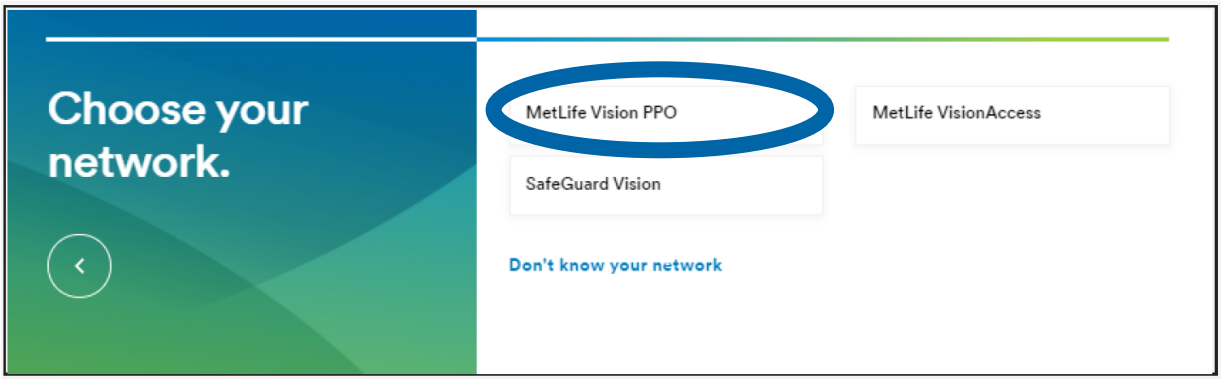
Step 1:
Go to metlife.com



Step 2:
Select "Find a Vision Provider" next to "What would you like to do today?"

Step 3:
Select your vision plan next to "Choose your network."

Enter your Zip, City or State and select the "Find a Vision Provider" button.



Creating a MetLife Account

How do I register on MyBenefits?

MyBenefits provides you with a personalized, integrated, and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information. As a first-time user, you will need to register on MyBenefits, by following the steps outlined below.

Step 1: Provide your group name

Access MyBenefits at www.metlife.com/mybenefits and enter the employer name and click to select it and then click **'Next.'**

Step 2: The login screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Log In'** at the top-middle of the page and on the next screen select '**Create New Account**' and complete the registration process. Going forward, you will be able to log-in directly.

www.Metlife.com/mybenefits

Step 3: Enter authentication information

Begin by entering your phone number, address, and e-mail to confirm your identity. You will then receive a code via email that you will need to enter to continue the registration process. Upon validation, you will be prompted to provide your SSN, first and last name, and date of birth.

Step 4: Establish account credentials

You will need to create a unique user name and password for future access to MyBenefits. You will also need to choose and answer three identity verifications questions, to be used in the event you forget your password. In addition to reading and agreeing to the website's Terms of Use, you will be asked to opt into electronic consent.

Step 5: Process complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the email address you provided during registration.

Continuation of Health Coverage

You must notify FAES within 30 days of the following qualifying event:

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

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. Once your termination of health insurance coverage is processed you will receive a continuation of coverage packet in mail from BRI, FAES's Continuation of Coverage administrator. You will have 60 days to elect continuation of coverage. Once continuation of coverage 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 continuation of coverage.

Each individual who is covered by the health plan immediately preceding the member's qualifying 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 Continuation Period expires.

Please contact a FAES insurance representative for additional information regarding continuation of coverage.

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

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.

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 2021 for coverage starting as early as January 1, 2022.

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.

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

- Eligible members regularly scheduled to work more than 30 hours each week.
- Dependent coverage - eligible dependents are spouses 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.

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