

2016 Benefits Guide

FAES@NIH
Foundation for Advanced
Education in the Sciences

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

Your guide to Benefits

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MEMBER RESOURCES

We make it easy to enroll in our health plan at no cost to you and your family.

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 October. 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, domestic partners, 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

1.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 Core Source 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>

Healthcare Reform

With all the buzz around health care reform, we understand this may create a number of questions and we are committed to keeping you informed about how health care reform may affect you and your family.

The Healthcare Reform's individual mandate will continue in 2016 with increased penalties as indicated below. All U.S. citizens are required to have medical insurance or will have to pay the tax penalty. It is important to know the medical plans offered to fellows by FAES meet this individual requirement and by enrolling in our plan(s), you will not be subject to any penalties. Should you decide not to enroll in our plan(s) or any other qualified plan, your penalty may be as follows:



IRS Penalty per Year

The penalty is the greater of the dollar amount or percentage of income as follows:

YEAR	ADULT	CHILD	FAMILY	OR	MAXIMUM PENALTY
2014	\$95 per adult	\$47.50 per child	\$285	OR	1% of family income
2015	\$325 per adult	\$162.50 per child	\$975	OR	2% of family income
2016	\$695 per adult	\$347.50 per child	\$2,085	OR	2.5% of family income

Example 1: For a family with 1 adult and a \$40,000 household income with 3 children, the penalty is \$812.50 in 2016.

Example 2: For a family with \$20,000 household income with 3 children and a spouse, the penalty is \$975.00 in 2016.

Also, individuals and families have the option to purchase medical coverage on their own through the State Health Insurance Marketplace. Should you choose to explore the State Health Insurance Marketplace, you will need to make the decision on your own regarding individual coverage that is not affiliated with FAES. As such, we will be unable to provide side-by-side comparison of the Marketplace and Company plans. It is also important to understand that the cost of coverage in the Marketplace depends on the benefit plan chosen and your income. It may be more or less expensive than the FAES plan.

The Marketplace Open Enrollment is November to February.

If you do not enroll during the above enrollment periods then you can't buy Marketplace health coverage for 2016 until the next Open Enrollment period for coverage the following year. The exception is if you experience a qualifying event then you have special enrollment rights.

During Open Enrollment, if you enroll:

- Between the 1st and 15th days of the month, your coverage starts the first day of the next month.
- Between the 16th and the last day of the month, your coverage starts the first day of the second following month. So if you enroll on January 16, your coverage starts on March 1

To get more details on the health insurance plans available in the Health Insurance Marketplace, please visit www.healthcare.gov.

IMPORTANT!

It may be more or less expensive to get health insurance coverage through the marketplace

What is Healthcare Reform?

The term “health care reform” refers to the Affordable Care Act (ACA), which was passed by the Federal Government into federal and state law in March 2010. These laws are intended to help more people get affordable health care coverage and receive better medical care.

Young adults up to age 26 can now stay on their parent’s health plan.

Adults who have been without health benefits for more than six months and were denied coverage because of a pre-existing condition may now get coverage.

Many preventive screenings and services, like annual physical exams and gynecological visits are now covered with no cost to you as long as you use a doctor in your network.

Here are some additional changes to your medical plan as a result of the Affordable Care Act:

- All health plans now include **unlimited lifetime benefits**.
- **Employer Mandate** – As of January 1, 2015, employer are required to provide all full-time equivalent employees with a health insurance plan or pay a fine.
- **Full-Time Equivalent (FTE)** – Full-time equivalent employees are employees that work at least 30 hours per week.
- **All medical expenses** (i.e., copays, deductible, and coinsurance) continue to be counted toward the annual out-of-pocket maximums.
- Health care reform requires most US citizens and legal immigrants to have a basic level of health coverage starting January 1, 2014 – this is called the **Individual Mandate**.
- **Flexible Spending Accounts** continue to be capped at \$2,500 for health care expenses and \$5,000 for dependent day care expenses.

For a complete list of covered preventive services visit:
www.healthcare.gov/coverage/preventive-care-benefits/

Preventive Services

A key provision of the Affordable Care Act (ACA) is the requirement that private insurance plans cover recommended preventive services without any patient cost-sharing.

- **Alcohol misuse screening and counseling**
Blood pressure screening
- **Cholesterol screening** for adults of certain ages or at higher risk
- **Colorectal cancer screening** adults over 50
Depression screening
- **Diabetes (Type 2) screening** for adults with high blood pressure
- **Diet counseling** for adults at higher risk for chronic disease
- **Obesity screening and counseling**
- **Sexually transmitted infection (STI) prevention** counseling for adults at higher risk
- **Tobacco Use screening** for all adults and cessation interventions for tobacco users
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.
- **Domestic and interpersonal violence screening** and counseling for all women
- **Well-woman visits** to obtain recommended preventive services
- **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary.

Medical Coverage



Services	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	None	\$200
Individual & Child(ren)	None	\$400
Individual & Adult	None	\$400
Family	None	\$400
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual	\$1,500	\$2,000
Individual & Child(ren)	\$3,000	\$4,000
Individual & Adult	\$3,000	\$4,000
Family	\$3,000	\$4,000
LIFETIME MAXIMUM BENEFIT	None	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	No charge	20% of Allowed Benefit
24 months-13 years (<i>immunization</i>)	No charge	20% of Allowed Benefit
24 months-13 years (<i>non-immunization</i>)	No charge	20% of Allowed Benefit
14-17 Years	No charge	20% of Allowed Benefit
Adult Physical Examination	No charge	20% of Allowed Benefit
Routine GYN Visits	No charge	20% of Allowed Benefit
Breast Cancer Screening/Mammograms	No charge	20% of Allowed Benefit
Cancer Screening (<i>Pap Test, Prostate and Colorectal</i>)	No charge	20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	\$10 per visit	Deductible, then 20% of Allowed Benefit
Diagnostic Services	<i>Office-</i> \$10 per visit <i>Facility-</i> No charge	<i>Office-</i> Deductible, 20% of Allowed Benefit <i>Facility-</i> Deductible then no charge
X-ray and Lab Tests	No charge	Deductible, then 20% of Allowed Benefit
Allergy Testing	No charge	Deductible, then 20% of Allowed Benefit
Allergy Injections	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Physical, Speech and Occupational Therapy (<i>limited to 30 visits/benefit period</i>)	\$10 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Chiropractic (<i>limited to 20 visits/benefit period</i>)	\$10 per visit	Deductible, then 20% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$10 per visit	Paid as in-network
Urgent Care Center	\$10 per visit	Paid as in-network
Hospital Emergency Room (<i>limited to emergency services</i>)	\$100 per visit (<i>copay waived if admitted</i>)	Paid as in-network
Ambulance (<i>if medically necessary</i>)	No charge	Paid as in-network
HOSPITALIZATION		
Inpatient Facility Services	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge	Deductible, then 20% of Allowed Benefit

Continued on next page...

Medical Coverage *(Continued)*



Services	In-Network	Out-of-Network
HOSPITAL ALTERNATIVES		
Home Health Care	No charge	Deductible, then 20% of Allowed Benefit
Hospice (Maximum 180 day Hospice eligibility period)	No charge	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days per benefit period)	No charge	Deductible, then 20% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	No charge	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge	No charge, subject to deductible
Initial Office Consultation(s) for Infertility Services/Procedures	\$10 per visit	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination (limited to 6 attempts per live birth)	50% of Allowed Benefit	Deductible, then 60% of Allowed Benefit
In Vitro Fertilization Procedures (limited to 3 attempts per live birth up to \$100,000 lifetime maximum)	50% of Allowed Benefit	Deductible, then 60% of Allowed Benefit
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	No charge	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge	Deductible, then 20% of Allowed Benefit
Office Visits	\$10 per visit	Deductible, then 20% of Allowed Benefit
Partial Hospitalization Facility Services	No charge	Deductible, then 20% of Allowed Benefit
Partial Hospitalization Physician Services	No charge	Deductible, then 20% of Allowed Benefit
Medication Management Visit	\$10 per visit	Deductible, then 20% of Allowed Benefit
MISCELLANEOUS		
Durable Medical Equipment	25% of Allowed Benefit	Paid as In-Network
Acupuncture	\$10 per visit, unlimited use for non-rehabilitative purposes	Not covered, only when Plan-approved for anesthesia
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

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 Human Resources Department.

Benefits administered by: **CORESOURCE**
A Trustmark Company

Find a Doctor or 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/docfind/

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DocFind® Home
Search Tips & FAQs
Tools & Resources

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

Aetna Signature Administrators's Custom DocFind

Welcome to Aetna Signature AdministratorsSM & Aetna Dental[®] Administrators Participating Provider Directory.

This site has been specially designed for participants in Aetna Signature Administrators and Aetna Dental Administrators Networks. You can use this site to easily locate participating network providers. If you are interested in a particular Aetna Signature Administrators and/or an Aetna Dental Administrators provider, you can view detailed information (i.e. hospital affiliation, medical school, dental school, languages spoken) about that provider by clicking on the Details button.

This site is specific to Aetna Signature Administrators and Aetna Dental Administrators; however, links from this site may direct you to the Aetna public site which would include information regarding other Aetna plans. Please note that if you no longer see the Aetna Signature Administrators & Aetna Dental Administrators DocFind wording in the blue bar near the top of the page, you have entered Aetna's public site.

Your ID Card provided by your benefits administrator will have an Aetna Signature Administrators Logo and/or Aetna Dental Administrators logo if you have access to these networks.

To begin a provider search, click on the Enter DocFind button below, and follow the screen prompts.

START A NEW SEARCH ➔

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

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 **Plan**, 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.

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**.

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

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

Urgent Care Center vs Emergency Department:

HOW TO MAKE THE RIGHT CHOICE.

WHEN SHOULD I USE AN URGENT CARE CENTER?

Urgent Care Centers offer patients easy access to care for minor, non-emergency medical needs. Some of the benefits of an Urgent Care Center include:

- No appointment required
- Economical
- Short wait times
- Open evenings, weekends, and most holidays
- Local and convenient
- Access to labs and X-rays

Conditions Cared for in an URGENT CARE CENTER

RESPIRATORY INFECTIONS

- Sinus pain
- Sore throat
- Cough/mild asthma
- Pink eye
- Earache

MINOR INJURIES

- Cuts needing skin glue or stitches
- Accidents, falls
- Sports injuries
- Broken bones
- Neck, back, and joint pain

OTHER CONDITIONS

- Bladder infections
- Sexually transmitted diseases
- Rashes
- Mild vomiting and diarrhea
- Sports, school and camp physicals

NOTE: If greater care is needed, our staff will direct patients to the proper health care provider. In a true emergency, we will transfer patients directly to an emergency department.

WHAT IS CONSIDERED AN EMERGENCY?

Patients may have many different types of emergencies. Most emergencies require at least one of the following:

- Immediate blood work
- Ultrasounds
- CAT Scans
- Placement of IV (intravenous) line

Conditions Cared for in an EMERGENCY DEPARTMENT

PAIN

- Severe/sudden onset headache
- Severe belly pain
- Difficulty walking

Signs of a Heart Attack:

- Severe chest pain
- Difficulty breathing
- Loss of consciousness

INJURIES

- Serious head, neck or back injury
- Severe fracture
- Deep or large wound
- Large burn
- Poisoning

OTHER CONDITIONS

- Pregnancy-related problem
- Heavy, uncontrollable bleeding
- Fever in infants
- Convulsions or seizure

Signs of a Stroke:

- Loss of vision
- Numbness/weakness
- Slurred speech/confusion

Pharmacy Benefits



Plan Feature	Amount	Description
Deductible	None	Your benefit does not have a deductible.
Annual Out-of-Pocket Maximum	Individual: \$1,500 Individual & Child(ren): \$3,000 Individual & Adult: \$3,000 Family: \$3,000	
Preferred Preventive Drugs (up to a 34-day supply)	\$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 (up to a 34-day supply)	\$5	All generic drugs are covered at this copay level.
(Tier 2) Preferred Brand Name Drugs (up to a 34-day supply)	\$10	All preferred brand name drugs are covered at this copay level.
(Tier 3) Non-Preferred Brand Name Drugs (up to a 34-day supply)	\$25	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: \$10 preferred: \$20 non-preferred: \$50 specialty drugs: \$25	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.

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 Human Resources Department.

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 nonpreferred brands.	Many Tier 3 drugs have lower-cost options in Tier 1 or 2. Ask your doctor if they could work for you.

CVS/caremark

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Welcome to CVS Caremark

Already a Member?

Username

Forgot Username?

Password

Forgot Password?

Sign In

Register Now

Want to Register?

• Order and manage prescriptions

• Check on drug coverage benefits

• Manage cost and save money

Register Now

Need to Order Mail Service Refills?

• Quick

• Easy

• Secure

Refill Now



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

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

CVS Caremark Specialty Pharmacy

Personalized Pharmacy 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.



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

**You can also find information about
your condition and medication at
www.cvscaremarkspecialtyrx.com**

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



Pharmacy – *mobile site and apps*



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



VSP Choice Exam Plus Plan®

The VSP Choice Exam Plus Plan includes 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	VSP Choice Preferred Providers <ul style="list-style-type: none"> • 46,000 access points nationwide. VSP preferred providers are located in retail, neighborhood, medical and professional settings. Other Providers <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.
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Benefits through a VSP Choice Preferred Provider

Plan Feature	Description
Exam Services	Comprehensive WellVision Exam ^a
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>

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

²Less any applicable copay.

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

⁴Rebates subject to change.

⁵Custom 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.

This brochure is intended to convey general information only and does not provide specific claims or coverage advice. This is not a guarantee or full description of coverage under the plan. Plan participants should contact the plan's claims department for detailed information regarding benefits provided under the plan and the level at which they will or will not be paid.



Get the best in eye care and eyewear with FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES (FAES) and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** To find a VSP provider, visit vsp.com or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Protect
your vision
with VSP.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more¹. Visit vsp.com to find a VSP provider who carries these brands.

Vision

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.

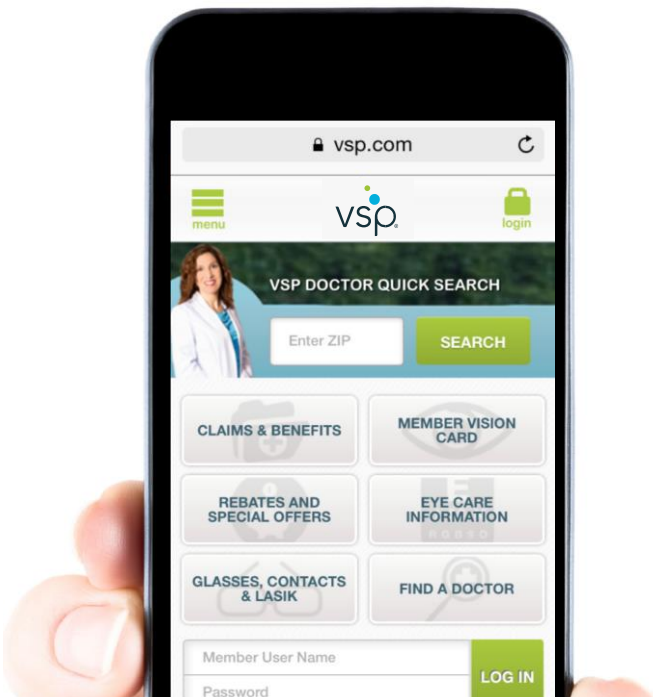
Contact VSP Member Services at **800.877.7195** for more information or to order the tools you need.

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



VSP.com
at your
Fingertips



- 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.

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

- Gain 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 EOBs

- View information on medical claims and payments made by CoreSource with secure electronic Explanations of Benefits (EOBs).
- 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.
- That your Message Center questions have a reply.



CoreSource solutions

Continuation of Health Coverage COBRA



COBRA

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 Automatic Data Processing (ADP). You will have 60 days to elect COBRA. Once COBRA is elected your coverage is retroactive to the date you lose 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.*

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*

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

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 "usual, customary, and reasonable (UCR)" charge, 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., \$10 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.

Health maintenance organization (HMO) — a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

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 because they have negotiated a discount for their 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 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 provides 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.

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**☐ Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ 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 ☐ NoIf 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:
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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

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
2 - (OH) Outpatient Hospital
3 - (O) Doctor's Office

4 - (H) Patient's Home
5 - Day Care Facility (Psy)
6 - Night Care Facility (PSY)

7 - (NH) Nursing Home
8 - (SNF) Skilled Nursing Facility
9 - Ambulance

O - (OL) Other Location
A - (IL) Independent Laboratory
B - Other Medical Surgical Facility

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

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

Pharmacist's Signature: _____

Comment Section

STEP 3**Mailing Instructions:**

CVS
CAREMARK

RXBIN: 610029

RXPCN: CRK

RXGRP: XXXXX

ISSUER: (80840)

ID

Name

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.



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 the 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.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help you pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined for eligible for premium assistance.

To view a list of states that offer added premium assistance or for more information on special enrollment rights, you can contact either:

US Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-ERSA (3272)

US Department of Health and Human Services

Centers for Medicare and Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Ext. 61565

Coordination of Benefits with other coverage

IF YOU	SITUATION	PAYS FIRST	PAYS SECOND
<i>Are covered by Medicare and Medicaid</i>	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage (such as employer group health plans) have paid
<i>Are 65 or older and covered by a group health plan because you or your spouse is still working</i>	<i>Entitled to Medicare</i>		
	The employer has 20 or more employees	Group Health Plan	Medicare
	The employer has less than 20 employees	Medicare	Group Health Plan
<i>Have an employer group health plan after you retire and are 65 or older</i>	Entitled to Medicare	Medicare	Retiree Coverage
<i>Are disabled and covered by a large group health plan from your work, or from a family member who is working</i>	<i>Entitled to Medicare</i>		
	The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees	Medicare	Large group health plan
<i>Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)</i>	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
<i>Have ESRD and COBRA coverage</i>	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA



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