AON ACTIVE HEALTH EXCHANGE™

Make It Yours To Go

A benefits overview for you and your family.

https://firstdata.makeityoursource.com/

Compare Coverage Levels

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Eligibility

It's up to you to understand who you can cover under your medical, dental, vision, and other benefits. Be sure to review the information below before you enroll in coverage.

Who is Eligible?

In general, you are eligible for coverage if you are on the U.S. payroll as a full-time owner-associate scheduled to work at least 30 hours per week.

Eligible dependents include:

- Spouses and domestic partners (see Dual Coverage Exclusion below)
- Children
    - From birth through the end of the month in which they turn age 26 (for medical, dental, vision, critical illness, accident insurance, employee assistance program, Health Care Flexible Spending Account expenses).
    - Unmarried children up to age 19, or age 23 if a full-time student, for child life insurance and voluntary accidental death and dismemberment (AD&D) insurance.

You and each of your dependents enrolled in a medical, dental, and/or vision plan must have a valid Social Security number (SSN) on file at the Your Benefits Resources (YBR) website. Please have the SSN and date of birth handy before accessing YBR.

Dual Coverage Exclusion—Spouse and Domestic Partner. A spouse/domestic partner is eligible for First Data medical plan coverage ONLY if he/she is NOT eligible for coverage through his/her own employer, regardless of whether or not he/she is enrolled in that coverage. When you enroll a spouse/domestic partner into a First Data medical plan, you must complete an online certification at the enrollment site validating that he/she is not eligible for their own employer coverage. Each year, you must re-enroll the spouse/domestic partner during Annual Enrollment. He/she is defaulted to "no coverage for medical" for the new plan year unless you actively enroll then.

The Dual Coverage Exclusion does not apply:

- When you and your spouse/domestic partner both work at First Data
- To dental or vision coverage

Dependent Verification Requirements

When enrolling any new dependents in a medical, dental, or vision plan, you will be required to complete dependent verification requirements. Within seven to 14 days after online enrollment, you will receive a Dependent Verification Packet in your home mail from First Data's Health and Life Help Desk. You are required to provide specific documents validating the enrolled dependents meet eligibility requirements. If you do not complete the verification request completely and timely, your dependents will become ineligible for coverage and will be dropped from coverage.

Owner-associates who have enrolled ineligible dependents will be subject to disciplinary action up to and including termination of employment. For detailed definitions of dependent eligibility, see the Summary Plan Description at www.firstdatabenefits.us.

Medical Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you do your homework before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Make sure to take your total costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to . nd the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different insurance carriers at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO that offers limited benefits for out-of-network care*
Paycheck contributions	$	$	$$	$$$	$$$$
			Annual Deductible		
In-network (individual / family)	$3,000 / $6,000	$2,250 / $4,500	$1,500 / $3,000	$600 / $1,200	N / A
Out-of-network (individual / family)	$3,000 / $6,000	$2,250 / $4,500	$1,500 / $3,000	$1,200 / $2,400	$5,000 / $10,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional
			Annual Out-of-Pocket Maximum		

In-network (individual / family)	$5,950 / $11,900	$3,575 / $7,150	$3,575 / $7,150	$3,500 / $7,000	$1,500 / $3,000
Out-of-network (individual / family)	$11,900 / $23,800	$10,000 / $20,000	$7,500 / $15,000	$7,000 / $14,000	$10,000 / $20,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional
		In-Network Bene. ts			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%
Doctor's office visit	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay $20 for PCP visit and $35 for specialist visit, no deductible	You pay $20 for PCP visit and $35 for specialist visit
Emergency room	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay $100
Urgent care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay $50
Inpatient care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay $250
Outpatient care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	If not an office visit, you pay 20% after deductible	If not an office visit, covered 100%**

*For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

**There is a $100 copay for outpatient surgery at a hospital or free-standing facility.

Note: There is no fourth quarter carryover of deductible and/or out-of-pocket maximum amounts.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive drugs	You pay $0*	You pay $0*	You pay $0*	You pay $0*	You pay $0*
		30-Day Retail Supply			

Tier 1 (generally lowest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $8	You pay $4
Tier 2 (generally medium cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $30	You pay $20
Tier 3 (generally highest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $50	You pay $40
90-Day Retail or Mail-Order Supply					
Tier 1 (generally lowest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $20	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $75	You pay $50
Tier 3 (generally highest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $125	You pay $100

*Preventive drugs are determined by the insurance carrier as required by the Affordable Care Act. You must have a doctor's prescription for the medication —even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

Important: If you're considering Aetna, Cigna, or UnitedHealthcare under the Bronze, Bronze Plus, or Silver coverage levels, you will pay 20% for certain maintenance medications without having to pay the deductible. Check with CVS Caremark to see if your medication is included on the preventive list with no deductible.

California Residents: Your options will be different, depending on the insurance carrier you choose. See what's di. erent.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to Your Benefits Resources for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Owner-associates who enroll under Aetna, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by CVS/Caremark.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. Get the details.

Questions?

It's easy to find answers! Check out the Frequently Asked Questions (PDF) and the Glossary.

California Medical Coverage Level

Live In California?

Your options will be di. erent, depending on the insurance carrier you choose.

For starters, each insurance carrier in California has the option to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) or an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer either the standard Gold option or a Gold II option—not both. The Gold II option offers only in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In-network only	In-network only
Health Net	Northern California In-network only Southern California In- and out-of-network	Northern California In-network only Southern California In- and out-of-network	Northern California In-network only Southern California In- and out-of-network	N/A	In-network only	In-network only
Kaiser Permanente	In-network only	In-network only	In-network only	N/A	In-network only	In-network only
United-Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Medical Coverage Level

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM

Option type	High-deductible option with HSA	High-deductible option with HSA	High-deductible option with HSA	PPO	HMO	PPO that offers limited benefits for out-of-network care*
Paycheck contributions	$	$	$$	$$$	$$$	$$$$
			Annual Deductible			
In-network (individual / family)	$3,000 / $6,000	$2,250 / $4,500†,§	$1,500 / $3,000†,#	$600 / $1,200	N / A	N / A
Out-of-network (individual / family)	$3,000 / $6,000	$2,250 / $4,500†,§	$1,500 / $3,000†,#	$1,200 / $2,400	N / A	$5,000 / $10,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional	Traditional
			Annual Out-of-Pocket Maximum			
In-network (individual / family)	$5,950 / $11,900	$3,575 / $7,150‡	$3,575 / $7,150‡	$3,500 / $7,000	$5,000 / $10,000	$1,500 / $3,000
Out-of-network (individual / family)	$11,900 / $23,800	$10,000 / $20,000‡	$7,500 / $15,000‡	$7,000 / $14,000	N / A	$10,000 / $20,000
Traditional or true family?	Traditional	True family	True family	Traditional	Traditional	Traditional
			In-Network Bene. ts			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%
Doctor's o**ffi**ce visit	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay $20 for PCP visit and $35 for specialist visit, no deductible	You pay $20 for PCP visit and $35 for specialist visit	You pay $20 for PCP visit and $35 for specialist visit
Emergency room	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30%	You pay $100

Urgent care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30%	You pay $50
Inpatient care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 30%	You pay $250
Outpatient care	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	If not an office visit, you pay 20% after deductible	If not an office visit, you pay 30%	If not an office visit, covered 100%**

*For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

**There is a $100 copay for outpatient surgery at a hospital or free-standing facility.

†Under Health Net and Kaiser Permanente, if you cover dependents, no covered member pays more than $2,700 toward the family deductible. Also, these options feature a traditional annual deductible.

§Under Health Net, the family deductible is $4,725.

‡Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.

#Under Health Net, the family deductible is $3,375.

Note: There is no fourth quarter carryover of deductible and/or out-of-pocket maximum amounts.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive drugs	You pay $0*	You pay $0*	You pay $0*	You pay $0*	You pay $0*	You pay $0*
			30-Day Retail Supply			
Tier 1 (generally lowest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $8	You pay $8	You pay $4
Tier 2 (generally medium cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $30	You pay $30	You pay $20

Tier 3 (generally highest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $50	You pay $50	You pay $40

90-Day Retail or Mail-Order Supply

Tier 1 (generally lowest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $20	You pay $20	You pay $10
Tier 2 (generally medium cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $75	You pay $75	You pay $50
Tier 3 (generally highest cost options)	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay 100% until you reach the deductible, then you pay 20%	You pay $125	You pay $125	You pay $100

*Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Your Benefits Resources gives a more detailed look at these and additional coverages—and does account for some carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click Compare. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on Your Benefits Resources.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the insurance carrier.

It Depends On Your Medical Coverage Level

Bronze and Gold Coverage Levels

These coverage levels have a traditional deductible

Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus and Silver Coverage Levels

These coverage levels have a "true family deductible." This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in these coverage levels when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family deductible is met.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Platinum Coverage Level

The Platinum coverage level does not have an in-network deductible. Keep in mind that as a trade-o. for no deductible, the Platinum coverage level is usually the most expensive coverage level per paycheck.

Do You Use Out-of-Network Providers?

Out-of-network charges will not count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will not count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network bene□ts at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

Here's how the out-of-pocket maximum works if you have family coverage:

It Depends On Your Medical Coverage Level

Bronze, Gold, and Platinum Coverage Levels

These coverage levels have a traditional out-of-pocket-maximum.

Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage or certain copays under the the Gold and Platinum options.

Bronze Plus and Silver Coverage Levels

These coverage levels have a "true family out-of-pocket maximum." This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in these coverage levels when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family out-of-pocket maximum is met.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?

Out-of-network charges will not count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will not count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Medical Price

You can choose the medical coverage level and medical carrier that offer the right balance.

You get to decide how much you want to pay for coverage through the exchange. You can choose the coverage level you want from the medical carrier offering it at the best price.

Other factors that impact how much you pay include how many family members you cover and the subsidy amount from First Data. First Data subsidizes based on annual benefits salary:

- $40,000 or less
- $40,001–$85,000
- $85,001–$125,000
- $125,001–$200,000
- More than $200,000

On average, First Data subsidizes the largest portion of the premium at 73%, with lower salary level owner-associates receiving a higher company subsidy. You'll pay the cost of medical coverage with before-tax dollars.

First Data Annual Medical Contribution

Owner-associates earning $85,000 or less, who elect First Data medical coverage, will automatically receive a $300 First Data Annual Medical Contribution deposited in their Health Savings Account (a lump-sum deposit in January 2019) when electing the Bronze, Bronze Plus, or Silver medical plan (or deposited in their paychecks throughout the year in equal amounts as taxable income when electing Gold and Platinum) to help fund out-of-pocket health care expenses.

Owner-associates earning $85,000 or less hired on or after January 1, 2019, who elect medical coverage, will have the contribution prorated quarterly and deposited in their Health Savings Account (or spread across their paychecks when electing Gold or Platinum) following benefit enrollment per this schedule:

Benefit Eligibility Date	First Data Medical Contribution
Jan. 1 – Mar. 31, 2019	$300
Apr. 1 – Jun. 30, 2019	$225
Jul. 1 – Sep. 30, 2019	$150
Oct. 1 – Dec. 31, 2019	$75

Price Shopping

You can compare the costs of your medical options using an interactive pricing tool before your enrollment period starts. From the home page, click Compare Your Costs and enter the case-sensitive access code that was mailed to your home.

When you enroll on Your Benefits Resources at www.firstdatabenefits.us, you'll be able to see the contribution amount from First Data and your price options for medical options for each medical carrier. The "low cost carrier" available in your region may be the best value for you because it will be the lowest paycheck contribution for your medical coverage level selected.

Pay Now or Later?

It's a trade-o. . It's up to you to choose which option gives you the best deal on your total health care costs.

Would you rather pay less now and more when you need care? Or pay more now and less when you need care?

Pay Less Now

The Bronze, Bronze Plus, and Silver coverage levels cost less per paycheck, but the deductibles are higher. That means you'll pay more out of your pocket when you need care.

Make sure you know how the deductible works. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an HSA when you enroll in a Bronze, Bronze Plus, or Silver coverage level. (And, you can save on your paycheck contributions if you select the lowest-cost medical carrier.)

Pay Less Later

The Gold and Platinum coverage levels cost more per paycheck, but the Gold deductible is lower. The Platinum coverage level does not have a deductible. If you don't have a lot of health care needs, you could be spending money for bene□ts you don't use.

How to Get the Right Medical Option

Do your homework now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Even if you can keep your current insurance carrier, the provider network could be di. erent and can change, so always check the provider networks before making a decision.

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount. And certain Platinum options won't cover out-of-network services at all.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Want to see whether a doctor participates in a carrier's network? To search for providers:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on Your Benefits Resources. For the best results, search for your provider by name—not medical practice—and only the office location where you will visit the provider.

Important! Do not rely on your provider's office to know the carriers' network(s). If you have any uncertainty or, for instance, you will cover out-of-area dependents, you need to call the insurance carrier to confirm whether a provider participates in a carrier's network.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a family member regularly takes medication, make sure you're comfortable with the carrier's coverage for drugs you and your covered family members need:

- Call CVS Caremark (if you're considering coverage under Aetna, Cigna, and UnitedHealthcare) or the medical insurance carrier (for other carriers) before you enroll. Get a list of prescription drug questions to ask the insurance carriers.
- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.
- When it's time to enroll, you can use the prescription drug search tool to look up your medication, see how it will be classified (Tier 1, Tier 2, Tier 3), and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage on Your Benefits Resources.

What to Do
If you need help deciding, there are tools to help you on Your Benefits Resources.

- See which coverage level could be best for you. By answering a few questions, you can see which option could be a good fit for you and your family.
- Compare your options side by side when you enroll. Just check the boxes next to medical options you want to review and click Compare (under the check marks). You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on Your Benefits Resources.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price for each coverage level, and you'll be able to see all of the prices in one place on Your Benefits Resources. (Note: The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- See how other people rate their health carriers on Your Benefits Resources at https://www.firstdatabenefits.us anytime.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking Compare. That makes it easy to see which carrier is offering you the best deal. (You may also find Summaries of Benefits and Coverage for comparison on Your Benefits Resources.)
- Browse the carrier preview sites to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? Find out how.

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze, Bronze Plus, or Silver coverage level. You can manage your account at www.payflex.com.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to decide how much to save.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze, Bronze Plus, or Silver coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee playing basketball. With a high deductible, you might worry about how you're going to a. ord the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy! You could already have the money you need saved up.

An HSA allows you to set aside tax-free money to pay for quali□ed health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

If you want, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on quali□ed health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on quali□ed health care expenses, you don't pay any taxes. That means you're saving money on your quali□ed medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for quali□ed health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

Wondering what the difference is between an HSA and a Health Care Flexible Spending Account (FSA)? Find out.

Questions?

Get answers to your questions, including what happens if you already have an HSA or FSA. Check out the Frequently Asked Questions (PDF).

If you enroll in a Bronze, Bronze Plus, or Silver coverage level, learn how the HSA works in the HSA User's Guide (PDF).

HSA vs FSA

Wondering how an HSA is di. erent from a Health Care Flexible Spending account (FSA)? Here's how:

Medical Plan
With an HSA, you must be enrolled in a high-deductible health plan such as the Bronze, Bronze Plus, or Silver coverage level to participate. With a Health Care FSA, you don't need to be enrolled in a particular medical plan to participate.

Contributions
With an HSA, you can contribute to your account before taxes. For 2019, the annual limits set by the IRS are $3,500 for individual coverage, and $7,000 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.

With a Health Care FSA, you can contribute to your account before taxes, up to the $2,650 annual limit.

Rollovers
With an HSA, unused dollars roll over from year to year. With a Health Care FSA, unused dollars roll over to the next year but must be used before March 15. Any money left in a Health Care FSA after March 15 is forfeited.

Earning Interest
With an HSA, the money in your account earns interest. With a Health Care FSA, the money in your account doesn't earn interest.

Debit Cards
With an HSA, you can use a debit card to pay for expenses. With a Health Care FSA, you can also use a debit card to pay for expenses.

Eligible Expenses
If you enroll in the Bronze, Bronze Plus, or Silver coverage levels, you can use an HSA, a Health Care FSA, or both an HSA and Health Care FSA. If you contribute to an:

- HSA or Health Care FSA, you can use your account to pay for quali□ed medical, dental, and vision expenses.
- HSA and Health Care FSA, your Health Care FSA will be "limited purpose" and can only be used to pay for quali□ed dental and vision expenses. Your HSA can be used for quali□ed medical, dental, and vision expenses.

If you enroll in the Gold or Platinum coverage level, you can use the Health Care FSA to pay for quali□ed medical, dental, and vision expenses. You are not eligible to contribute to an HSA.

Investing Your Account
With an HSA, when your HSA balance reaches $1,000, you can open an investment account to help your money grow. With a Health Care FSA, you aren't able to invest your FSA balance.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2019, you can save up to $3,500 if you're covering just yourself, or $7,000 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Note: If you want to, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

Prescription Drugs

This is a really big deal! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Owner-associates who enroll under Aetna, Cigna, or UnitedHealthCare will have their pharmacy benefits managed by CVS Caremark.

That means your prescription drug coverage depends on the medical coverage level you choose and your medical insurance carrier.

Your Coverage Level Matters

You pay nothing for preventive drugs, as determined by your insurance carrier according to ACA guidelines. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze, Bronze Plus, or Silver
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

For members enrolled under Aetna, Cigna, or UnitedHealthCare, you will pay 20% for certain maintenance medications without having to pay the deductible.

Gold or Platinum
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—before choosing an insurance carrier.

Get a list of prescription drug questions to ask the insurance carriers.

Prescription Drug Questions

Do you or a family member take medications? This could be a big deal for you!

Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager. The pharmacy benefit manager could be a separate prescription drug company. Owner-associates who enroll under Aetna, Cigna, or UnitedHealthcare will have their pharmacy benefits managed by CVS Caremark. Your prescription drug coverage depends on the medical coverage level you choose.

However, each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—before you choose an insurance carrier.

What To Ask

Here's a cheat sheet of questions to ask CVS Caremark (if you're considering coverage under Aetna, Cigna, and UnitedHealthcare) or the medical insurance carrier (for other carriers you're considering).

Tip: You can also print out the Prescription Drug Transition Worksheet (PDF) and use it to take notes.

Is my drug on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified by your insurance carrier—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, insurance carriers can classify higher-cost generics as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information on the carrier preview sites. Or you can use the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical insurance carriers will require you to pay the copay or coinsurance of a higher tier—plus the cost di. erence between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you ll them in network. But each insurance carrier determines which drugs it considers "preventive." If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many insurance carriers require approval of certain medications before covering them. This may apply for costly medications that aren't considered medically necessary.

Will I have a step therapy program?
If this applies to one of your medications, you'll need to try using the most cost-effective version rst—usually the generic. A more expensive version will be covered only if the rst drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Things To Consider

After you enroll, check out things to know before your benefits start.

Wellness Program

At times throughout the year, Own It Your Health will o. er opportunities to participate in health improvement activities to help you live well.

Your Medical Carrier Resources

We also encourage you and your family to use the wellness tools and resources offered through your medical carrier, such as an online health assessment that promotes healthy lifestyle practices personalized to you. Many medical carriers provide online and/or telephonic coaching to help you manage certain health conditions, and programs focused on nutrition, physical activity, stress reduction, and/or quitting tobacco use. Preventive care visits, screenings, and flu shots are at no charge from the medical carrier and are an important step to help you live a healthier life.

Employee Assistance Program (EAP)

The employee assistance program (EAP) is administered by Health Advocate. The EAP provides you, your dependents, and household members with up to five face-to-face sessions per issue per rolling calendar year and unlimited telephonic counseling with trained professional counselors 24 hours per day, seven days per week. The counselors provide confidential support to help you handle both small problems and major issues in your life. There is no charge to you for this service. You can reach the EAP at 1.877.240.6863.

Wellness Wednesday

Take advantage of the healthy food choice options in your on-site cafe. Wellness Wednesday offers a 20% discount on salad bar purchases and daily choices of FIT meals that are lower in calories, fat, and sodium.

Gym Membership Discounts And More

Log on to https://www.perksatwork.com and receive discounts on gym memberships, fitness equipment, weight loss programs, and more.

Flexible Spending Accounts (FSAs) Options

Health Care Flexible Spending Account (Health Care FSA)

You can contribute from $10 to $2,650 per year to the Health Care FSA to be reimbursed for quali. ed medical, dental, and vision expenses that are not covered by a benefit plan including:

- Deductibles
- Prescription drug copayments or coinsurance
- Certain over-the-counter health supplies such as bandages, contact lens solution, and reading glasses
- Other over-the-counter medications with a prescription, such as allergy, sinus, cold and flu medication, pain relievers, and digestive aids

You have immediate access to the money you have elected to your Health Care FSA. When you have a qualified expense, you can pay with your debit card or pay out of your pocket and submit a paper claim for reimbursement (www.payflex.com).

Important Note: Keep in mind, if you contribute to a Health Savings Account, your Health Care FSA must be "limited purpose" and can only be used to pay for qualified dental and vision expenses.

Day Care Flexible Spending Account (Day Care FSA)

You can contribute from $100 to $5,000 (including the Care$ Benefit) per year in the Day Care FSA to be reimbursed for day care related expenses incurred for a dependent child up to the age 13 and/or dependent adult so you can come to work. A $2,500 maximum applies if you are married and file separate federal income tax returns.

The Day Care FSA cannot be used for your dependent child's medical or dental expenses.

Care$ Benefit

First Data will contribute a Care$ Benefit to your Day Care FSA if you work full-time, earn $40,000 or less per year, and have eligible dependent children with eligible day care expenses.

If you make under $40,000 and pay for day care services so you can come to work, make sure you elect the Care$ Benefit in order to receive up to $60 a month in day care assistance from First Data. When you elect to contribute at least $100 per year of your own paycheck dollars to a Day Care FSA, First Data will automatically contribute up to $765 per year ($63.75 per month). If you do not make a paycheck contribution to a Day Care FSA, you can receive a Care$ Benefit of up to $510 per year ($42.50 per month) when you enroll in the Care$ Benefit.

Timing Considerations

All FSA reimbursement requests incurred during the plan year in which you contribute to the FSA must be filed with PayFlex by March 31 of the following year.

The Health Care FSA allows you to incur eligible expenses for up to 2½ months after the end of the plan year (through March 15) before the "use it or lose it" forfeiture rule applies.

The Day Care FSA will also allow you to incur eligible expenses for up to 2½ months after the end of the 2019 plan year (through March 15, 2020) before the “use it or lose it” forfeiture rule applies.

Flexible Spending Accounts Are Administered By PayFlex

You can manage your account at www.payflex.com. You will receive a debit card from PayFlex to conveniently pay qualified expenses directly from your account or you may request reimbursement online at www.payflex.com. You can also contact PayFlex at 1.800.284.4885 from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday and 10:00 a.m. to 3:00 p.m. ET, Saturday.

Dental Coverage

Dental Benefits For Your Dental Needs

You should choose the option that's right for you. Depending on your work or home location, your dental options may include:

- Aetna Dental Maintenance Organization (DMO)
- MetLife Preferred Dentist Plan (PDP) A
- MetLife Preferred Dentist Plan (PDP) B
- No coverage

Is A Primary Care Dentist Required?

You must designate a primary care dentist to coordinate your care if you choose the Aetna DMO dental option. If you don't designate a network primary care dentist when you enroll, one may be assigned to you by Aetna DMO.

A primary care dentist designation is not required by either MetLife PDP plan.

Paying For Coverage

You and First Data share the cost of dental coverage. You'll pay your portion of dental coverage with before-tax dollars deducted from your paychecks.

Bi-Weekly Deductions

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Aetna DMO	$ 2.68	$ 5.36	$ 6.43	$ 9.11
MetLife PDP A	$ 6.04	$12.08	$14.50	$20.53
MetLife PDP B	$16.47	$32.97	$39.56	$56.04

Semi-Monthly Deductions

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Aetna DMO	$ 2.90	$ 5.81	$ 6.97	$ 9.87
MetLife PDP A	$ 6.54	$13.09	$15.71	$22.25

MetLife PDP B	$17.85	$35.72	$42.86	$60.72

Annual Deductible And Plan Limits

The deductible is what you pay out of pocket before your dental carrier starts paying its share of your costs. The annual maximum is the most the dental carrier will pay in a year for dental costs. The orthodontia lifetime maximum is the total amount the dental carrier will pay per person.

	AETNA DMO*	METLIFE PDP A	METLIFE PDP B
Annual Deductible (individual/family)	$0	$50/$150	$50/$150
Annual Maximum (in-network shown) (excludes orthodontia)	Not applicable	$1,500 per person	$3,000 per person
Orthodontia Lifetime Maximum (for children up to age 19)	Not applicable	$1,500 per child	$3,000 per child

*Not available in some limited areas. Only the coverage options for which you are eligible will show as options when you enroll online.

	AETNA DMO*	METLIFE PDP A	METLIFE PDP B
Preventive Care (e.g., cleanings, oral exams)	Covered 100%	Covered 100%, no deductible	Covered 100%, no deductible
Basic Restorative Care (e.g., fillings, periodontics)	You pay 10%	You pay 20% after deductible	You pay 10% after deductible
Major Restorative Care (e.g., crowns, bridges, dentures)	You pay 40%	You pay 40% after deductible	You pay 30% after deductible
Orthodontia (for children up to age 19)	You pay 50%	You pay 50%, no deductible, lifetime maximum applies	You pay 50%, no deductible, lifetime maximum applies

*Not available in some limited areas. Only the coverage options for which you are eligible will show as options when you enroll online.

Considering The Aetna DMO?

It may cost less than some of the other dental options, but you must get care from a dentist who participates in the Aetna DMO network. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll. If you don't use an Aetna DMO network dentist, you'll pay for the

full cost of services.

Find Network Providers

- Aetna DMO – www.aetna.com/docfind or 1.800.843.3661
- MetLife PDP – www.metlife.com/dental or 1.877.638.4332

Vision Coverage

See how you can benefit from vision coverage.

The vision plan gives you access to in-network and out-of-network providers.

The vision plan is administered by Vision Service Plan (VSP). You can also contact VSP at 1.800.877.7195.

Helpful hints about your vision benefit option:

- To find VSP providers, go to www.vsp.com, and click Find a Doctor.
- When you schedule your appointment, let them know you are a VSP member and provide the covered member's identification number. When using a network provider, he/she will submit your claim to VSP.
- When using an out-of-network provider, you must submit a claim to VSP for reimbursement.

In-Network Benefits

Eye Exams

- You pay a $10 copay and the plan pays the rest.
- Contact lens exams are covered after a copay. Copay cannot exceed $60.
- Once per calendar year.

Lenses And Frames

- Your copay is $20 for lenses covered under the plan (additional costs may apply for lens enhancements, such as progressive lenses, polycarbonate lenses, or scratch-resistant coating).
- Your copay is $20 for frames, which are then covered up to the $180 plan allowance. There's a 20% discount on the amount over your allowance. Check with your VSP provider for details.
- Please note: When you purchase lenses and frames during the same visit, your total copay is only $20.
- Once per calendar year.

Contact Lenses

- Covered by the plan up to $180 maximum (copay does not apply), elective and in lieu of glasses.
- Contact lens exam (fitting and evaluation) up to $60 maximum copay.

Paying For Coverage

You'll pay the cost of vision coverage with before-tax dollars from your paychecks.

Bi-Weekly Deductions

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
	$ 4.30	$ 6.85	$ 6.91	$ 11.32

Semi-Monthly Deductions

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
	$ 4.66	$ 7.43	$ 7.49	$ 12.26

Critical Illness Insurance

When illness strikes, you can strike back.

If you have a serious health condition, critical illness coverage can help lighten the load.

Critical illness insurance pays a benefit if you or a covered family member is treated for a major medical event or diagnosed with a critical illness. Covered conditions include cancer, heart attack, kidney failure, major organ transplant, stroke, Alzheimer's disease, and many other conditions (some exceptions or limitations such as pre-existing condition exclusions may apply). It is not a replacement for medical coverage.

Why Do You Need It?

Critical illness insurance can provide you with extra cash when a health emergency strikes. Even with medical insurance, you could have to pay a deductible, coinsurance, and costs for any other services that may not be covered (e.g., long-term rehabilitation, home modification).

Critical illness insurance is administered by MetLife. You can also contact MetLife at 1.800.438.6388.

Choose Your Insurance Coverage Level

If you decide you want critical illness insurance for you or you and your family (spouse/domestic partner and children), you may choose from a $15,000 option or $30,000 option.

Things To Consider

When deciding whether to enroll in critical illness insurance, be sure to consider the following:

- Cost per paycheck

  The cost of coverage is based on your age, tobacco use status and the level of coverage you elect. You'll be able to see the cost per paycheck for all your options when you enroll through the YBR website. You pay the cost of coverage with after-tax deductions from your paychecks.

- Your and your family's needs

  Does a serious health condition run in your family? Would you need financial help to o. set the cost of a serious health situation? If you answered "yes" to either question, having critical illness insurance could give you peace of mind. The "initial bene□t" provides a lump-sum payment upon the □rst diagnosis of a covered condition. The plan pays a "recurrence bene□t" for certain covered conditions. For questions, call MetLife at 1.800.638.6420.

- Other coverage

  Consider how critical illness insurance could □t in with other coverage for which you might enroll. Metlife's Critical Illness Insurance is not intended to be a substitute for medical coverage. All persons enrolled must have medical coverage that provides bene□ts for medical treatment, hospitalization, and surgical and medical expense (either through First Data or another eligible medical plan). Critical Illness Insurance does not reimburse for such expenses.

Accident Insurance

Accidents can slam your wallet too.

You may not be able to avoid accidents, but you can avoid part of the cost.

Accident insurance pays you a benefit in the event you or your covered family members are injured in an accident. It is not a replacement for medical coverage. And, unlike accidental death and dismemberment (AD&D) coverage, accident insurance does not require death or serious injury for you to be eligible for a benefit.

Why Would I Enroll In It?

Even with medical coverage, your costs related to an accident can be hefty. Depending on the injury, you may be faced with copays, deductibles, hospital charges, transportation fees, and lodging expenses.

Accident insurance is administered by MetLife. You can also contact MetLife at 1.800.438.6388.

Choose Your Coverage Level

If you decide you want accident insurance, you may choose from a Low Plan and High Plan.

Here are some covered events/services and insurance payments you might receive:
(Certain limitations such as waiting periods, benefit reductions at age 65, and pre-existing condition exclusions may apply.)

Benefit Type	Low Plan–MetLife Pays You	High Plan—MetLife Pays You
Fractures	$50 – $3,000	$100 – $6,000
Second and Third Degree Burns	$50 – $5,000	$100 – $10,000
Ambulance	$200 – $ 750	$300 – $1,000
Hospital Admission (accident)	$500 – $1,000 per accident	$1,000 – $2,000 per accident
Inpatient Rehab (paid per accident)	$100 per day, up to 15 days	$200 per day, up to 15 days
Accidental Death (owner-associate receives 100% of amount shown, spouse receives 50%, and children receive 20% of amount shown)	$25,000 $75,000 for common carrier	$50,000 $150,000 for common carrier

Things To Consider

When deciding whether to enroll in accident insurance, be sure to consider the following:

- Cost per paycheck

The cost of coverage is based on who you cover and your coverage level you elect. You'll be able to see the cost per paycheck when you enroll through the YBR website.*

Bi-Weekly Deductions

	Employee Only	Employee + Spouse	Employee+ Child(ren)	Employee + Family
Low	$3.00	$4.51	$5.76	$7.34
High	$5.73	$8.53	$10.86	$13.99

Semi-Monthly Deductions

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Low	$3.26	$4.89	$6.24	$7.96
High	$6.21	$9.24	$11.76	$15.16

*You pay the cost of coverage with after-tax deductions from your paycheck.

- How does it work with medical insurance?

  If you were to enroll in accident insurance and su. er a broken foot, for example, the plan would pay you an amount to be used for anything you need, including a deductible, coinsurance, or transportation (e.g., expenses to and from the hospital). Metlife's Accident Insurance is not intended to be a substitute for medical coverage. All persons enrolled must have medical coverage that provides bene□ts for medical treatment, hospitalization, and surgical and medical expenses (either through First Data or another eligible medical plan).

Life Insurance

Hope for the best, plan for the worst. Protect your loved ones.

Choose the amount of life insurance coverage that's right for you and your family.

Life insurance protects your family financially in the event of a death. First Data automatically provides basic life insurance for you free of charge.* And, if you decide your family needs more protection, you can buy optional coverage for yourself and dependents.

Life insurance plans are administered by MetLife.

*Federal tax law requires you to pay taxes on the cost of basic life insurance coverage over $50,000. This is called "imputed income" and will be added to your gross taxable income. It will be included on your paychecks and on your Form W-2 each year. The amount of imputed income is based on your age and coverage amount.

Basic Coverage

(You are automatically enrolled and First Data pays 100% of the cost.)

Basic Life Insurance pays benefits if you die.

- Equals one times your annual benefits salary* rounded up to the nearest $1,000.
- Maximum benefit is $1,000,000.

Business Travel Accident Insurance (administered by Chartis) is provided for you when traveling on authorized company business.

- Equals four times your annual benefits salary.
- Maximum benefit is $1,000,000.

*Your annual benefits salary is calculated each year in August for benefits beginning the following January 1, and includes your base compensation and commissions paid between September and August.

Optional Coverage

(You elect the additional coverage and pay the full cost.)

Supplemental Life Insurance pays benefits if you die.

- Choose from one to eight times your annual benefits salary.
- Amount you pay each pay period is based on the coverage option you elect, your age as of January 1, 2019, and your tobacco-user status.
- Certain options may require EOI.

Spouse/Domestic Partner Life Insurance pays benefits if your spouse/domestic partner dies.

- Choose from eight coverage options ($10,000 – $500,000).
- To choose coverage of $50,000 or more, you must be enrolled in Supplemental Life Insurance.
- Coverage over $50,000 is limited to one-half of your Supplemental coverage amount.

- Amount you pay each pay period is based on the spouse/domestic partner coverage option you elect and their age as of January 1, 2019.
- Certain options may require EOI.

Child Life Insurance pays benefits if your child dies.

- Choose from two coverage options ($5,000 or $10,000).
- All eligible children are insured at the same option level.
- You must designate which eligible child(ren) is/are covered on the YBR website.
- Cover a child until the end of the month in which he/she reaches age 19 or, if a full-time student, until the end of the month he/she reaches age 23.
- Amount you pay each pay period depends on the option elected. You pay one price no matter how many children you elect to cover.

Choose Your Beneficiaries

Your family depends on you for all kinds of things—including your pay. Make sure to choose the people and/or estate that should receive your life insurance benefit if you die. It is important you make your beneficiary elections on the YBR enrollment website.

First, gather the Social Security number and birth date for each beneficiary. Then, when you're enrolling in life insurance through the YBR enrollment website, you'll be prompted to designate your beneficiaries.

You can change beneficiaries at any time. If you die and have no beneficiaries on file, the benefit may—or may not—eventually reach the individual(s) you would prefer. The result could be a significant delay in payment during an already challenging time for your loved ones.

Things To Consider

When deciding whether to enroll in supplemental and dependent life insurance coverage, be sure to consider the following:

- Cost per paycheck

  The cost of supplemental life insurance coverage is based on your age, pay, coverage level, and tobacco use. The cost of spouse life insurance coverage is based on your spouse/domestic partner's age and level of coverage. You'll be able to see the cost per paycheck for your options when you enroll through the YBR website. You pay the cost of coverage with after-tax deductions from your paycheck.

- Your family's needs

  Remember that life insurance is intended to help protect your family financially if a covered family member dies. Would you have enough money to pay funeral expenses? Would you need to replace an income? Every situation is di. erent, so consider your family situation carefully.

- EOI Requirements

  In order to buy certain levels of supplemental and dependent life insurance coverage, you'll need to prove that you are in good physical health. This is called providing evidence of insurability (EOI).

If EOI is required, you will get instructions on how to access the form as you complete your enrollment online at YBR (i.e., a message on the Submitted Successfully page). Please fill out the form and submit it promptly by the specified deadline date. Full coverage won't take effect until MetLife approves your coverage request.

If you don't submit the EOI form or it doesn't get approved by MetLife, you'll get the highest level of coverage that doesn't require EOI, if any. For questions, call MetLife at 1.800.638.6420.

You need to provide EOI in the event of the following:

- You want to purchase supplemental life insurance AND you elect supplemental coverage greater than $300,000;
- You want to purchase spouse/domestic partner life insurance AND you elect coverage greater than $50,000; or
- You want to increase your coverage at any point in the future.

Accidental Death and Dismemberment (AD&D) Insurance

Accidents happen. It's a fact of life.

But you can soften the financial impact of an accidental death or injury.

AD&D benefits protect your family financially in the event of a tragic accident. First Data automatically provides basic AD&D coverage for you free of charge. And, if you decide your family needs more protection, you can elect voluntary AD&D coverage.

AD&D plans are administered by Chartis/AIG.

Basic And Voluntary Coverage

Basic AD&D Insurance pays benefits if you die or su. er a covered loss as the result of an accident.

- Equals one times your annual bene□ts salary rounded up to the nearest $1,000.
- Maximum bene□t is $1,000,000.

Voluntary AD&D Insurance pays bene□ts if you (your spouse, or your children, if applicable) die or suffer a covered loss as the result of an accident.

- Choose from 19 coverage options ($25,000 to $1,000,000); coverage can be up to 10 times your annual bene□ts salary limited to $1,000,000.
- Choose from two coverage categories (employee only, or employee plus family).
- Cover a child until the end of the month in which he/she reaches age 19, or, if a full-time student, until the end of the month he/she reaches age 23.

Choose Your Bene**fi**ciaries

Your family depends on you for all kinds of things—including your pay. Make sure to choose the people and/or estate that should receive your life insurance bene□t if you die. It is important you make your bene□ciary elections on the YBR enrollment website.

First, gather the Social Security number and birth date for each bene□ciary. Then, when you're enrolling in life insurance through the YBR enrollment website, you'll be prompted to designate your bene□ciaries.

You can change bene□ciaries at any time. If you die and have no bene□ciaries on □le, the bene□t may—or may not—eventually reach the individual(s) you would prefer. The result could be a signi□cant delay in payment during an already challenging time for your loved ones.

Things To Consider

When deciding whether to enroll in voluntary AD&D for you or you and your family, be sure to consider the following:

- Cost per paycheck

The cost of voluntary AD&D coverage is based on level of coverage you elect, and the coverage option you elect. You'll be able to see the cost per paycheck for your election when you enroll through the YBR website. You pay the cost of coverage with after-tax deductions from your paycheck. You are automatically enrolled in basic AD&D coverage, with First Data paying 100% of the cost.

- Your life insurance election(s)

  Remember that basic and voluntary AD&D coverage is intended to help protect your family □nancially if you or a covered family member dies or suffers a serious injury resulting from an accident. Because AD&D only pays a bene□t in the event of an accident or death, it is not a substitute for life insurance.

Disability

Peace of mind when you are disabled and can't work.

Could you pay your bills if an illness or injury prevented you from working? Disability bene. ts can help.

Long-term disability insurance coverage is administered by MetLife.

Long-Term Disability (LTD)

It is designed to replace a percentage of your earnings if you become disabled and unable to work. First Data automatically provides basic LTD (50%) coverage for you free of charge. You have the option to buy additional voluntary LTD (60%) coverage for more income protection.

Voluntary LTD Coverage

You are automatically enrolled in voluntary LTD coverage resulting in nonrefundable payroll deductions. If you do not want the additional voluntary LTD coverage, you must affirmatively elect the basic LTD coverage (which is at no cost to you) during enrollment at the YBR website.

You do not need to complete an EOI for the voluntary LTD coverage; however, the plan may limit the benefit paid if you received treatment or were diagnosed for a condition in the three-month period before your coverage start date.

Coverage Highlights

Basic LTD Insurance—First Data pays 100% of the cost.

- Equals 50% of your annual benefits salary.
- Minimum benefit is $100 per month.
- Maximum benefit is $15,000 per month.

Voluntary LTD Insurance—You pay for additional LTD coverage with after-tax dollars from your paychecks. Your rate is based on your annual benefit salary.

- Additional 10% buy-up on the Basic LTD coverage (total benefit is 60% of your annual benefit salary).
- Minimum benefit is $100 per month.
- Maximum benefit is $18,000 per month.

Things To Consider

When deciding whether to enroll in additional voluntary LTD coverage, be sure to consider the following:

- Cost per paycheck

  You'll be able to see the cost per paycheck of voluntary LTD when you enroll through the YBR website. You pay the cost of coverage with after-tax deductions from your paycheck.

- Other income sources

  If you were unable to work, would other sources of income be available to you, such as Social Security or Workers' Compensation. If so, the LTD benefit is reduced, by the amount received under those plans. However, in no case would you receive less than the $100 per month minimum benefit level.

- Taxes

  Benefits paid to you from the basic LTD benefit are subject to federal and state taxes. That means these taxes will be deducted from disability benefit checks from MetLife. Since you pay voluntary LTD with after-tax paycheck dollars, that portion of your LTD benefit is not considered taxable income.

- EOI Requirements

  If you are currently enrolled in the basic LTD level and want to increase your LTD coverage in a future enrollment period, you will need to prove that you are in good physical health. This is called providing evidence of insurability (EOI).

Legal Plan

Legal advice doesn't have to break the bank.

You have an a. ordable way to get help with your personal legal needs.

You don't want to spend a fortune to get legal advice when you need it. Legal services offers a network of attorneys who can help with divorce and separation, creating or updating a will, real estate matters, tax audits, document preparation, and more.

If you use a network attorney, you don't pay any fees, deductibles, or copays. For a complete list of network attorneys and covered services, go to www.araglegalcenter.com or call the ARAG Group at 1.800.247.4184. Plan members also have access to online legal tools and resources, including a law guide, do-it-yourself document library, and a list of network attorneys.

Things To Consider

When deciding whether to enroll in the legal plan, be sure to consider the following:

- Cost per paycheck

  If you expect to need legal services, the cost of the legal plan coverage could be less than if you paid an in-network attorney directly. You pay the full cost of coverage with after-tax dollars deducted from your paychecks.

  Your 2019 rate is $7.38 (bi-weekly) or $8.00 (semi-monthly).

- Network and out-of-network attorneys

  You must see an in-network attorney for services to receive the maximum coverage. When you select an out-of-network attorney, the plan pays fees according to a set fee schedule.

For any legal matter that occurs or is initiated prior to coverage in the plan, coverage will be excluded and no bene□ts will apply.

How to Enroll

Log on to Your Benefits Resources at https://www.firstdatabenefits.us to enroll in your benefits for 2019.

Logging on for the first time? From Your Benefits Resources, register as a new user and follow the prompts to provide requested information and set up your username and password.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success after you enroll.

In the weeks following your enrollment, you could be asked to complete a short, confidential survey about your enrollment experience. The survey will be sent from an Aon email address. Please take a few minutes to share your thoughts and help us improve your experience.

Questions?

Start with the Frequently Asked Questions (PDF). When you enroll, customer service representatives will be available at First Data's Health and Life Help Desk from 9:00 a.m. to 7:00 p.m. ET, Monday through Friday, to answer questions. Just call 1.800.965.2238.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do now to use your bene. ts successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

Your prescription drug coverage is provided through your medical insurance carrier's pharmacy benefits manager, who sets the rules for how medications are covered.

The pharmacy benefit manager could be a separate prescription drug company. Owner-associates who enroll under Aetna, Cigna, or UntedHealthcare will have their pharmacy benefits managed by CVS Caremark.

Don't be caught by surprise! Visit your carrier's website for information about your medications. And, check out the Prescription Drug Transition Worksheet (PDF) for tips and questions you may need to ask your carrier.

Is your medication on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. Check with your carrier to make sure your drug is listed on the formulary before you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they typically cost less. And, because brand name drugs are so expensive, some pharmacy benefit managers don't cover them at all if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new pharmacy benefit manager, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized! Print the Prescription Drug Transition Worksheet (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your new medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, call customer service at your new medical insurance carrier as soon as possible to ask for help with "transition of care."

Give your new insurance carrier information about your treatment and the providers you use today.

Track your to-dos and get organized! Print the Medical Transition of Care Worksheet (PDF).

Avoid Unexpected Out-Of-Network Costs

It's very important to know whether your doctor participates in your medical insurance carrier's network.

You Could Pay a Lot More for Out-of-Network Care

Your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 40% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 40% of $2,000 and 100% of the remaining $3,000, for a total of $3,800.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 40% of $3,000 and 100% of the remaining $2,000, for a total of $3,200.

Take These Steps to Protect Yourself

If you didn't check your doctor's status before you enrolled or you want to look up a di. erent doctor, do it now—before making an appointment with that doctor.

You can check the provider directory through Your Benefits Resources at https://www.□rstdatabene□ts.us or your medical insurance carrier's website.

Important! Do not rely on your provider's office to know the carriers' network(s). If you have any uncertainty or, for instance, you will cover out-of-area dependents, you need to call the insurance carrier to confirm whether a provider participates in a carrier's network.

Even if you're keeping the same insurance carrier, the provider network could be different. Always check the provider directories before making a decision.

If your doctor is out-of-network and you still want to see him or her, check the cost with your doctor before you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you'll be responsible. That way you'll be prepared for any potentially significant costs.

When To Expect New Cards

You'll receive a new ID card when you enroll for the first time or change insurance carriers or coverage levels. You'll use your ID card for medical and prescription drug needs.

For questions about ID cards, contact the insurance carrier. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze, Bronze Plus, or Silver option, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing debit card. New money added to your account will be accessible through your current debit card.

HSA vs. FSA: Which One Should You Use?
Heads up: If you enrolled in an HSA and a Health Care Flexible Spending Account (FSA), you will use the same debit card for both accounts. And PayFlex will automatically follow IRS guidelines on how to use each account. So when you use the debit card to pay for medical, dental, or vision expenses, the expense will automatically be deducted from the correct account.

Your HSA can be used for medical, dental, and vision expenses.

Your Health Care FSA will be "limited purpose" and can only be used to pay for eligible dental and vision expenses.

If you currently have money in a Health Care FSA, use it before you begin contributing to your HSA.

Want to Print?
Track your to-dos and get organized! Print these worksheets and get a step-by-step guide to what to do and what to ask as you get ready to use your new plan.

Prescription Drug Transition Worksheet (PDF)
Medical Transition of Care Worksheet (PDF)

How to Get Care

When you get care, it helps to know what you can expect:

Getting Care At The Doctor's O. ce

Present your medical ID card at your doctor's o. ce to get discounted rates. Ask your doctor to file a claim with your insurance carrier and bill you after the carrier processes the claim.

Have an HSA?
Don't present your HSA debit card at the doctor's office—just your medical ID card! Wait to pay until you get your doctor's bill. Then, you can use your HSA or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical or prescription drug ID card each time you drop off a prescription. If payment is due, you pay out of pocket. Or you can pay with your HSA if you have one.

Know When You'll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you'll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You'll Pay Less With In-Network Providers

You can check the provider directory on Your Benefits Resources at https://www.firstdatabenefits.us or refer to your insurance carrier's website.

If a doctor is out-of-network and you still want to see him or her, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you'll be prepared for any potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying For Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay a lot less when you see in-network providers. You can check the provider directory on Your Benefits Resources at https://www.firstdatabenefits.us or refer to your insurance carrier's website.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical Or Prescription Drug ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is not a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket. Or, if you have an HSA, you can use your HSA to pay for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze, Bronze Plus, or Silver plan. When it's time for you to pay for care or prescription drugs, your HSA gives you options.

Use Your HSA Debit Card

Just swipe it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card on eligible expenses, and that you have enough money in your HSA to cover it.

Log on to PayFlex's website at www.pay. ex.com to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to PayFlex's website at www.payflex.com to transfer money from your HSA to your regular bank account. If you need help with this, contact PayFlex at 1.800.284.4885.

Set Up Direct Payments

Another option is to have PayFlex make direct payments to your provider from your HSA. Log on to Your Benefits Resources at https://www.firstdatabenefits.us to set up direct payments.

Eligible Expenses

You can find a complete list of eligible expenses at https://www.irs.gov/publications/p502.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Learn more in the HSA User's Guide (PDF).

Contacts

Need Help Enrolling?
Customer service representatives at First Data's Health and Life Help Desk are available from 9:00 a.m. to 7:00 p.m. ET, Monday through Friday, to answer questions. Call 1.800.965.2238.

Questions About Coverage?
Start by contacting the medical insurance carriers directly. They know their coverage rules best.

Have an Issue or Need More Help?
Advocates are available through First Data's Health and Life Help Desk at 1.800.965.2238 to assist with tough issues like claims and billing disputes. Representatives are available from 9:00 a.m. to 7:00 p.m. ET.

If you enrolled in a Bronze, Bronze Plus, or Silver medical plan, check out the HSA User's Guide (PDF) for additional contacts during the year.

Discover your carrier options

Insurance carriers are competing for your business, but which will best meet your needs? Check out the unique features and services offered by each carrier. You might be surprised by what you discover.

Medical

Carrier Name: Aetna

Areas We Serve: O. ered in all states except AK, ID, MT, WY and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/si

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Pharmacy Contact (CVS Caremark): 1.844.345.2793

Who We Are: We're not just a health insurance company. We're a health company that understands your health is about more than just coverage and costs. That's why we offer you personalized, easy-to-access care. Plus, resources that can help you achieve your health ambitions.

Learn More

Carrier Name: Cigna

Areas We Serve: Generally offered in all states except MN and ND. Availability in some states may be limited.

Before you're a member (preview site): http://www.cigna.com/aonactivehealth-withyou-2019

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna One Guides are available Monday - Friday: 8:00 am - 9:00 pm (all US continental time zones)
Outside of the standard hours, customer service advocates are available 24 hours a day, 7 days a week.

Phone Number: 1.855.694.9638

Pharmacy Contact (CVS Caremark): 1.844.345.2793

Who We Are: A healthy partnership starts here. Cigna is ready to help with the support you need, when and how you need it. Offered by Cigna Health and Life Insurance Company or its affiliates.

Learn More

Carrier Name: Dean/Prevea360

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours: Mon - Thurs: 7:30 a.m. - 5:00 p.m. CST
Friday: 8:00 a.m. - 4:30 p.m CST

Phone Number: 1.877.232.9375

Who We Are: With access to more than 4,000 practitioners and close to 200 primary care sites and 28 hospitals, Dean Health Plan connects a strong network of health care providers, innovative

hospitals, and comprehensive insurance coverage into one integrated health care system working for you.

Learn More

Carrier Name: Geisinger Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://geisinger.org/aon

Once you're a member (website): https://www.geisinger.org/member-portal

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m EST

Phone Number: 1.844.390.8332

Who We Are: Choosing a good health insurance plan is more important than ever. With Geisinger Health Plan, we cover the services you need and help you stay healthy by better managing your healthcare needs.

Learn More

Carrier Name: Health Net

Areas We Serve: Oregon and select markets in California

Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PT

Phone Number: 1.888.926.1692

Who We Are: Health Net helps you get the right care at the right price.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): http://www.kp.org

Customer Service Hours: CA: 24/7 except holidays
CO: Mon - Fri: 8:00 a.m. - 5:00 p.m. CST
GA: Mon - Fri: 7:00 a.m. - 9:00 p.m. EST
Sat - Sun: 8:00 a.m. - 2:00p.m. EST
DC, MD, VA: Mon - Fri: 7:30 a.m. - 5:30 p.m. EST
OR and southwest WA: Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number: 1.877.580.6125CA Post-enrollment: 1.800.464.4000
CO Post-enrollment: 1.303.338.3800
GA Post-enrollment: 1.404.261.2590
DC, MD, VA Post-enrollment: 1.800.777.7902
OR and southwest WA Post-enrollment: 1.800.813.2000

Pre-enrollment Phone Number: 1.877.580.6125

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/wa/aonactivehealth

Once you're a member (website): https://wa-member.kaiserpermanente.org

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PST

Phone Number: 1.855.407.0900

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://welcometouhc.com/aon1

Once you're a member (website): http://myuhc.com

Customer Service Hours: Customer Care Center:
Monday - Friday: 7:00 a.m. - 7:00 p.m. EST
Transaction Center: Monday - Friday: 8:00 a.m. - 5:00 p.m. PT

Phone Number: 1.888.297.0878

Pharmacy Contact (CVS Caremark): 1.844.345.2793

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: UPMC Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours: Monday-Friday: 7:00 a.m. - 7:00 p.m. EST Saturday: 8:00 a.m. - 3:00 p.m. EST

Phone Number: 1.844.252.0690

Who We Are: Here's the plan for getting the high-quality care you and your family deserve: Choose UPMC Health Plan. When you do, you can expect the best.

Learn More

Get Carrier Ratings

See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available on Your Benefits Resources at https://www.firstdatabenefits.us during enrollment and throughout the year.

* Your specific medical options are based on where you live. You'll be able to see the options available to you when you enroll. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: Coverage may

be slightly different than the Silver option on this site. Refer to Your Benefits Resources for details.)

Contact an Advocate

Have questions about your claims or coverage? Start by contacting your medical insurance carrier directly. They know their coverage rules best and have the final say on all claims and billing disputes.

Sometimes you need more help than your insurance carrier can provide. If you have a billing issue, such as your provider charging you more than the amount your EOB says you owe, or you believe your plan covers more than what your EOB shows, advocates are available through First Data's Health and Life Help Desk. They are experts in handling claims and billing disputes and can work with you on your behalf to resolve issues. Find more information about advocates here.

If you aren't satisfied with the resolution of a claim or billing dispute, you can file an appeal through your insurance carrier, who will be able to direct you through that process.

Questions?

Don't worry. You have backups. When you face a billing issue:

1. Start with your insurance carrier.
2. Contact First Data's Health and Life Help Desk at 1.800.965.2238 to connect with an advocate if you need help.
3. File an appeal if you're unhappy with the final outcome.

Get the Answers

Have a question? We've got you covered.

Start with the Frequently Asked Questions (PDF).

Wondering what something means? Check out the Glossary.

Just want to talk to a real person? No sweat! Here's who to contact.

Glossary

Wondering what a term means? Find it here!

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Coverage Level
A benefit level that determines how services are covered.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. How the deductible works depends on your coverage level. Out-of-network charges do not count toward your in-network annual deductible. They only count toward your out-of-network deductible.

EOB
Also known as an Explanation of Benefits. An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
A list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and e. ective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for quali□ed health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. How the out-of-pocket maximum works depends on your coverage level. Out-of-network charges do not count toward your in-network annual out-of-pocket maximum. They only count toward your out-of-network out-of-pocket maximum.

Payroll Contribution
The amount deducted from your paycheck on a pre-tax basis to cover your share of health care bene□t costs.

Pharmacy Bene**fi**t Manager
The insurance carrier or third-party administrator who manages your retail and mail-order prescription drug bene□t.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a speci□c area for a speci□c service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying bene□ts for that family member.

Traditional Out-of-Pocket Maximum
Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

True Family Deductible
The entire family deductible must be met before your insurance will pay bene□ts for any covered family member.

True Family Out-of-Pocket Maximum
The entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

New to the Company?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in First Data benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2019 benefits, you can start here:

- Quick Guide (PDF)
- Compare Costs (use the access code provided in recent communications)
- Medical

Need To Enroll For 2018 And 2019 Benefits?

If you’re enrolling in benefits for the rest of 2018 and all of 2019, you should know what to expect for both years. While most things don’t change from year to year, some things could be di. erent.

For your 2018 bene□ts, you can start here:

- Benefits Guide (PDF)
- Compare Costs (use the access code provided in recent communications)
- What's Changing for 2019 (PDF) (see what’s different from 2018 to 2019)

Make It Yours

Once you’ve done your homework, if you want coverage through First Data, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug coverage through First Data for you and your family.

Enroll now

Questions?

Check out the Frequently Asked Questions (PDF) for more details.

Helpful Documents

General Resources

- First Data Benefits Website (find information and enroll in First Data's Health and Life Benefits through Your Benefits Resources)
- Benefits At-a-Glance (PDF)
- Quick Guide (PDF)

Legal Documents

- Summary of Benefits and Coverage - Medical Carriers (PDF)
- Legal Notices (PDF)