FAES
FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

2026-27 Benefit Comparison Grid

The FAES insurance plan offers a comprehensive insurance plan to meet your medical, prescription and dental needs in one convenient bundled insurance plan. This Benefit Comparison Grid is designed to help you easily compare the key features of the benefit options available to you. This tool empowers you to make informed choices about which benefits best fit your needs and ensures you have a transparent view of what's offered.

Benefit Coverage	FAES Member Benefit Plan	Option 1	Option 2	Option 3
Medical				
Member Out of Pocket Costs				
Medical Deductible In-network (Individual / Family)	**$125 / $250**			
Medical Deductible Out-of-network (Individual / Family)	**$400 / $800**			
Prescription Deductible In-network (Individual / Family)	**$100 / $200**			
Annual Out-of-Pocket Maximum In-network (Individual / Family)	**$2,500 / $5,000**			
Annual Out-of-Pocket Maximum Out-of-Network (Individual / Family)	**$5,000 / $10,000**			
Coinsurance for In-Network Claims	**10%**			
Coinsurance for Out-of-Network Claims	**30%**			
Are out-of-network claims covered?	**Yes, subject to different deductible and coinsurance levels**			
Mental Health Inpatient facility/physician services In-Network	**Deductible, then 10%**			
Mental Health Outpatient facility/physician services In-Network	**Deductible, then 10%**			
Does Behavioral Health include autism spectrum disorders?	**Yes, including an applied behavioral analysis (ABA).**			

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Medical (Continued)				
Copayments for Key Services – In-Network				
Annual wellness visit	**No Charge**			
Primary Care Office Visit	**$15 copay**			
Specialist Office Visit	**$25 copay**			
Mental Health Office Visits In-Network and Out-of-Network	**$15 copay**			
In-patient Hospital/Surgery	**Deductible, then 10%**			
Outpatient Hospital/Surgery	**Deductible, then 10%**			
Urgent Care	**$25 per visit**			
Emergency Care	**$125 per visit**			
Referrals required?	**No**			
Prescription Drugs				
Generic	**$10**			
Preferred Brand	**$15**			
Non-Preferred Brand	**45% coinsurance**			
Specialty	**10% coinsurance to a maximum of $150**			
Vision (Included with Medical Plan)				
Vision Exam	**Covered at 100%; every 12 months**			
Dental (Included with Medical Plan)				
Annual Deductible				
Individual	**$50**			
Family	**$150**			
Coverage Coinsurance				
Preventive Services (Type A)	**Plan pays 100%**			
Basic Services (Type B)	**Plan pays 80%**			
Major Restorative Services (Type C)	**Plan pays 50%**			
Orthodontia (Type D)	**Plan pays 50% (Child Only, to age 26)**			
Maximum Benefit				
Annual Plan Year Maximum: Type A, B, and C	**$2,500**			
Orthodontia Lifetime Maximum	**$2,000 (Child Only, to age 26)**			