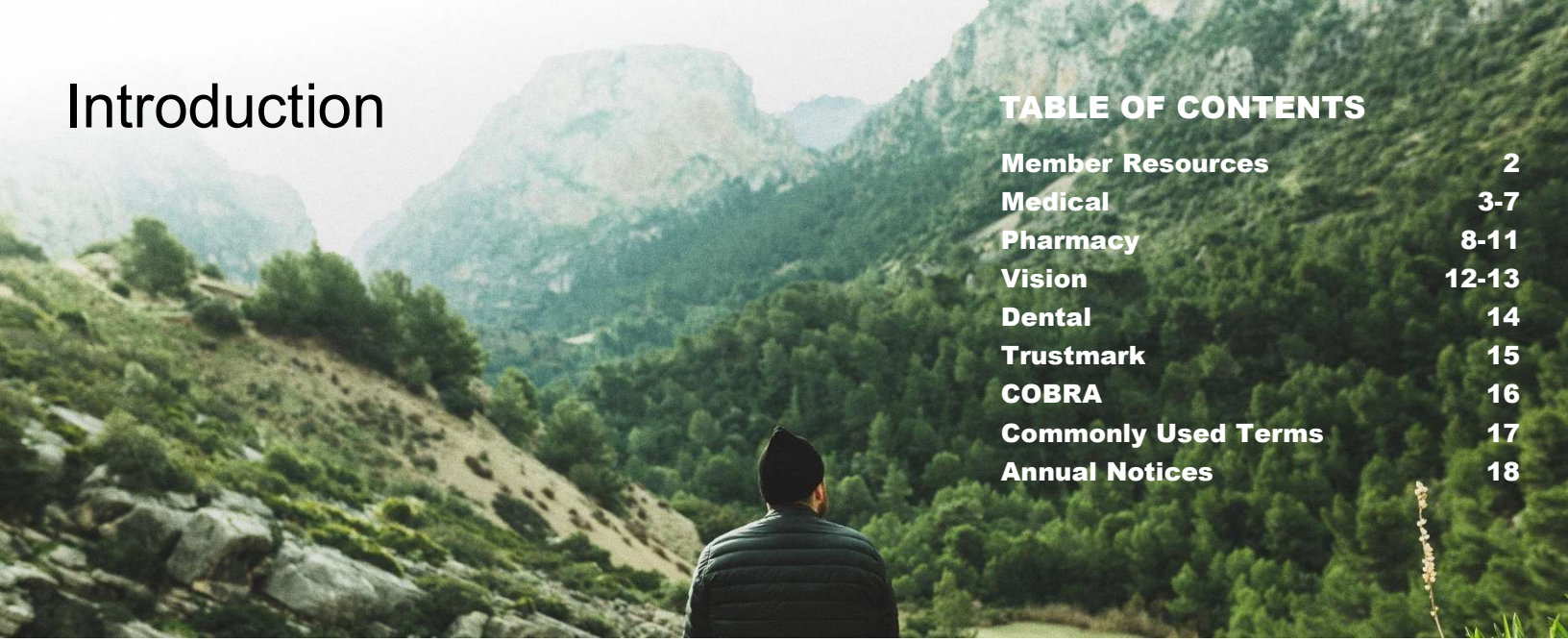
FAES Serving the NIH 1959-2019

2019/2020 Benefits Guide

November 1, 2019 – October 31, 2020

Medical

Introduction



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MEMBER RESOURCES

We make it easy to enroll in our health plan.

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

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

Your one-stop shop for insurance forms and information

FAES Claims Secure Fax Line 877-247-0022
This line is to be used when members are asked for additional documentation for pending or denied claims – ***it goes right to the Trustmark claims department.***

Insurance Team Website:
https://faes.org/content/health-insurance-services
https://faes.org/content/member-resources
https://faes.org/content/frequently-asked-questions

Medical Coverage

Services	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	$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/injury/benefit period)	$15 copay	Deductible, then 30% of Allowed Benefit
Outpatient Chiropractic (limited to 20 visits/benefit period)	$15 copay	Deductible, then 30% of Allowed Benefit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center	$25 per visit	Paid as in-network benefits
Hospital Emergency Room (limited to emergency services)	$125 per visit (copay waived if admitted)	Paid as in-network benefits
Ambulance (if medically necessary)	$125 Copay per event	Paid as in-network benefits
HOSPITALIZATION		
Inpatient Facility Services	Deductible, then 5%	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 5%	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 5%	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 5%	Deductible, then 30% of Allowed Benefit

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

Medical Coverage *continued*

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

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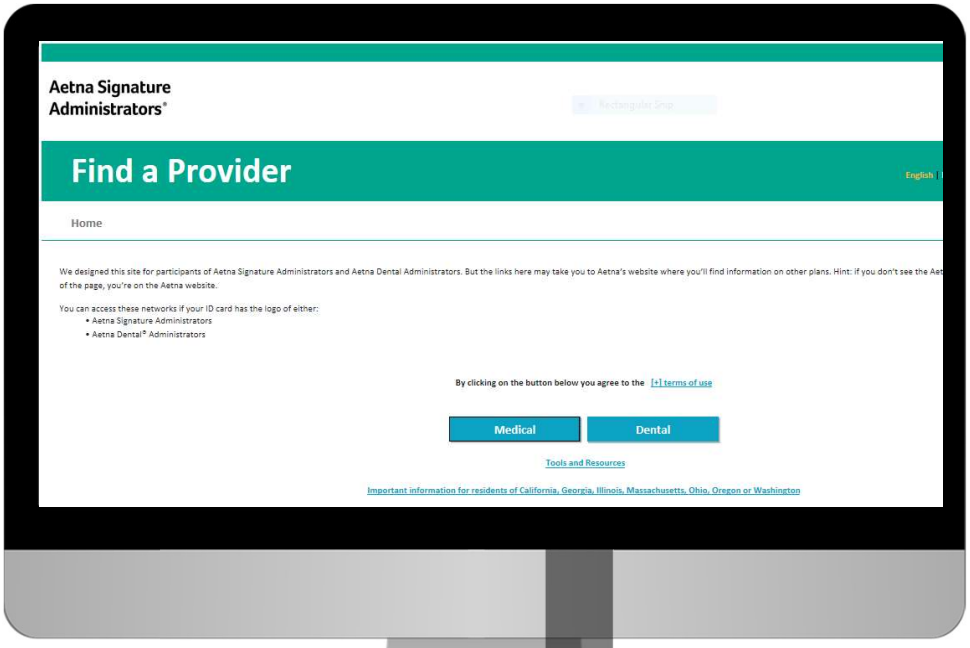
Find a Provider or a Behavioral Health Practitioner

Aetna Signature Administrators® PPO By aetna℠

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



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

www.aetna.com/ASA

HOW TO NARROW YOUR SEARCH

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

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

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

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

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

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

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

Filing a Claim

Notice of Claim

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

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

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

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

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

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

Pre-Service Claim Procedure

Health Care Management

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

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

Filing A Pre-certification Claim

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

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

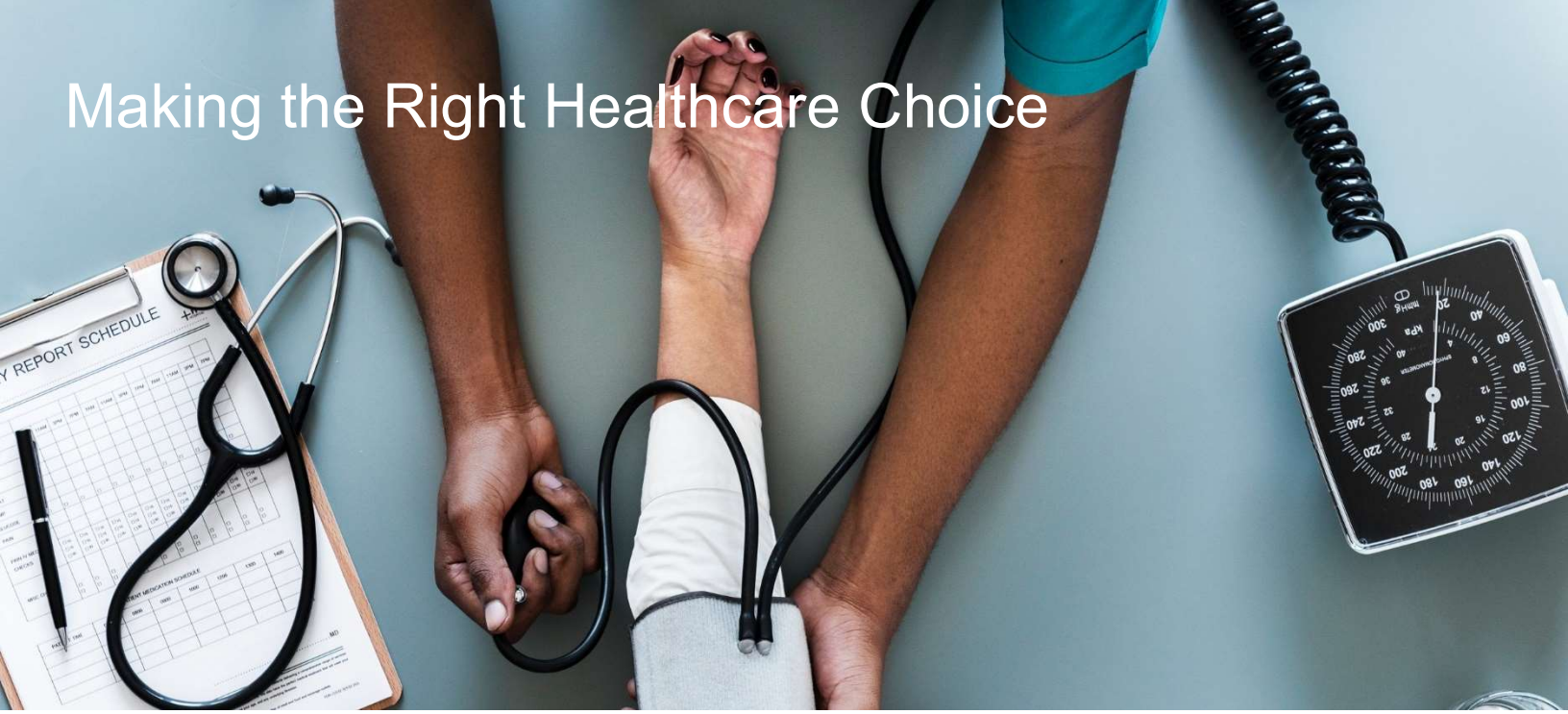
Review Of A Denied Claim

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

Stop Health Care Fraud: If you suspect fraud.

Call our Fraud Hotline 877-45-FRAUD

Making the Right Healthcare Choice



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

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

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

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

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

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

Pharmacy Benefits **Effective 1/1/2020**

EXPRESS SCRIPTS®

Plan Feature	Amount	Description
Deductible	None	Your benefit does not have a deductible.
Annual Out-of-Pocket Maximum	Included in medical out of pocket maximum	
Preferred Preventive Drugs *(up to a 34-day supply)*	$0	A Preferred Preventive Drug *(not subject to any copay and deductible)* is a medication or item on Express Scripts' 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)*	$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 Infertility Rx – Not covered	All non-preferred brand name drugs are covered at this copay level. These drugs are not on the preferred drug list. Check the online preferred drug list to see if there is an alternative drug available. Discuss using alternatives with your physician or pharmacist.
Maintenance Copays *(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 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 800-922-1557 to begin the prior authorization process.

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Pharmacy

Go to **Express-Scripts.com** for complete and up-to-date drug information

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

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

Getting Started with Home Delivery from the Express Scripts Pharmacy

Whether you are viewing the member website or using the Express Scripts™ mobile app1, 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 us and we’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 our app to view details and track shipping.
- ***Transfer retail prescriptions to home delivery.*** Just click *Add to Cart* for eligible prescriptions and check out. We’ll contact your provider on your behalf and take care of the rest. Check ***Order Status*** to track your order.
- ***Refill and Renew Prescriptions f***or yourself and your family while online or while using our app. Just click Add to Cart for eligible prescriptions and check out. We’ll contact your provider on your behalf, if renewals are included, and take care of the rest.

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

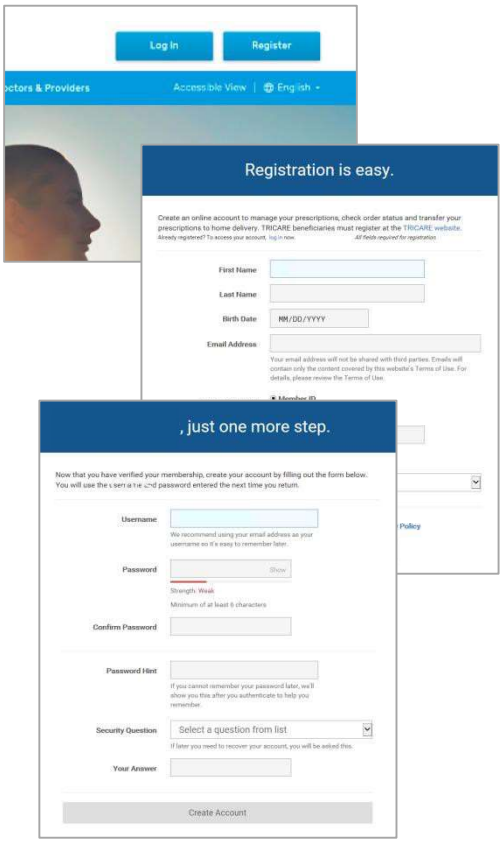
Register now so you can experience:

More savings.
Compare prices of medicines at multiple pharmacies. Get free standard shipping[1] from the Express Scripts Pharmacy℠.

More convenience.
Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.

More confidence.
Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.

More flexibility.
Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

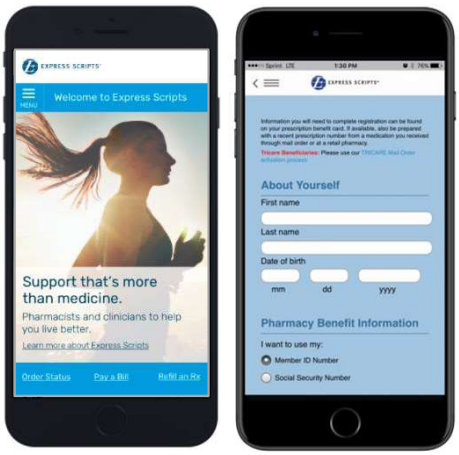


Get Started Today!

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 preferences2, 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.



1Standard shipping costs are included as part of your prescription plan benefit.
2Preferences 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®, Android™, Windows Phone®, Amazon™, and Blackberry® mobile devices.

Your Journey with Accredo

EXPRESS SCRIPTS®

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.

accredo®

One journey.

Three ways we focus on supporting you.

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, 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 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 & 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 patients3

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

Vision (included in your plan)

VSP CHOICE EXAM PLUS PLAN®

The VSP Choice Exam Plus Plan includes a full eye exam for $10 and discounts on eyewear through a VSP Choice Preferred Provider[1], or a set exam allowance through any other provider

Provider Choices	**VSP Choice Preferred Providers** • 46,000 access points nationwide. VSP preferred providers are located in retail, neighborhood, medical and professional settings. **Other Providers** • We also have a direct pay or assignment of benefits arrangement with Walmart Vision Center and Sam's Club Optical Center. • Members have the freedom to choose any provider, national retailer, or local retail chain.
Benefits through a VSP Choice Preferred Provider	
Plan Feature	Description
Exam Services	Comprehensive WellVision Exam
Exam Copay	$10
Discounts on Glasses	• 20% off complete pairs of prescription glasses 20% off all lens options 20% off unlimited non-prescription sunglasses[3]
Contact Lenses	• 15% off contact lens exam, excluding materials • Exclusive offers for VSP members include: Mail-in rebate savings[4] up to $110 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses[4]
VSP Laser VisionCare℠ 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®	• 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	**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. **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.

[1] Plan available through various provider networks including the VSP Network, Choice Network, and Advantage Network.
[2] Less any applicable copay.
[3] Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.
[4] Rebates subject to change.
[5] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVision Care discounts are only available from VSP-contracted facilities.

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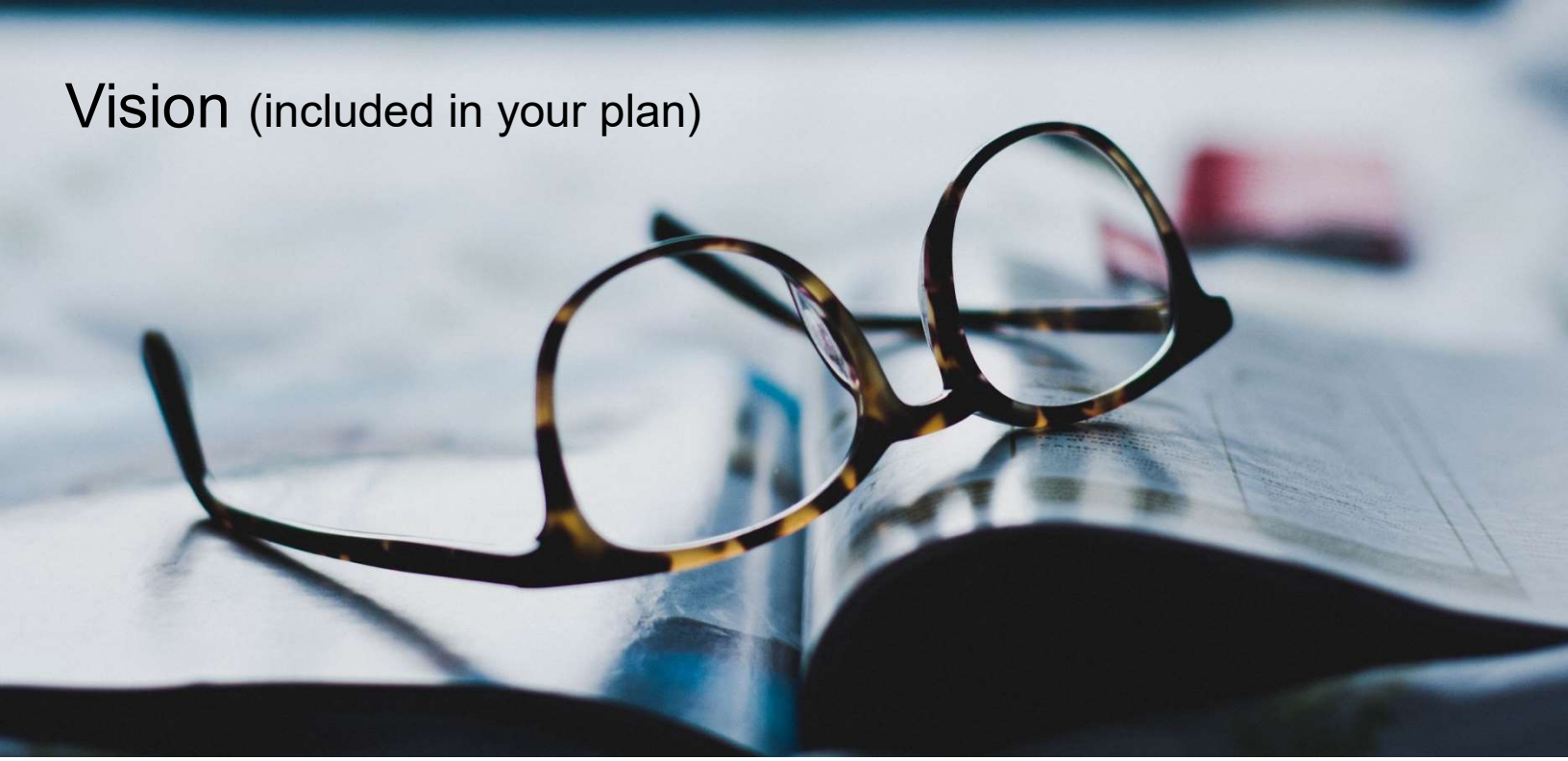
Vision (included in your plan)



VSP.com at your Fingertips

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

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

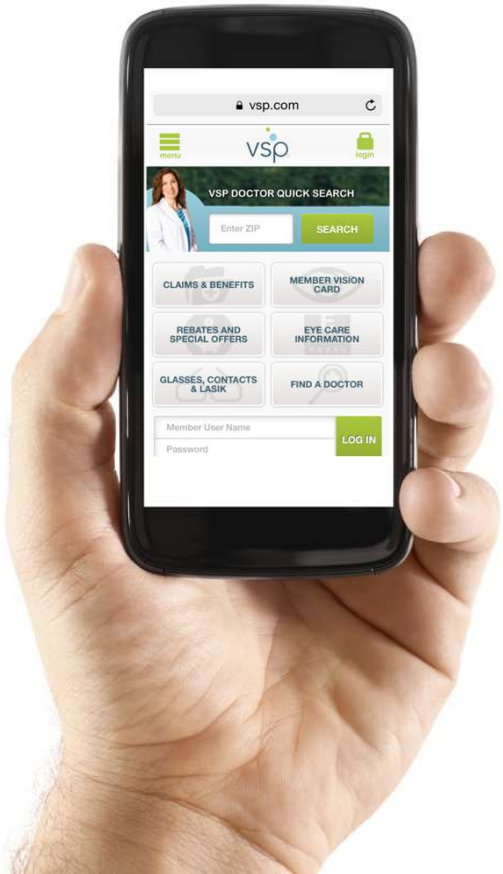
Contact VSP Member Services at **800.877.7195** for more information or to order the tools you need.

An ID Card, or Member Vision Card, isn't required for members to receive services or care.
Members simply call a VSP provider to schedule an appointment, and tell them that they're a VSP Member. The provider and VSP handle the rest. If a member wishes to have an ID Card, they can register an log on to VSP.com to print one.

VSP Member Services 800.877.7195

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

VSP® Vision care for life



Dental (optional)

METLIFE TAKEALONG DENTAL

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

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

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.

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

MEMBER COST

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

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Connect with customer service when you have questions, including the ability to immediately send a question about a claim while viewing its details.

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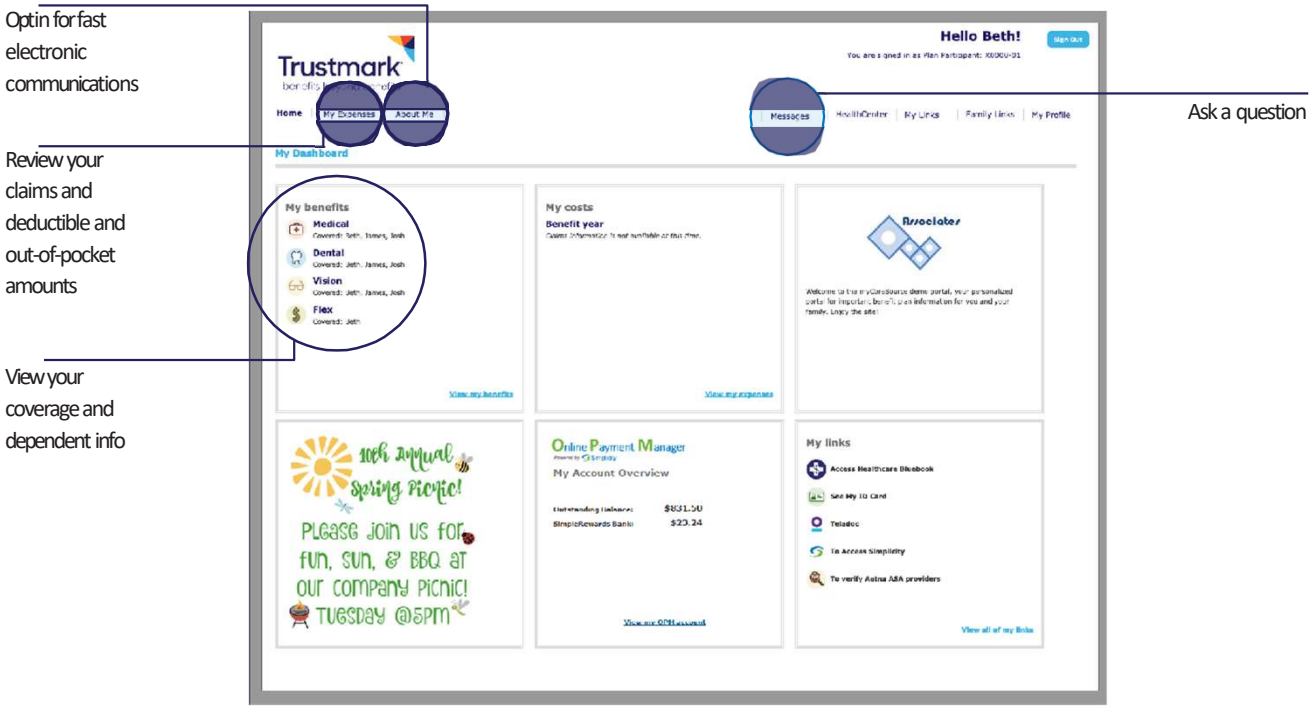
Click the My Benefits tile to review the details of your plan, including your coverage, your member ID, and your dependents and their information.



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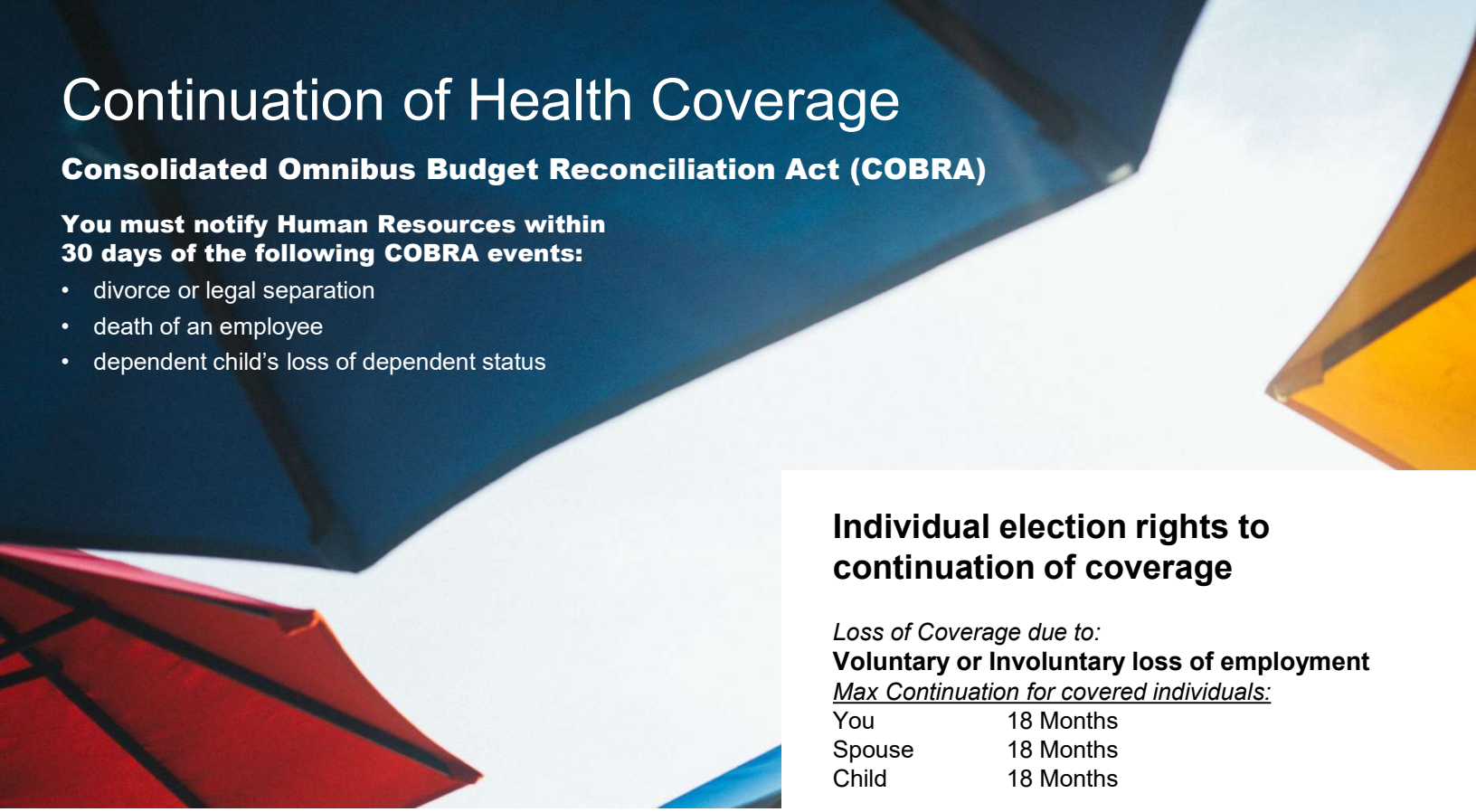

Continuation of Health Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

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

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 Trustmark. You will have 60 days to elect COBRA. Once COBRA is elected your coverage is retroactive to the date you lost coverage. There will be no lapse in coverage. Please contact a FAES insurance representative for additional information on pricing regarding COBRA coverage.

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

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

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

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.

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

Medicare Part D Notice

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

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

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

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

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

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

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

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

New Health Insurance Marketplace Coverage Options

PART A: General Information

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

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

Part B: Information about Health Coverage Offered by Your Employer

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

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/domestic partners and children (biological, adopted and step-children)
- Coverage meets minimum value standards, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

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