FAES

FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

Member Benefits Guide

November 1, 2025 – October 31, 2026

Contents

Welcome to Your Benefits

This guide contains important information to help you make informed decisions during this open enrollment period and throughout the plan year. We encourage all members to carefully review the material contained in this guide.

FAES strives to provide a comprehensive and competitive benefit package. Please take the time to review this guide in its entirety to fully understand the array of benefits available to you and your dependents. We are dedicated to the personal, professional and financial health of our members and will continue to provide meaningful benefits at affordable rates.

This guide describing the benefit plans is only a summary of the provisions of the plan. While every effort has been made to ensure that this booklet accurately reflects the provisions of the plans, only the official plan documents govern the operation of the plans and payment of benefits. We hope you have a happy, healthy plan year!

— FAES Insurance

Who Can I Contact for Insurance Forms and Information?

FAES Insurance Contact Information:
Main Number: 301-496-8063
Email: FAESinsurance@mail.nih.gov
Hours of Operation: M-F 9:00 am – 4:00 pm
Or Scan the QR Code
FAES Insurance Website: https://w.faes.org/health-insurance

Eligibility

Plan Participant Eligibility

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

New Hire Eligibility

Your coverage is effective on your date of hire.

When Coverage Ends

If your employment ends, your medical, dental and vision coverage will end on the date of your separation. Depending upon the circumstances of your termination, you may be eligible to continue coverage under Continuation of Coverage.

Dependent Eligibility

Eligible dependents include:

- Your spouse (unless you are legally separated).
- Your dependent children up to age 26 including children, stepchildren, and legally adopted children.
- A child who has a disability may be eligible for coverage past the age of 26 with proof of disability.

Newly Eligible Participants

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

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

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

Please note: 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. Carrier plan documents supersede any information in this benefit guide. If you have any questions about a specific service or treatment, please contact FAES Insurance.

Enrollment

What Steps Should I Take to Enroll?

1. It's time to enroll.
You have 30 days from the date you're hired to enroll in our health insurance plan. Coverage will begin on your award start date. If you do not enroll within 30 days of your start date, you may do so during the open enrollment period, which is usually held during September. Coverage for those who enroll during the Open Enrollment period will begin on November 1st of that same year.

2. Determine which (if any) family members you want to include in your plan.
Spouses, dependent children (through their 26th birthday), and disabled dependent children over the age of 26 are all eligible to be included in your plan.

3. Provide FAES with NIH Fellowship Activation Forms.
These can be obtained from your Administrative Office (AO). Your sponsor must sign the form. FAES requires pages 1, 2 and 3 of the 6 pages of the NIH Fellowship Activation Form.

4. Complete the FAES Election Form.
The form can be downloaded here.

5. Email the completed NIH Fellowship Activation Form and completed FAES Election Form to FAES Insurance
Email: FAESinsurance@mail.nih.gov

6. Enjoy your coverage!
If you have any questions or need help completing these steps, please contact us.

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

Enrollment *(continued)*

Changing Your Elections

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

Qualifying Life Events include:

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

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

What if I am Having a Baby?

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

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

If you experience any of the above qualifying events, you have **30 days** to notify FAES Insurance Department. Otherwise, elections you make will remain in effect for the entire plan year.

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

New for 2025-2026

Effective 11/1/25, the following changes will apply to the benefits:

Medical

- Out-of-pocket maximum for in-network services is set to $2,000 for an individual and $4,000 for a family.
- Out-of-pocket maximum for out-of-network services is set to $4,500 for an individual and $9,000 for a family.
- In-network coinsurance is set to 10% when coinsurance is applicable.
- Added eye exam to medical plan covered at 100% for both in-network or out-of-network providers.
- Coinsurance of 10% will apply to delivery and facility services after the deductible is met.

Pharmacy

- Added prescription deductible of $100 for an individual and $200 for a family that applies to Tier 1, 2, 3 and Specialty (not preferred preventive drugs).
- Expanded prescriptions that require prior authorization. If you are currently taking a medication that will require prior authorization, you will receive notice from RxBenefits with instructions for submitting prior authorization prior to 11/1/25. For more information, please contact RxBenefits and/or see page 18.

Dental

- New MetLife group/policy number is 200017. Instructions for how to set up your MetLife account are found on page 27. If you already have a MetLife account, instructions for how to link the new policy number to your account are on page 28.

Vision

- Removed vision plan through MetLife.
- Added eye exam to medical plan covered at 100% for both in-network or out-of-network providers.

Pregnancy and Postpartum

- Added Pregnancy and Postpartum program through Progyny available to Fellows and their covered dependents at no cost. Progyny provides one-on-one, personalized support and education. To learn more visit page 24 or watch the short Progyny Pregnancy and Postpartum Overview video.

Medical Benefits

luminare health℠
Experience. Solutions. Results.

aetna™

FAES offers one medical PPO plan utilizing the Aetna Signature Administrators provider network. Luminare Health is the administrator that processes the claims for the FAES plan. Pharmacy benefits are through Express Scripts.

Services	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	$125	$400
Family	$250	$800
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual	$2,000	$4,500
Family	$4,000	$9,000
LIFETIME MAXIMUM BENEFIT	None	None
MEMBER COINSURANCE	10%	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
Eye Exam (limited to one per plan year)	No charge	No charge
Diagnostic Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
X-ray and Lab Tests (Outpatient Only)	Deductible, then 10%	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 50 visits maximum benefit per plan year combined)	$15 copay	Deductible, then 30% of Allowed Benefit
Outpatient Chiropractic (limited to 20 visits per plan year)	$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 10%	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit

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

Medical Benefits *(continued)*

Services	In-Network	Out-of-Network
HOSPITAL ALTERNATIVES		
Home Health Care	No charge	Deductible, then 30% of Allowed Benefit
Hospice (Maximum 180 days per lifetime)	No charge	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days per plan year)	No charge	Deductible, then 30% of Allowed Benefit
MATERNITY		
Prenatal and Postnatal Office Visits	No charge	Deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
NICU (follows in-patient hospital stay)	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
Initial Office Consultation(s) & Testing for Infertility Services/Procedures	$25 copay	Not covered
Breast Pump Benefit (once per lifetime)	Member can purchase any breast pump (including online) and submit receipt for reimbursement	
MENTAL HEALTH AND SUBSTANCE ABUSE *See page 10 for additional details on Mental Health coverage*		
Inpatient Facility Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10%	Deductible, then 30% of Allowed Benefit
Outpatient Facility Services	Deductible, then 10%	Deductible, then 10% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10%	Deductible, then 10% of Allowed Benefit
Office Visits	$15 copay	
Medication Management/Methadone Maintenance	$15 copay	
MISCELLANEOUS		
Durable Medical Equipment	25% of Allowed Benefit	Paid as in-network benefits
Acupuncture	$15 copay	Not covered
Transplants	Member is responsible for obtaining authorization for services in-network and out-of-network	
Hearing Aids (limited to $5,000 per hearing impaired ear every 3 years)	No charge	Paid as in-network benefits

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.

luminare health℠
Experience. Solutions. Results.

aetna™

Medical Benefits *(continued)*

In-Network vs. Out-of-Network

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

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

Example of Surgery Costs	In-Network Provider	Out-of-Network Provider
Knee Surgery	$5,380	$10,954
Member Deductible Responsibility (Individual Level)	$125	$400
Remaining Event Exposure	$5,255	$10,554
Member Coinsurance Responsibility (percentage of the remaining expense after Deductible, capped by the Out-of-Pocket Maximum)	$5,255 x 10% coinsurance = $525.50	$10,544 x 30% coinsurance = $3,166.20
Total Member Responsibility	**$650.50**	**$3,566.20** + amount balance billed
Important Note	The plan covers ALL remaining expenses after the member responsibility for this specific surgery. The total member responsibility amount counts towards the annual out-of-pocket maximum.	The provider can balance bill the member for the $5,574 above the allowed benefit amount. The balance bill amount does not count towards the out-of-pocket maximum.

luminare health℠
Experience. Solutions. Results.

aetna™

Medical Benefits *(continued)*

Out-of-Network Mental Health Benefits

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

What does this mean for me?

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

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

If you have a mental health office visit with an out-of-network provider, you will need to submit the claim to Luminare for reimbursement by following these simple steps:

1. Fill out a Luminare Health Claim Form. Pay special attention to the portion pertaining to the authorization of who should be paid to ensure you are only signing one of the options – either to pay the provider or to pay the member.
2. Include either an itemized statement or complete page 2 of the Health Claim Form.
3. Attach proof of your payment.
4. Submit your claim for reimbursement to one of the following:

   Email:

   a. hbevclaimsubmission@luminarehealth.com
   b. In the subject line, write "FAES OON Claim Submission"

   Portal - Option 1:

   a. Sign into your www.myluminarehealth.com account
   b. Click on the link for "Messages"
   c. Select "General Inquiry"
   d. In the Subject line type "OON Claim Submission"
   e. Attach claim/itemized statement/proof of payment

   Portal - Option 2:

   a. Sign into your www.myluminarehealth.com account
   b. From the My Expenses tab, select Claim Submissions
   c. Click the "Submit a Claim" button
   d. Mandatory fields are identified with a star – complete all mandatory fields
   e. If you answer "Yes" to Accident Details and/or Other Coverage Information, additional mandatory fields will display
   f. Click the "Save" button to save your changes

   Mail to:

   Luminare Health Benefits
   PO Box 2920
   Clinton, IA 52733-2920

5. If you have any questions during this process, please contact Luminare's customer service number, 1-888-270-2044, which can be found on your ID card.

You will have one year from the date of service to submit to Luminare for processing. If Luminare does not receive the claim within 365 days from the date of service, the claim will be denied as it will be considered outside of the claims filing deadline.

Please contact FAES Insurance if you go to an out-of-network mental health provider and have questions about how to submit for reimbursement.

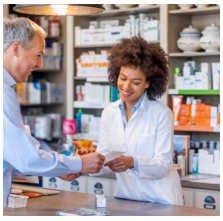
Medical Benefits *(continued)*

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) - $15 copay

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide medical guidance via telehealth (i.e., phone, video) or can schedule an appointment for an in-person visit with you right away.



Convenience Care Centers (Retail Health Clinics) - $15 copay

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. Extended hours from Dr. office.

Urgent Care Centers - $25 copay

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. Open nights and weekends.

Emergency Room (ER) - $125 copay

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.

Medical Benefits *(continued)*

How to Find a Provider

Aetna Signature Administrators® PPO By aetna®

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

www.aetna.com/ASA

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

How To Narrow Your Search

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

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

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

Medical Benefits *(continued)*

Filing a Claim

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

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

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

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

Stop Health Care Fraud: If you suspect fraud, call Luminare's Fraud Hotline 888-270-2044.

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

luminare health℠
Experience. Solutions. Results.

Medical Benefits *(continued)*

Pre-Authorization

How Do I Get Pre-Authorization?
Health care management is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care. Consult with your provider to verify if pre-authorization is needed.

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

For non-urgent care, the ***covered person*** (or their authorized representative) must call the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services. If the ***Health Care Management Organization*** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For ***urgent care,*** the ***covered person*** (or their authorized representative) must call the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the ***covered person*** needs medical care that would be considered as ***urgent care,*** then there is no requirement that the ***Plan*** be contacted for approval prior to the care.

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

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

Covered persons needing pre-authorization shall contact the
Luminare Health Care Management Organization by calling:
1-888-270-2044

luminare health℠
Experience. Solutions. Results.

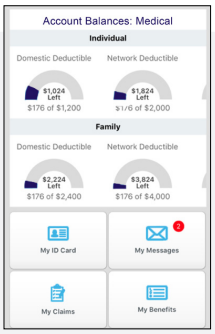
Medical Benefits *(continued)*

Luminare Mobile App

More Connected from Anywhere

You still need to connect with your health benefits while you're on the go. Our mobile app lets you stay in control from anywhere.

- See the status of your deductible and out-of-pocket maximum
- Show your ID card to providers
- View and filter claims for quick reference
- Find a doctor
- Access important benefits information
- Connect with customer service by phone
- Ask questions and receive answers from customer service through our message center
- Easily access member-specific services in your benefit plan through the My Programs section
- View each family member's information and benefits



- Filter claims by family member name and type
- Submit a claim using the secure message center

Download our mobile app for free from the Apple App Store or Google Play. Just search for myLuminareHealth Mobile.

Self-funded plans are administered by Luminare Health Benefits, Inc.
800.832.3332 • LuminareHealth.com

luminare health
Experience. Solutions. Results.

LH-1162-11-23

Pharmacy Benefits

EXPRESS SCRIPTS®

Your Pharmacy Vendors

FAES partners with Express Scripts, RxBenefits, and Accredo to provide Prescription Coverage. A description of each vendor is listed below.

- **RxBenefits -** Provides enhanced member services, helps members find lower cost alternatives, assists with transitions of care, and works with your physician to get approval for any medications that need Prior Authorization. See page 18 more information.
- **Express Scripts -** Provides pharmacy benefits and tools for reviewing drug pricing and managing mail order benefits. See page 19 for how to register your Express Scripts account and page 20 for how to setup home delivery.
- **Accredo -** Provides specialty pharmacy benefits and enhanced member support. See page 21 for more information on how Accredo can assist you and your specialty pharmacy needs.

Plan Details	Cost	Description
Deductible	$100 Individual / $200 Family	Applies to Tier 1, 2, 3 and Specialty (does not apply to preferred preventive drugs)
Annual Out-of-Pocket Maximum	Combined with medical out-of-pocket maximum	
Preferred Preventive Drugs *(up to a 34-day supply)*	$0	N/A
(Tier 1) - Generic Drugs except Preferred Preventive Drugs *(up to a 34-day supply)*	$10	All generic drugs are covered at this copay level.
(Tier 2) Preferred Brand Name Drugs *(up to a 34-day supply)*	$15	All preferred brand name drugs are covered at this copay level.
(Tier 3) Non-Preferred Brand Name Drugs *(up to a 34-day supply)*	45% coinsurance Specialty – 10% coinsurance to a maximum of $150	All non-preferred brand name drugs are covered at these copay levels. These drugs are not on the preferred drug list. Check the ESI member portal to see if there is an alternative lower cost drug available. Discuss alternatives with your provider.
Maintenance Copays *(up to a 90-day supply)*	Generic: $20 Preferred: $30 Specialty – 10% coinsurance to a maximum of $300	Maintenance drugs of up to a 90- day supply are available for twice the copay only through the Home Delivery or participating 90-day fill pharmacy.

Plan Feature	Description
Restricted Generic Substitution	If you choose a non-preferred brand name drug (Tier 3) instead of its generic equivalent, you will pay the highest copay plus the difference in cost between the brand and generic. If a generic version is not available, you will only pay the copay. Also, if your prescription is written for brand name drug and DAW (dispense as written) is noted on the prescription, you will pay the difference in cost between the brand and generic drugs. The cost difference is added to the generic copay and does not count towards your out-of-pocket maximum.

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.

Pharmacy Benefits *(continued)*

Prior Authorization

What is Prior Authorization?
A prior authorization (PA) is when your benefit plan requires approval of a prescription before it is covered, to ensure it is being used safely and appropriately as approved by the U.S. Food and Drug Administration (FDA). PA reviews may also be needed based on the medication dose (quantity limits) or prior therapy requirements (step therapy).

How is the PA Medication List Determined?
Which drugs require a PA review is based on a variety of factors, including FDA-approved guidelines, standards of practice, dosing schedule, method of administration, and cost.

Examples of medication subject to PA review include:

- Drugs that have dangerous side eects
- Drugs that are harmful when used in combination with other drugs
- Drugs with limited indications
- Drugs that are subject to abuse and misuse
- High-cost drugs with clinically equivalent, lower-cost alternatives available

How Does a PA Work?
During claim processing, any medication with a National Drug Code (NDC) on the PA list is automatically reviewed electronically. The claim system scans the member's claim history to determine whether the member has an active PA. If no active PA is found, the claim will be rejected as not covered because a PA is required.

If a Claim is Rejected For Not Having a PA in Place, Can the Member Request an Approval?
Yes. In the case where a previous PA has lapsed or was not in place, the member can request one. The pharmacist is provided a dedicated phone number that the pharmacy or prescriber can use to initiate a PA request. RxBenefits manages the PA review process for any exceptions submitted by members. PA requests require supporting documentation to be submitted by your prescriber. Our clinical reviewers evaluate requests against specific clinical criteria and based on this review, determine whether to approve or deny the request.

Who is Notified if a PA Request is Approved and How is Notification Provided?
If a PA is approved, a notification letter is mailed to the member and faxed or mailed to the prescriber.

How Long Will a PA Approval be Granted?
Most PA approvals are for one year; however, the duration of approval varies based on the medication requested. The dates for which all PAs are approved are included on approval notifications that are sent out to members and their prescriber.

We Are Here To Help

Chat: With a live agent via the RxBenefits member portal at Member.RxBenefits.com, Monday-Friday, 9:00 a.m. to 6:00 p.m. Central

Email: CustomerCare@RxBenefits.com, Monday-Friday, 7:00 a.m. to 8:00 p.m. Central

Call: RxBenefits Member Services at **1-800-334-8134**, Monday-Friday, 7:00 a.m. to 8:00 p.m. Central

My RxBenefits®

Access your pharmacy benefits information 24/7 from any device by registering on the My RxBenefits member portal at Member.RxBenefits.com. Once registered, you can view and download your ID card, set up your communication preferences, access up to 18 months of prior authorization and claims history, chat with a live agent, and so much more.

Pharmacy Benefits *(continued)*

EXPRESS SCRIPTS® + RxBenefits®

Who is RxBenefits®?

FAES has partnered with RxBenefits to provide an enhanced customer service experience. RxBenefits will work in partnership with Express Scripts (ESI), your pharmacy benefit manager, to bring you improved member services and support for your prescription needs. RxBenefits also works with your physician to get approval for any medications that need Prior Authorization.

RxBenefits® Member Services

Our Member Services representatives have access to the same system utilized by Express Scripts (ESI) and are equipped to help you, your physician, and your pharmacy with questions such as:

- "Is my pharmacy in the network?"
- "Is my drug covered?"
- "How do I start using Mail Order for my medications?"
- "How do I get a Prior Authorization?"
- "Can you assist me with general benefit questions?"

No matter what the issue or need, members can always expect RxBenefits to:

- Act with urgency
- Remain responsive to change
- Follow all issues to Resolution

Contact the RxBenefits Member Services Team at **800.334.8134** or **CustomerCare@rxbenefits.com**

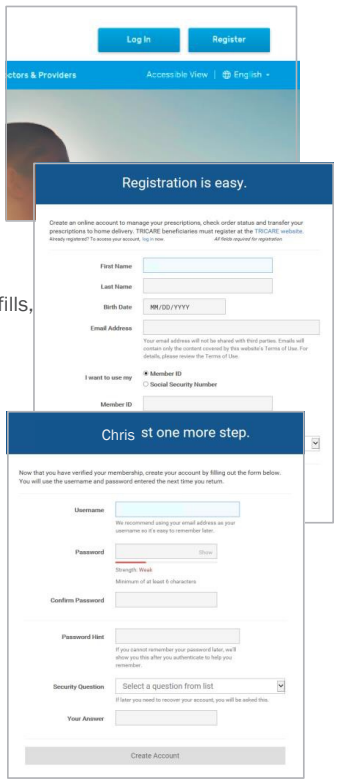
RxBenefits Member Services Team members are available from **7:00 AM to 8:00 PM CST, Monday – Friday.** On weekends, after hours, and on holidays, members are given the option to speak with a Express Scripts (ESI) representative or leave a message for the RxBenefits Member Services Team to return their call.

Pharmacy Benefits *(continued)*

EXPRESS SCRIPTS® + RxBenefits®

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

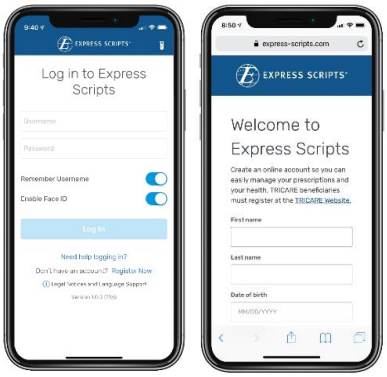
Register now so you can experience:

- **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 and select **Register,** or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register.**
- Complete the information requested, including personal information and member ID number or Social Security number (SSN). Create your username and password, along with security information in case you ever forget your password.
- Click **Register now** and you're registered.
- To set preferences,[2] select **Communication Preferences** from the menu under **Account**, then scroll to **Communication** and **Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.



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

[1] Standard shipping costs are included as part of your prescription plan benefit.

[2] Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.

Pharmacy Benefits *(continued)*

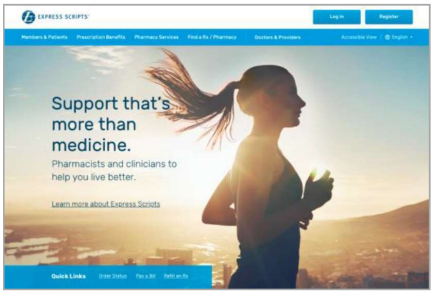
EXPRESS SCRIPTS® + RxBenefits®

Getting Started with Home Delivery from the Express Scripts Pharmacy℠

Online access to savings and convenience

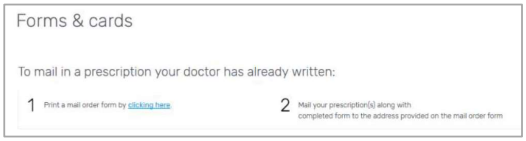
Whether you are viewing the member website or using the Express Scripts® mobile app,[1] you can easily manage your home delivery prescriptions:

- Check order status
- Refill and renew prescriptions
- Check prices and coverage
- Find convenient pharmacies
- View your Rx claims and balances
- Pay your balance using a variety of payment options
- View our therapeutic resource centers for information
- And much more



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 ...

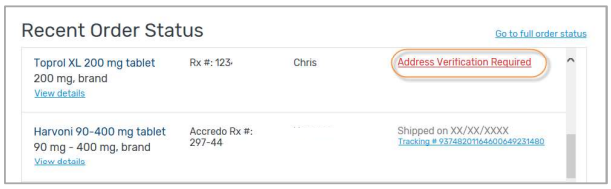
Get started by contacting your doctor to request a 90-day prescription that he or she can e-prescribe directly to Express Scripts
Or print a form by selecting "Forms & Cards" from the menu under "Benefits." Print a mail order form and follow the mailing instructions.
Or call us and we'll contact your doctor for you.

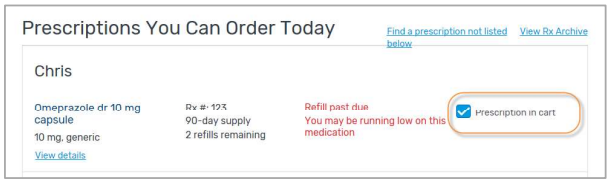
Please allow 10 to 14 days for your first prescription order to be shipped.

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 for 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.

[1] You can search for "Express Scripts" in your app store and download it for free. Then register, if first visit, or log in.

CRP1905_0334 EME52445
MG48738M

Pharmacy Benefits *(continued)*

EXPRESS SCRIPTS®

accredo

Accredo Health Group, Inc.
an Express Scripts company

Your Journey with Accredo, Express Scripts' Specialty Pharmacy

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.

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

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, our mobile app or by calling the number on your prescription label

Navigate Insurance and Financial Assistance

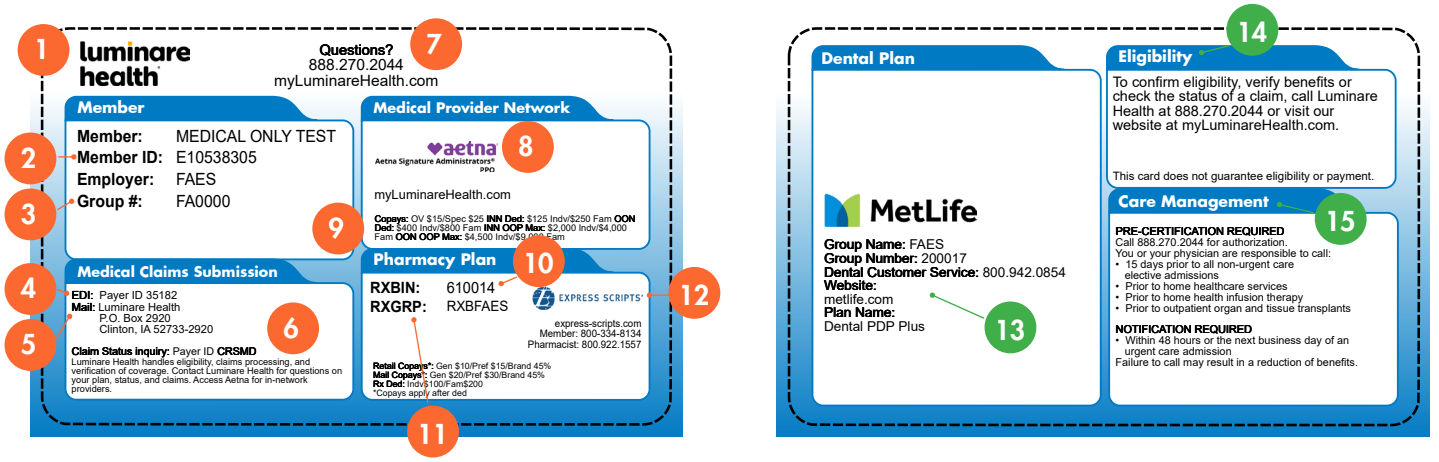
- Get help **understanding your insurance coverage** and coordinating with your health plan on approvals and eligibility
- **We'll find financial assistance** programs that may be available from drug manufacturers and community organizations

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

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

Contact Accredo by calling: 877-895-9697

Understanding Your ID Card



Front Of Card:

1. **Plan Administrator** – your insurance is through Luminare Health and utilizes the Aetna network of providers. Luminare Health processes claims and manages the day-to-day aspects of your group plan
2. **Member ID** – used by Luminare Health Customer Service to verify eligibility and coverage
3. **Group Number** – helps Luminare Health identify the benefits of your particular plan
4. **EDI Payer ID** – the number your provider uses to submit claims information to Luminare Health
5. **Mail** – mailing address for claims submissions
6. **Aetna Notice** – Aetna is your network of providers; benefits are insured by Luminare Health
7. **Questions?** – Toll free and online support to get information or access care
8. **Network of providers** – to find a provider search www.aetna.com/asa
9. **Office Visit Copays** – amount you pay on the day you visit your provider. These are your deductible and out-of-pocket amounts.
10. **RXBIN** – pharmacists use this number to process your prescriptions
11. **RXGRP** – pharmacists use this number to identify plan benefits
12. **Express Scripts** – prescription coverage administrator and customer service

Back Of Card:

13. **MetLife** – the back of your ID card contains important Group Name, Group Number, and Contact Information for your Dental Plan through MetLife
14. **Eligibility** – contact Luminare Health to confirm your eligibility, verify benefits, and check the status of your claim
15. **Care Management** – For authorization of certain services under your Luminare Health plan, you and your provider will need to contact Care Management

Luminare Claims

Contact Luminare for Claims and Coverage Questions

This health plan uses a third-party administrator (TPA) to process claims and manage other aspects of their health benefits, including contracting for PPO network access. Luminare Health Benefits is the TPA for this plan. Aetna Signature Administrators is the PPO network this plan can access for in-network care.

Luminare vs. Network Responsibility

The information below outlines some of the general responsibilities of Luminare and Aetna Signature Administrators.

Luminare's Responsibility

- Answer provider eligibility questions and benefit verification
- Answer provider claims questions
- Receive and process claims
- Manage precertification and appeals
- Provide customer service

Aetna Signature Administrators Responsibility

- Provide network access
- Resolve provider contract issues

Questions and Claims Submissions

Log in to the Luminare provider portal, myLuminareBenefits.com, or call Luminare at **888.270.2044** for all claims and eligibility questions. This number is also located at the top of the patient's ID card.

Submit all claims to Luminare at the address listed on the patients ID card under *Medical Claims Submission.*

EDI: Payer ID 35182

Mail: Luminare Health Benefits
P.O. Box 2920
Clinton, IA 52733-2920

Do not submit claims or direct questions to Aetna Signature Administrators. Submitting claims to the network instead of Luminare will result in payment delays and incorrect denials.

luminare health℠
Experience. Solutions. Results.

Pregnancy & Postpartum Support

progyny

Pregnancy & Postpartum

Support and guidance for a healthy pregnancy and beyond

Receive ongoing one-on-one support from a dedicated Progyny Care Advocate (PCA) and unlock access to exclusive resources that empower you with knowledge and confidence for the many milestones to come. We've got you covered - access personalized coaching and digital tools at no cost.

You'll get:

Personalized Support:

- Contact Progyny to verify your eligibility and enroll
- Meet your PCA (labor and delivery nurses), who will provide you with personalized education and support
- Receive advice at key stages of your pregnancy and postpartum journey, including return-to-work
- Connect with lactation consultants and baby feeding experts

Curated Digital Resources:

- Sign up for the member portal via web or by downloading the Progyny app on your mobile device. You must be enrolled to gain access
- Explore curated content, education, and checklists to support each milestone
- Access health trackers to monitor your pregnancy (i.e., blood pressure, mood, and weight)
- Track your baby's diapers, feeding, and growth

Receive a Progyny provided care package + gift

Call Progyny at 888.510.1489 to get started

Visit progyny.com/benefits or vimeo.com/welcome

The program is available to any FAES plan participant, their covered spouse, and their dependents over the age 18 enrolled in an eligible plan throughout pregnancy and up to 12 months postpartum. Personalized coaching and access to digital tools are offered to you for free by your employer with no member financial responsibility.

Dental Benefits

The MetLife 2025-2026 Dental Plan offers comprehensive in-network and out-of-network benefits. In-network refers to the benefits provided under this program for covered dental services that are provided by a participating dentist. Out-of-network benefits refer to benefits provided under this program for covered dental services that are not provided by a participating dentist. Please see the back of your Luminare ID Card for your MetLife Dental PDP Plus Plan group number and contact information.

Member Responsibility	In-Network	Out-of-Network
Deductible - Individual / Family	$50 / $150	$50 / $150
Annual Maximum Benefit - Per Individual	$3,000	$3,000
Type A - Preventive	No charge	No charge, unless exceeding 100% of Allowed Benefit
Type B - Basic Restorative	Deductible, then 20%	Deductible, then 20% of Allowed Benefit
Type C - Major Restorative	Deductible, then 50%	Deductible, then 50% of Allowed Benefit
Type D - Orthodontia	50%	50% of Allowed Benefit
Orthodontia Lifetime Maximum (adult & child up to age 26)	$2,000 per Person	$2,000 per Person

Dental Coverage Details

Service Category	Selected Covered Services	Frequency Limitations
Type A - Preventive	Oral Examinations, Prophylaxis - Cleanings	2 in a year
	Bitewing X-rays (Adult/Child)	1 in 12 months
	Topical Fluoride Applications	1 in a year - Children to age 14
	Sealants	1 in 60 months - Children to age 16
Type B - Basic Restorative	Full Mouth X-rays	1 in 60 months
	Space Maintainers	1 per lifetime per tooth area - Children up to age 14
	Amalgam and Composite Fillings	1 in 24 months. Anterior teeth only
	Periodontal Scaling & Root Planing	1 in 24 months per quadrant
	Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Type C - Major Restorative	Crowns/Inlays/Onlays	1 per tooth in 84 months
	Prefabricated Crowns, Bridges, Dentures	1 in 84 months
	Repairs	1 in 12 months
	Endodontics Root Canal	1 per tooth per lifetime
	Periodontal Surgery	1 in 36 months per quadrant
	General Anesthesia, Consultations	2 in 12 months
	Implant Services	1 service per tooth in 84 months - 1 repair per 12 months
Type D - Orthodontia	The orthodontia benefits cover both the adult and child (up to age 26). The lifetime maximum coverage amount is $2,000. The services performed for the purpose of orthodontia benefits will be considered at the 50% coinsurance amount.	

How to Find a Provider

Find a Dental Provider

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

To find a dental provider:

1. Go to www.metlife.com
2. Select Find a Dentist
3. Under choose your network, select the PDP Plus option
4. Enter your zip code

Please note - If you go out-of-network your dentist can balance bill you up to their charges. MetLife will only pay up to their allowed fee. It is recommended that you speak to your providers billing office about their balance billing processes prior to having any services rendered.

MetLife

Creating a MetLife Account

How Do I Register on MyBenefits?

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

Step 1: Provide Your Group Name

Access MyBenefits at www.metlife.com/mybenefits and enter the employer name and click to select it and then click 'Next.' Employer Name: **Foundation for Advanced Education in the Sciences, Inc.**

Step 2: The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on "Register" at the top-middle of the page and complete the registration process. Going forward, you will be able to log-in directly.

www.Metlife.com/mybenefits

Step 3: Enter Authentication Information

Begin by entering your personal information: first name, last name, email, phone number, date of birth, zip code, and state. You will then receive a verification code that you will need to enter to continue the registration process.

Step 4: Establish Account Credentials

Your email address will be suggested username in the first text field, but you may change it. Enter and confirm your desired password in the next two text fields. Decide whether you'd like to receive documents electronically by selecting one of the radio buttons at the bottom of the page. Click "Submit".

Step 5: Process Complete

Upon successful submission, you should receive a confirmation message. Finally, select "Go to Dashboard" and you will be taken to your Dashboard.

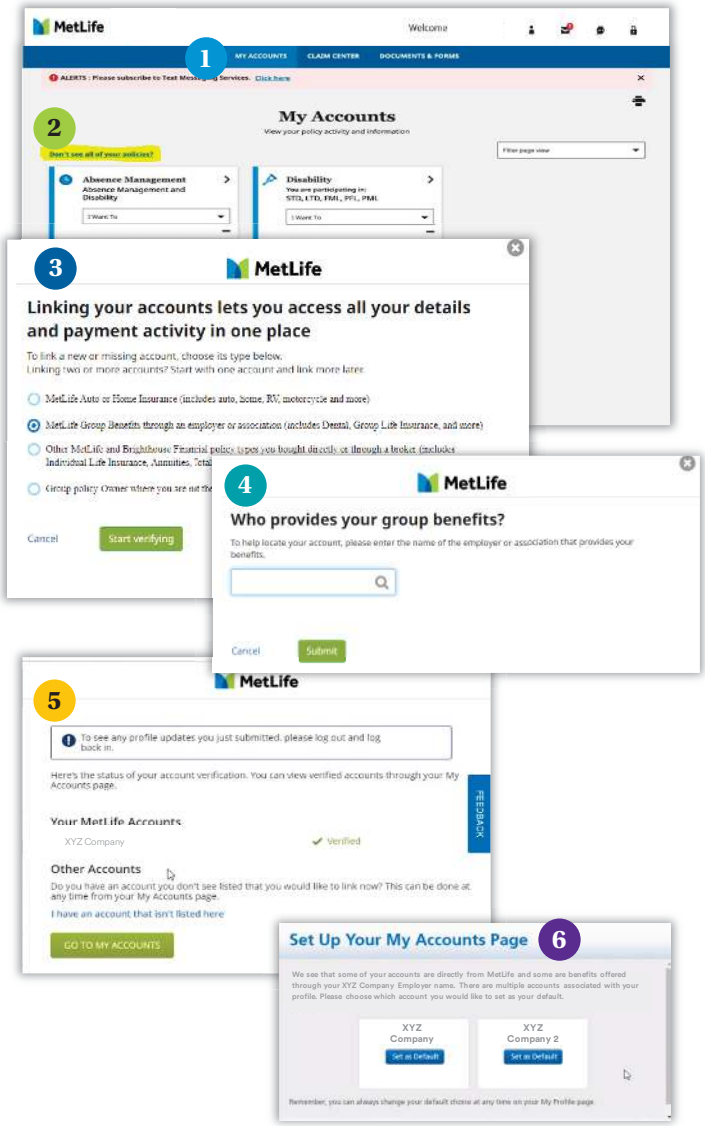
Linking MetLife MyBenefits Accounts

Don't see all your policies on MyBenefits? Here's how to find them and link them to your account.

The MyBenefits website, **mybenefits.metlife.com**, is a quick and easy way for you to access the information you need about your coverage — all in one place. However, what do you do if all your policies don't show up?

We're here to help! Once you're registered on MyBenefits, you can link your missing accounts. Just follow the simple steps below!

1. Log in to MyBenefits. Or, if this is your first time visiting the site, create an account by following the registration process. Once logged in, go to the **My Accounts** tab.
2. Click the **Don't See All Your Policies** link.
3. A page will appear that says **Linking your accounts lets you access all your details and payment activity in one place**. Select the correct option for your situation. For this scenario, we chose **MetLife Group Benefits through an employer or association (includes Dental, Group Life Insurance, and more)**. After you make your selection, click **Start verifying**.
4. The next screen will ask who provides your group benefits. Type in your employer or association that provides your benefits. Then click **Submit**.
5. The next screen will confirm that the additional account has been added to your MyBenefits profile. Please note, you'll need to log out of MyBenefits and then log back in to complete the update. You may need to log out and back in a few times for it to completely update. When it's done updating, the additional account will show up on your profile.
6. Once the update is complete, you'll need to set up your accounts by choosing a customer as the default account you want to see when logging in. You can change the default account at any time through your profile menu.



Having trouble online?

You can reach us at 1-866-363-8669. We're available Monday through Friday, from 8:00 a.m. to 11:00 p.m. Eastern Time.

visit mybenefits.metlife.com

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

FAES Additional Programs

FAES Academic Programs

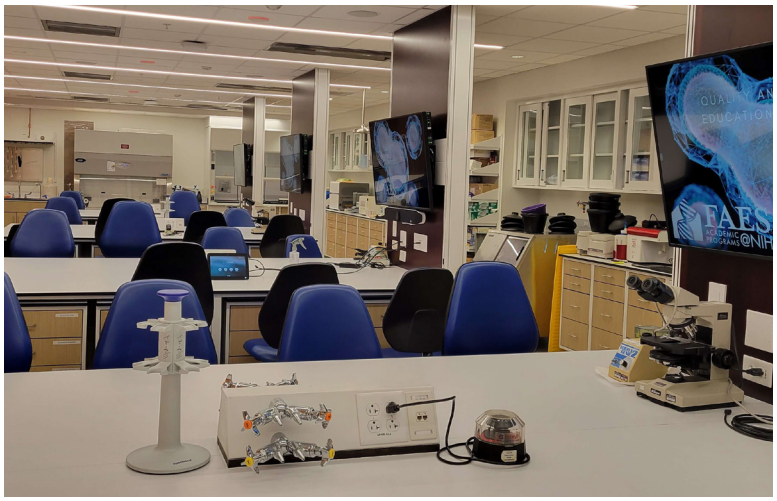
The Academic Programs department at FAES delivers high-quality and innovative credit-bearing courses and non-credit workshops to dynamic and diverse professionals from the NIH and biomedical science community. We offer approximately 150 online courses and workshops as well as in-person workshops annually, designed to accommodate the schedule of working professionals.

We prepare learners for lifelong professional success in careers in biomedical research, academic research, education, clinical practice, private businesses, and non-profit organizations. In addition, we provide a dynamic teaching environment and faculty development opportunities for NIH postdoctoral fellows and others interested in pursuing an academic career.

- Online registration at https://education.faes.org/ – Fall, Spring, and Summer course terms; year-round workshops
- Variety of laboratory training programs offered at the state-of-the-art FAES Learning Labs
- Discounted tuition rates for members of the NIH community
- Exclusive savings on test prep courses offered by The Princeton Review® at discounted prices
- Flexible payment options, including invoice to NIH Institute or Center
- Scholarships available for self-funded students
- Official transcripts available for medical school applicants, students seeking to transfer credits to degree-granting institutions, and others
- FAES academic programs are also open to the public

FAES is an equal opportunity organization and does not discriminate against faculty members or learners. FAES admits learners of any race, sex, disability, and age to all the rights, privileges, programs, and activities accorded or made available to learners at FAES. FAES does not discriminate based on race, sex, disability, age, or any other protected class in the administration of its educational policies, admissions policies, scholarships, and other academically administered programs.

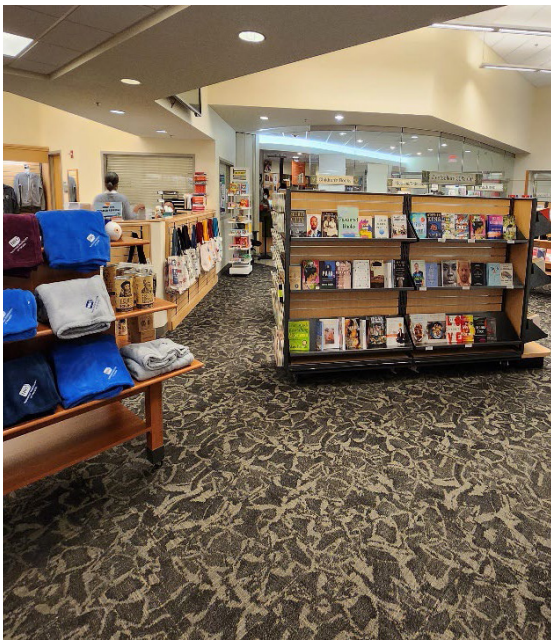
Scan the QR code for a full list of upcoming courses and workshops as well as more information on the Academic Programs department at FAES.



FAES Additional Programs *(continued)*

FAES Housing

FAES Housing provides large private, single occupancy bedrooms close to the NIH main campus in Bethesda, Maryland. All units have a private bathroom, individual refrigerator, pantry, and entry cubby. Houses may be co-occupied by up to 5 visiting NIH trainees. FAES Housing offers flexible agreement terms for trainees looking for long-term or short-term accommodations. All utilities, including high-speed internet, complimentary basic household supplies, monthly cleaning services, and maintenance services are included in the monthly payment. FAES Housing is designed to inspire and deliver practical solutions for NIH trainees while offering a collaborative environment to enhance professional and personal development during your NIH assignment. For more information, please visit their website at https://w.faes.org/housing.



FAES Retail

FAES Retail sells NIH-branded apparel and merchandise to celebrate and honor the NIH community with three convenient locations in the NIH Clinical Center!

The FAES Bookstore, Rm 1C172 near the South entrance and the FAES Administrative offices, specializes in books, stationary, and science-themed gifts and toys. You can find greeting cards, health and beauty items, and snacks alongside NIH-branded clothing and drinkware. Special orders for books still in print can be handled by Bookstore staff, including textbooks and medical reference. They will research the availability of books and provide you with a quote. Once your order is placed, it can either be picked up in-store or shipped anywhere in the United States. Let us do the research and work for you!

Please also visit the FAES Gift Shops, located in the Clinical Center Atrium or next to the B1 Cafeteria. Each offer unique cards, gifts, and a wide selection of NIH-emblematic clothing and merchandise. Our selection is always changing so stop by and see what's new!

You can conveniently shop from anywhere at www.shopfaes.com. Just like special order books, you can pick up in store or have your order shipped within the continental US. Contact FAES Retail at FAESBookstore@mail.nih.gov or call 301-496-5272.

Contact Information

Plan Questions	FAES Insurance	301-496-8063 FAESinsurance@mail.nih.gov
Medical Provider Network	Aetna	www.aetna.com/ASA
Medical Administrator	Luminare Health	1-888-270-2044 myLuminareHealth.com
Dental	MetLife	1-800-275-4638 www.metlife.com
Pregnancy & Postpartum Support	Progyny	1-888-510-1489 www.progyny.com/benefits
Pharmacy Customer Service	RxBenefits - Members	1-800-334-8134
Specialty Pharmacy	Express Scripts - Accredo	877-895-9697 www.accredo.com

Download Apps for free from the Apple App Store or Google Play:

Luminare Health

Express Scripts

MetLife

Progyny

Continuation of Health Coverage

When any covered member loses health insurance coverage based on a termination of employment or the occurrence of other qualifying events, the member will be eligible to elect continuation of coverage. Once your termination of health insurance coverage is processed you will receive a continuation of coverage packet in mail from BRI, FAES's Continuation of Coverage administrator. You will have 60 days to elect continuation of coverage. Once continuation of coverage is elected your coverage is retroactive to the date you lost coverage. There will be no lapse in coverage. Please contact a FAES Insurance representative for additional information on pricing regarding continuation of coverage.

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

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

Individual Election Rights to Continuation of Coverage

	Max Continuation for Covered Individuals		
Loss of Coverage Due to:	**You**	**Spouse**	**Child**
Voluntary or Involuntary Loss of Employment	18 months	18 months	18 months
Disability (at the time of event)	29 months	29 months	29 months
Your Death	N/A	36 months	36 months
Your Divorce or Legal Separation	N/A	36 months	36 months
You Become Entitled to Medicare	N/A	36 months	36 months

Please contact a FAES Insurance representative for additional information regarding continuation of coverage:

FAESinsurance@mail.nih.gov

Legal Notices

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 of 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

In-Network	**Out-of-Network**
Individual Deductible: $125	Individual Deductible: $400
Family Deductible: $250	Family Deductible: $800
Member Coinsurance: 10%	Member Coinsurance: 30%

NEWBORNS ACT DISCLOSURE – FEDERAL

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 issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
301-496-8063
FAESinsurance@mail.nih.gov

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Legal Notices *(continued)*

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.

Legal Notices *(continued)*

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

Date:	11/01/2025
Name/Entity of Sender:	Foundation for Advanced Education in the Sciences
Contact Position/Office:	FAES Insurance
Address:	10 Center Drive, Bethesda, MD 20892
Phone Number:	301-496-8063

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from Foundation for Advanced Education in the Sciences 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 with Foundation for Advanced Education in the Sciences and about 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:

1. 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.
2. Foundation for Advanced Education in the Sciences has determined that the prescription drug coverage offered by the Health and Welfare Benefits Plan for the plan year 2024-2025 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. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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, the following options may apply:

- You may stay in the Health and Welfare Benefits Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Health and Welfare Benefits Plan creditable coverage.
- You may stay in the Health and Welfare Benefits Plan and also enroll in a Medicare prescription drug plan. The Health and Welfare Benefits Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Health and Welfare Benefits Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Health and Welfare Benefits Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 coverage with Foundation for Advanced Education in the Sciences 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 the person listed below for further information.

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 coverage through Foundation for Advanced Education in the Sciences changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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
- 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).

Date:	11/01/2025
Name/Entity of Sender:	Foundation for Advanced Education in the Sciences
Contact Position/Office:	FAES Insurance
Address:	10 Center Drive, Bethesda, MD, 20892
Phone Number:	301-496-8063

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Legal Notices *(continued)*

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Legal Notices *(continued)*

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Legal Notices *(continued)*

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

Legal Notices *(continued)*

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Foundation for Advanced Education in the Sciences
Contact--Position/Office:	FAES Insurance
Address:	10 Center Drive, Bethesda, MD, 20892
Phone Number:	301-496-8063

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.

Legal Notices *(continued)*

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.

3. Employer Name Foundation for Advanced Education in the Sciences		4. Employer Identification Number (EIN) 52-0743814
5. Employer address 10 Center Drive Room1n241-Msc 1115		6. Employer phone number 301-496-8063
7. City Bethesda	8. State MD	9. ZIP code 20892
10. Who can we contact about employee health coverage at this job? Christina Farias		
11. Phone number (if different from above)	12. Email address FAESinsurance@mail.nih.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:

    Work 30 hours per week

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse and dependent children up to age 26. A child who has a disability may be eligible for coverage past the age of 26 with proof of disability.

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, 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. Here's 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.

FAES
INSURANCE @NIH

Provided By:

3190 Fairview Park Drive, Suite 400
Falls Church, VA 22042
(703) 698-0788
www.usi.com