Way Station Inc.

Benefit Guide

January 1, 2018 through June 30, 2018

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Important Contact Information

PRODUCTS		
MEDICAL Allegeant / CareFirst PPO (in MD, DC, N. VA) / PHCS (outside of CareFirst area)	www.myallegeant.com (after you have enrolled) To find a doctor (see "Medical/Rx Plan" section for detailed instructions): CareFirst www.carefirst.com PHCS www.multiplan.com	1-800-553-8635
RX Magellan Rx	www.magellanrx.com	1-800-424-0472
VISION VSP	www.vsp.com	1-800-877-7195
DENTAL MetLife	www.metlife.com/dental	1-800-275-4638
FSA/HRA Choice Strategies	www.choice-strategies.com	1-888-278-2555 x2
BASIC LIFE / AD&D, SUPP LIFE / AD&D, STD The Hartford	www.thehartford.com	
CRITICAL ILLNESS, ACCIDENT Unum	www.unum.com	1-800-635-5597 x1
ABILITY ASSIST COUNSELING SERVICES The Hartford (disability only)	www.Guidanceresourcescom	1-800-964-3577
FUNERAL PLANNING AND CONCIERGE SERVICES The Hartford (life only)	www.everestfuneral.com/hartford	1-866-854-5429
TRAVEL ASSISTANCE AND ID THEFT SERVICES The Hartford	Thehartford.com/employeebenefits	1-800-243-6108
ESTATE GUIDANCE The Hartford (life only)	www.estateguidance.com/wills	

The Human Resources Team

KIMBERLY LUNDY
- Chief of Human Resources
- klundy@waystationinc.org
- 301-662-0099 ext. 1015

RACHEL CHRISTENSEN
- Training, Mileage Sheets
- rchristensen@waystationinc.org
- 301-662-0099 ext. 1017

MARGARET WATERFIELD
- Employee Recruitment
- mwaterfield@waystationinc.org
- 301-662-0099 ext. 1021

DAWN MURPHY
- Employee Changes
- dmurphy@waystationinc.org
- 301-662-0099 ext. 1016

STEVEN SMITH
- Benefits
- ssmith@waystationinc.org
- 301-662-0099 ext. 1018

TRICIA FORCHETTI
- Employee Recruitment
- tforchetti@waystationinc.org
- 301-662-0099 ext. 1246

TERESA JAINNINEY
- Washington County HR
- tjainniney@waystationinc.org
- 301-733-6063 ext. 8249

BEVERLY FOSTER
- Howard County HR
- bfoster@waystationinc.org
- 410-740-1901 ext. 7730

MELIANIE JOYNES, CPP
- Payroll
- mjoynes@waystationinc.org
- 301-662-0099 ext. 1019

Welcome

Employee benefits is the second largest cost, behind payroll, for most companies. Providing our employees with the very best benefits at an affordable cost is a responsibility we take very seriously. This year, we took some important steps to ensure that we will be able to provide our employees a highly competitive benefit package with a fair and equitable employee premium co-share for many years to come. In October 2017, Cigna increased our premiums by 35%. This was unacceptable for all of us. As an affiliate of the Sheppard Pratt Health System, we are able to join their self-funded health plan. This is a terrific opportunity for our two organizations to work together in maintaining affordable, high-quality health care for all of our employees.

Sincerely,

Kimberly Lundy
Chief of Human Resources

Way Station Inc.

How to Use This Guide

This benefit guide serves as a summary of your employer's entire health and welfare package. For detailed descriptions of each of the products outlined in this guide, please go to www.waystationbenefits.org for Certificates of Coverage, Plan Documents, or Plan Policies.

Eligibility

If you are a regular, active employee working at least 30 hours per week, you are eligible for the benefits described in this guide. Most coverage is effective on the 1st day of the month following the Employee's completion of 30 days of continuous employment from date of hire.

Eligible dependents include:

- Your legally married spouse or domestic partner.
- Your dependent children are eligible to participate until the end of the calendar year that they then turn age 26, regardless of their marital and/or student status.
- Your disabled children of any age provided the incapacity commenced before age 26.

Section 125

Certain benefits described in this guide may be purchased with pre-tax payroll deductions as permitted by Section 125 of the Internal Revenue Code. When you purchase benefits with pre-tax dollars, you reduce your taxable income, so fewer taxes are taken out of your paycheck. You can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis, you are certifying that the dependent meets the IRS' definition of a dependent [IRC §§ 152, 21(b)(1) and 105(b)]. Dependents that do not satisfy the IRS' definition will result in a tax liability to you receiving imputed income for the ineligible dependent's pre-tax coverage.

Benefit Changes

The benefit elections you make during Open Enrollment will remain in effect for the short plan year (**1/1/2018 through 6/30/2018**). You will not be able to change or revoke your elections once they have been made unless a life event (status change) occurs.

Changes can be made to your medical, dental, vision, disability and life insurance when you experience a qualifying Life Status Change. In order to be permitted to make a change of election relating to your coverage due to a Status Change, the change must result in you or your spouse/domestic partner, dependent gaining or losing coverage under this Plan or a plan sponsored by another employer by whom you, your spouse/domestic partner or dependent are employed. The election change must correspond with that gain or loss of coverage. Qualifying Life Status Changes include:

- Your marital status changes through marriage, the death of your spouse/domestic partner, divorce, legal separation or annulment;
- Your number of dependents changes through birth, adoption, placement for adoption or death of a dependent;
- You, your spouse/domestic partner or dependents terminate or begin employment;
- You, your spouse/domestic partner or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment);
- Gain or loss of coverage under a plan offered by your employer or your spouse/domestic partner's employer;
- Your dependent is no longer eligible due to attainment of age, student status, or similar circumstance;
- A change in residence for you, your spouse/domestic partner or your dependent resulting in a gain or loss of coverage.

You may also be permitted to change your elections for health coverage under the following circumstances:

- You or your spouse/domestic partner experience(s) a significant change in health coverage attributable to your spouse/domestic partner's employment (not applicable to Healthcare FSAs).
- There is a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody including a qualified medical child support order (as defined in ERISA) that requires accident or health coverage for an employee's child. The employee can change his or her election to:
    1. Provide coverage for the child if the order requires coverage under the employee's plan; or,
    2. Cancel coverage for the child if the order requires the former spouse to provide coverage.
- You, your spouse/domestic partner or dependent become entitled to Medicare or Medicaid;
- You have a Special Enrollment Right.

For purposes of all other benefits under the Plan you will be deemed to have a Status Change if the change is on account of and consistent with a change in Family Status, as determined by the Plan Administrator, in his/her discretion, under applicable law and the Plan provisions.

You must notify the HR Department within 30 days of any Status Change in order to make a change to your Benefits elections, except as outlined in the Notice Regarding Special Enrollment Rights.

Medical/Rx Plan

Way Station Inc. (WSI) is joining the Sheppard Pratt Health System's (SPHS) health plan. The SPHS health plan is administered by Allegeant. Because SPHS is self-insured for medical and prescription coverage, Allegeant functions as our third-party administrator. They provide claims administration and customer service for our health plan.

In-Network Providers

Through Allegeant, SPHS members have access to the CareFirst BlueCross BlueShield (CFBCBS) Regional Provider Network in the Maryland, Washington DC, and Northern Virginia service area and PHCS outside of the CareFirst service area. Network providers are doctors, hospitals, and other health care providers who have contracted with CareFirst or PHCS. They have agreed to honor your medical ID card and to bill Allegeant directly for services rendered. They have also agreed to accept the network's allowed amount. You benefit because your out-of-pocket costs are kept to a minimum.

If you live in the CareFirst service area, you can locate a provider at www.carefirst.com, click "Find a Doctor"; then select "CareFirst – Network Leasing" under *Other Sites;* under "Type of Care", choose "Medical" or "Mental Health"; then enter your search parameters. If you live outside the CareFirst service area, you can locate a provider at www.multiplan.com; click "Search for a Doctor or Facility"; click on the PHCS logo that corresponds with the back of your ID card, click "continue"; then enter your search parameters. Provider information can also be obtained by contacting Allegeant at 1-800-553-8635.

Once you are enrolled in the SPHS health plan, sign up for www.myallegeant.com so you can locate a provider, view claims and EOBs, order ID cards, and more.

Out-of-Network Providers

If you choose to use an out-of-network medical provider, you will be responsible for the higher out-of-network deductible and coinsurance, since your provider is non-participating. Non-participating providers have no contractual status with CareFirst or PHCS and may not be reimbursed directly by Allegeant. You may be responsible for paying your provider in full, and then you are reimbursed directly by Allegeant based on the "usual, customary and reasonable charges" (UCR) for the services rendered.

Employees have access to a "wrap" network provided by Multiplan for discount out-of-network benefits. This means that if your provider does not participate with CareFirst or PHCS, then he or she may participate with Multiplan. If you choose a Multiplan provider, although they will be considered out-of-network, your out-of-pocket costs will be reduced because these providers accept the allowed amount. Once you are enrolled, you can locate a Multiplan provider at www.myallegeant.com under "Find a Doctor", select the Multiplan network. Provider information can also be obtained by contacting Allegeant at 1-800-553-8635.

Pre-Certification Guidelines

Pre-certification is required for several benefits, please see the Summary of Medical Benefits below. Your physician may handle this on your behalf, but it is your responsibility to confirm that authorization has been made. Requests for pre-certification can be made by calling the number on the back of your medical ID card.

Your Prescription Drug Coverage will be provided through Magellan RX if you are enrolled in the health plan. The cost of the prescription benefit is included in your health plan premium.

Summary of Medical Benefits

Claim Administrator:	Allegeant LLC
Member Services:	Allegeant LLC
PPO Network(s):	CFBCBS Regional Provider Network (MD, DC, N. VA) and/or PHCS (outside of MD, DC, N. VA)
Eligibility:	Active full-time employees working at least 30 hours / week

	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
PLAN YEAR DEDUCTIBLE	$2,000 Individual / $4,000 Family	$4,000 Individual / $8,000 Family
PLAN YEAR OUT-OF-POCKET MAXIMUM	$4,000 Individual / $8,000 Family	$8,000 Individual / $16,000 Family
Eligible deductible and out-of-pocket expenses apply to both the in-network and out-of-network limits. Copays do not apply to the deductible. Expenses for penalties for non-certification of hospital admissions, non-covered services, and charges in excess of usual & customary do not apply toward the out-of-pocket limit. Deductible payments do count toward the Out-of-Pocket Maximum. Medical and prescription copays and coinsurance count toward the out-of-pocket maximum.		
FACILITY CHARGES		
Inpatient Hospital*	100% of AA after deductible	60% of AA after deductible
Emergency Room	100% of AA after deductible	100% of AA after deductible
Urgent Care	$40 copay, then 100% of AA after deductible	60% of AA after deductible
Outpatient Surgery (*pre-cert required for biopsy*)	100% of AA after deductible	60% of AA after deductible
Outpatient Diagnostic/X-ray/Laboratory	100% of AA after deductible	60% of AA after deductible
Extended Care Facility (*maximum of 60 days per plan year*)*	100% of AA after deductible	60% of AA after deductible
Hospice Care (*inpatient maximum of 30 days*)	100% of AA after deductible	60% of AA after deductible
Outpatient Therapy (*Physical, Speech, Occupational combined maximum of 60 visits per plan year*)	100% of AA after deductible	60% of AA after deductible
PRIMARY CARE & WELL CARE CHARGES		
Office Services	$20 copay, then 100% of AA after deductible	60% of AA after deductible
Inpatient Hospital Visits PCP	100% of AA after deductible	60% of AA after deductible
Adult & Child Preventative Care Services (*Exam/Visit, X-Ray & Lab, Immunizations, Screenings*)	100% of AA	Not covered
Routine GYN exam	100% of AA	Not covered
Routine Screenings (*Mammogram, Pap Smear, Colonoscopy, Prostate*)	100% of AA	Not covered
Women's Preventive Services (*Well Women Preventive care, Human papillomavirus testing, Contraception, Prenatal visits, screening and counseling*)	100% of AA	Not covered
SPECIALIST CHARGES		
Specialty Physician's Office Services	$40 copay, 100% of AA after deductible	60% of AA after deductible
Surgeon – Inpatient or Outpatient	100% of AA after deductible	60% of AA after deductible
Anesthesia – Inpatient or Outpatient	100% of AA after deductible	60% of AA after deductible
Outpatient Therapy (*Chemotherapy, Radiation, Renal Dialysis*) *	100% of AA after deductible	60% of AA after deductible
Inpatient Hospital Visits Specialists	100% of AA after deductible	60% of AA after deductible
Chiropractor (*maximum 10 visits per plan year*)	100% of AA after deductible	60% of AA after deductible
Acupuncture (*maximum 10 visits per plan year*)	100% of AA after deductible	60% of AA after deductible
Outpatient Therapy (*Physical, Speech, Occupational combined maximum of 60 visits per plan year*)	100% of AA after deductible	60% of AA after deductible
Outpatient Diagnostic X-ray or Laboratory	100% of AA after deductible	60% of AA after deductible
OTHER FACILITY AND/OR PROFESSIONAL CHARGES		
Emergency Room Physicians	100% of AA after deductible	100% of AA after deductible
Infusion - Home, Office or Outpatient*	100% of AA after deductible	60% of AA after deductible
Home Health Care (*maximum 40 visits per plan year*)	100% of AA after deductible	60% of AA after deductible
Durable Medical Equipment/Prosthetic Devices (*plan year max of $2,500 for all DME, then precertification required*)	100% of AA after deductible	60% of AA after deductible
Ambulance Service	100% of AA after deductible	100% of AA after deductible

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS**		
Inpatient Hospital*	100% of AA after deductible	60% of AA after deductible
Hospital Visits by Physicians	100% of AA after deductible	60% of AA after deductible
Outpatient facility/visit (*precertification required on intensive outpatient services*)	100% of AA after deductible	60% of AA after deductible
Psychiatric Partial Hospitalization	100% of AA after deductible	60% of AA after deductible

AA= Allowed Amount *Precertification Required

** Applicable copay or coinsurance for inpatient and outpatient network benefits will be waived when provided by Sheppard Pratt Health System, Sheppard Pratt Physicians, P.A., Family Services, Inc., Mosaic Community Services or Way Station, Inc. mental health providers

SUMMARY OF BENEFITS: This is an overview only. Refer to actual summary plan document (SPD) for full description, rules and/or exceptions.

Summary of Rx Benefits

Your Prescription Drug Coverage will be provided through Magellan RX if you are enrolled in our health plan. The cost of the prescription benefit is included in your health plan premium.

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Combined Medical and Rx Deductible, Per Plan Year		
Per Individual	$2,000	$4,000
Per Family	$4,000	$8,000
Combined Medical and Rx Out-of-Pocket Maximum, Per Plan Year		
Per Individual	$4,000	$8,000
Per Family	$8,000	$16,000
	RETAIL BENEFITS (34 day supply)	**MAIL ORDER (90 day supply)**
Generic Drugs*	$5 copay after deductible	$10 copay after deductible
Brand Preferred Drugs	$30 copay after deductible	$60 copay after deductible
Brand Non-Preferred Drugs	$60 copay after deductible	$120 copay after deductible
Specialty Drugs	20% coinsurance after deductible to a maximum of $100	20% coinsurance after deductible to a maximum of $100
Contraceptive Methods Under expanded Women's Preventative Services including oral, injections and devices; includes all generics, certain brand name drugs and approved over-the-counter contraceptives	$0 copay (not subject to deductible; requires prescription from physician for OTC contraceptives)	
Preventative OTC and Prescription Drugs Certain drugs covered under the Patient Protection and Affordable Care Act (ACA), such as Aspirin, Iron Supplements, Oral Fluorides, Folic Acid, Smoking Cessation and Vaccines based on age, sex and diagnosis are covered. Call Magellan RX at 1-800-424-0472 for a complete list.	$0 copay (not subject to deductible; requires prescription from physician)	

*Certain generic prevention drugs to protect against or manage a medical condition relating to blood pressure, asthma, cholesterol, diabetes therapy, osteoporosis therapy and stroke are not subject to the deductible but subject to the co-payments only. A list of these drugs can be found on www.magellanrx.com or by calling Magellan Rx at 800-424-0472.

Vision Plan

Carrier:	Vision Service Provider (VSP)
Eligibility:	Active full-time employees working at least 30 hours / week
Contribution:	Included with your health premium
ID Card:	No ID card – just tell your doctor that you have VSP

Since health and vision are bundled together, WSI will also integrate its vision plan with SPHS. VSP manages the SPHS vision plan. The VSP network is the exact same as Cigna Vision, in fact, Cigna leases VSPs vision network, so you will have little to no disruption.

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you**. The decision is yours to make—choose a VSP provider or any out-of-network provider. To find a VSP provider, visit www.vsp.com or call 800.877.7195.
- **At your appointment, tell them you have VSP**. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

There are no claim forms to complete when you see a VSP provider.

Summary of Vision Benefits

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
SERVICE FREQUENCY (in months)		
Exams/Lenses/Frames	One each per 12 month period	
EYE EXAMINATION		
Well Vision Exam	$15 copay, then covered in full	$15 copay, covered up to $50
PRESCRIPTION GLASSES		
Frame	$25 copay applies to a frame if lenses are not purchased. The frame of your choice is covered up to $150.	$25 copay applies to a frame if lenses are not purchased. The frame is covered up to $70.
Lenses • Single Vision • Bi-focal • Tri-focal	$25 copay applies to lenses and a frame: • Covered in full • Covered in full • Covered in full Frame is covered up to $150	$25 copay applies to lenses and a frame: • Covered up to $50 • Covered up to $75 • Covered up to $100 Frame is covered up to $70
Contacts (instead of glasses)	$60 copay (max) for lens fitting and evaluation exam. Lenses covered in full up to $130.	Lens fitting and evaluation exam and lenses covered in full up to $105

Wellness – Way Station "Healthy Incentive" Program

$5 per pay discount on health plan premium (available to all health plan enrollees)

In an effort to encourage a healthy lifestyle and manage costs for all, Way Station, Inc. (WSI) has developed a Healthy Incentive Program for staff enrolled in any of the (2) Health Plans offered. This is a voluntary program offered by WSI to help control the rising costs of health coverage and to encourage healthy habits for employees and their families. We believe the Healthy Incentive Program will enhance physical, emotional, and intellectual health of our employees and their families through various means of awareness, education and healthy programs. In addition, over the long term, this will assist us in decreasing health care costs. The goals of the Healthy Incentive Program are to:

- Increase employee participation in wellness activities
- Change participant behavior to more healthy lifestyles;
- Ultimately improve the health status of participants; and
- Manage rising costs of health benefits

The program is designed to provide every employee enrolled in the health plan an opportunity to earn an incentive of an additional **$5 per pay discount on their health plan premium contribution**.

- Employees who meet designated "Healthy Incentives" are eligible to receive this discount. Details are below:
- Employees must earn five (5) "Healthy Incentives" in order to receive the $5 per pay incentive.
- See attached chart for the list of "Healthy Incentives" you can choose from.
- Employees need to provide proof to WSI HR in order to receive the incentives. See chart below for details. Due to HIPPA privacy regulations and confidentiality, proof submitted to earn incentives should just verify enrollment and/or completion. Refrain from submitting any documentation that shows a diagnosis.
- Incentive amounts earned will then be processed by Payroll at the beginning of the month following confirmation of your "incentives" earned.
- Upon enrolling in one of the health insurance plans listed above, an employee has up to (3) months to earn "Healthy Incentives" in a given plan year. This short plan year runs from **January 1 through June 30**.

Healthy Incentive	Description of Requirement	Verification Required for WSI HR Dept
Sign-up for www.AllegeantWellness.com *(This incentive is allowed one-time only)*	1) Go to www.allegeantwellness.com 2) Click on *Register* 3) Accept the Terms & Condition 4) Find your ID card for the SPHS Health Plan 5) Enter Group #, Member #, DOB, Gender and Email	Print the web page showing registration.
Health Assessment *(This incentive is allowed one-time only)*	1) Go to www.allegeantwellness.com 2) Find the tab called *Assessment* 3) Click "Complete"	Print the web page showing you completed
Adult Physical exam	1) Go to your Primary Care Physician 2) Get (annual) exam *(at no charge for In Network Providers!)*	Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)*
Age/gender specific test (i.e. cancer screening)	1) Go to your Primary Care Physician or Specialist 2) Get (annual) exam *(at no charge if Preventive & In Network)*	Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)*

Diagnostic Lab Work	1) Go to a Participating Lab 2) Get Lab test done	Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)* or Copy of Lab Slip or Copy of EOB
Engaging with a Health Coordinator, Pre-Natal Care Coordinator, Weight Management Program/Coordinator, Case Management and/or Disease Management		Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)*
Smoking Cessation program	Proof or participation in a Smoking Cessation program and/or tools to quitting tobacco use	Receipt of Attendance or Receipt for qualified expense such as Nicorette, Patch, etc
Gym or Fitness Center	Proof of membership and at least 3-month's participation/ visits	Gym Attendance Log (print-out)
"Personal Workout"	Proof of 3-month's participation in a "personal workout" program. Examples include Walk, Run, Swim, Bike, Home Gym, Workout videos, etc	Personal Exercise Log w/ verification signature *(a log sheet is on WSI intranet)*
"Essential Learning Classes"	Completion of WSI "Essential Learning Classes" online: Defensive Driving; Stress Management for Mental Health Professionals; and/or any health-related course that isn't already a requirement for you job.	Verification is automatic when class is completed online
WSI Blood Drive Participation		Attendance will be taken and turned in to WSI HR
WSI Flu Shot Participation		Attendance will be taken and turned in to WSI HR
Yoga, Meditation, Massage, Acupuncture, Alternative Therapy *(Sol Yoga is available at discount for WSI)*	Proof or participation in a Yoga, Meditation, Massage, Acupuncture or Alternative Therapy Program	Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)*
Stress Management Program	Proof of participation in a Stress Management Program	Completed & signed ***"Verification Sheet"*** *(located on WSI intranet)*
EAP Program	Proof or participation in a EAP Program	Documented Confirmation
WSI Safety Program	Proof of Level 3 Certification in WSI's Safety Program	Attendance will be taken and turned in to WSI HR
Weight Watchers	Participation in program with Goals	See WSI HR for details.

Dental Plan

Carrier:	MetLife
Network:	Participating Dental Provider (PDP) Plus
Eligibility:	Active Full-time employees working at least 30 hours / week
Contribution:	100% employee paid

The best way to maintain your oral health is through a sound program of regular dental care. Receiving the appropriate dental care is especially important for maintaining healthy teeth and gums.

To find a network dentist, go to www.metlife.com/dental, select "Find a Participating Dentist", check off "PDP Plus" under the *Network Type* field, then enter your search parameters.

	HIGH PLAN		LOW PLAN	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
PLAN YEAR DEDUCTIBLE				
Per Individual (*waived for preventative*)	$50	$50	$50	$75
Per Family (*waived for preventative*)	$150	$150	$150	$225
PLAN YEAR BENEFIT MAXIMUM Per person per calendar year	$1,500	$1,000	$1,000	$1,000
COINSURANCE				
Preventive	100% of PDP fee	100% of R&C fee**	100% of PDP fee	80% of R&C fee**
Basic	80% of PDP fee	80% of R&C fee**	50% of PDP fee	40% of R&C fee**
Major	50% of PDP fee	50% of R&C fee**	25% of PDP fee	20% of R&C fee**
ORTHODONTIA (children up to age 19)				
Lifetime Maximum per Child	$1,000		$1,000	
Coinsurance	50%		50%	

**R&C Fee: Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary

Flexible Spending Account (FSA)

Carrier:	Choice-Strategies (CHOICE)
Eligibility:	Active Full-time employees working at least 30 hours / week. New hires must also wait until 30 days of continuous employment.
Contribution:	100% employee paid
Contribution Maximums*:	Health FSA: **$1,325** Dependent Care FSA: **$2,500** (**$1,250** if married, filing separately)
What is eligible:	Medical, Rx, Dental & Vision (see table below for Dependent Care)
How to use it:	Choice Mastercard – one card for FSA and HRA
Helpful tip:	Save your receipts for substantiation! You will be notified by Choice within 2 weeks of purchase to substantiate your transaction.

TYPE OF COVERAGE	
Healthcare Account	• Used for paying: o Healthcare deductibles, copays and coinsurance o Eye glasses o Contacts o Over the counter medications, etc.
Dependent Care Account	• Can be used for day care costs while working for children under 13, o Day camps o After school programs o Relative payment for child care

Please note that because the Way Station is covering the full in-network deductible through the HRA, there will be **no FBA (Limited Purpose FSA)**

*Please note that due to the short plan year, the contribution maximum amounts have been prorated for 6 months.

Health Reimbursement Account (HRA)

Carrier:	Choice-Strategies (CHOICE)
Eligibility:	Active Full-time employees working at least 30 hours / week. New hires must also wait until 30 days of continuous employment.
Contribution:	100% employer paid
Contribution Amount:	Individual: **$2,000** Family: **$4,000**
What is eligible:	Only allowed to pay for Medical and RX expenses, no dental or vision.
How to use it:	Choice Mastercard – one card for FSA and HRA

To accommodate employees through the transition to Sheppard Pratt Health Plan, Way Station is funding the HRA in the amounts equal to the in-network deductible for individuals and families. This means that if you and your family receive **in-network services your deductible will be 100% covered**. Once your deductible is met, pay any copays and coinsurance with your FSA, if elected.

Basic Life / AD&D

Carrier:	The Hartford
Eligibility:	Active employees working at least 30 hours / week
Contribution:	100% employer paid

BENEFIT / BENEFIT DETAILS	BENEFITS
Amount (Life / AD&D)	1.5x employee annual earnings Up to $200,000
Guarantee Issue	Yes. No medical underwriting
Age Reduction Formula	• 65% at age 65 • 50% at age 70
Basic (Term) Life Features (see Appendix for The Hartford fliers)	• Everest Services – funeral planning and concierge services • ComPsych – EstateGuidance Will Services • Portability

Supplemental Life / AD&D

Carrier:	The Hartford
Eligibility:	Active employees working at least 30 hours / week
Contribution:	100% employee paid
Dependent Children:	Must be between 6 mos and 18 yrs. Extended to 26 yrs if child is a full-time student.

	EMPLOYEE	SPOUSE	CHILD
Minimum	$10,000	$5,000	Increments of $2,000 to a maximum of $10,000 for each child – no medical information required
Maximum	Lesser of $500,000 or 5x salary	$250,000	$10,000 per child
Guarantee Issue Amount*	Up to $100,000	Up to $25,000	Up to full amount

* Guarantee issue is available at initial eligibility only – new hires. All others are subject to carrier approval of Evidence of Insurability.

Voluntary Short Term Disability (STD)

Carrier:	The Hartford
Eligibility:	Active employees working at least 30 hours / week
Contribution:	100% employee paid

Way Station offers employees the opportunity to purchase Short Term Disability (STD) Insurance through The Hartford. Individual STD can pay you a percentage of your monthly salary if you become injured or ill due to a covered off-the-job disability or covered pregnancy. Below is a summary of the benefits available to you through The Hartford's individual STD products.

BENEFIT OVERVIEW	
BENEFIT PERIOD	12 weeks is the maximum amount of time you can receive disability benefits.
ELIMINATION PERIOD	8th day after Accidental Injury 8th day after Illness
BENEFIT AMOUNT	50% of Weekly Earnings Maximum benefit amount per week: $500

Long Term Disability (LTD)

Carrier:	The Hartford
Eligibility:	Active employees working at least 30 hours / week
Coverage:	100% employer paid
Max Monthly Benefit:	$4,000
Min Monthly Benefit:	Greater of $100 or 10% of the benefit based on monthly income loss before the deduction of other income benefits
Max Benefit Duration:	5 years if disabled prior to age 61
Initial Benefit Period:	First 27 months of disability
Initial Benefit Period %:	50% of monthly earnings
Continuing Benefit Period:	Period of disability that extends beyond the Initial Benefit Period
Continuing Benefit Period %:	20% of monthly earnings
Elimination Period:	90 days from day of becoming disabled. After that, you are eligible to receive a benefit.
Guarantee Issue:	Yes

Long term disability benefit replaces a portion of your pre-disability monthly earnings, less other income you may receive from other sources during the same disability (e.g. Social security, Workers' Compensation, vacation pay etc.).

The amount of LTD benefit may not exceed the maximum monthly benefit established under the plan, regardless of your annual salary amount. The maximum under this plan is $4,000.

Voluntary Critical Illness

Carrier:	Unum Life Insurance Company of America (Unum)
Eligibility:	Active employees working at least 20 hours / week
Contribution:	100% employee paid
For Pricing and Enrollment:	Please note that UNUM products are not elected through the Kelly online enrollment site. If interested in enrolling, please look for an email from UNUM with a link to enroll.

Critical Illness provides financial protection for you by paying a benefit if you are diagnosed with a critical illness. The amount you receive is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy. You also have the opportunity to have coverage for your spouse.

This plan is portable, which means that it stays in force, if you keep paying the premium, regardless of your employment with Way Station. You must make contributions for your spouse, if covered. Dependents, if covered, are automatically included with your coverage.

Benefit Plan Choices:

Benefit Plan 1: Base covered conditions with additional critical illness for dependent children;
Benefit Plan 2: Base covered conditions with additional critical illness for dependent children; cancer conditions

Summary of Critical Illness Benefits

COVERAGE	COVERAGE AMOUNT
Employee:	$5,000, $10,000, or $15,000
Spouse, if covered:	$5,000 or $10,000
Dependent, if covered:	25% of Employee Coverage Amount
BASE COVERED CONDITIONS	**PERCENTAGE OF COVERAGE AMOUNT**
Benign Brain Tumor Initial Diagnosis Benefit	100%
Blindness Initial Diagnosis Benefit	100%
Coma as the Result of Severe Traumatic Brain Injury Initial Diagnosis Benefit	100%
Coronary Artery Bypass Surgery Initial Diagnosis Benefit	25%
End Stage Renal (Kidney) Failure Initial Diagnosis Benefit	100%
Heart Attack (Myocardial Infarction) Initial Diagnosis Benefit	100%
Major Organ Failure Initial Diagnosis Benefit	100%
Occupational HIV Initial Diagnosis Benefit	100%
Permanent Paralysis as the result of a Covered Accident Initial Diagnosis Benefit	100%
Stroke Initial Diagnosis Benefit	100%
CANCER CONDITIONS	
Cancer Initial Diagnosis Benefit	100%
Carcinoma in Situ Initial Diagnosis Benefit	25%
ADDITIONAL CRITICAL ILLNESS FOR DEPENDENT CHILDREN	
Cerebral Palsy Initial Diagnosis Benefit	100%
Cleft Lip or Palate Initial Diagnosis Benefit	100%
Cystic Fibrosis Initial Diagnosis Benefit	100%
Down Syndrome Initial Diagnosis Benefit	100%
Spina Bifida Initial Diagnosis Benefit	100%

Voluntary Accident Insurance

Carrier:	Unum Life Insurance Company of America (Unum)
Eligibility:	Active employees working at least 30 hours / week
Contribution:	100% Employee Paid
For Pricing and Enrollment:	Please note that UNUM products are not elected through the Kelly online enrollment site. If interested in enrolling, please look for an email from UNUM with a link to enroll.

This accident policy provides financial protection for you by paying a benefit if you suffer a covered accident. The amount you receive is based on the amount of coverage in effect on the date of the accident according to the terms and provisions of the policy.

This plan is portable, which means that it stays in force, if you keep paying the premium, regardless of your employment with WSI. You must make contributions for your spouse and/or dependents, if covered.

Summary of Accident Insurance Benefits

COVERAGE	COVERAGE AMOUNT
ACCIDENTAL DEATH	
Employee	$50,000
Spouse	$20,000
Dependent Child(ren)	$10,000
ACCIDENTAL DEATH – COMMON CARRIER	
Employee	$150,000
Spouse	$60,000
Dependent Child(ren)	$30,000
ACCIDENTAL DISMEMBERMENT	
INIITAL ACCIDENTAL DISMEMBERMENT	
Loss of both hands or both feet; or	$15,000
loss of one hand and one foot; or	$15,000
loss of one hand or foot; or	$7,500
loss of two or more fingers, toes or any combination; or	$1,500
loss of one finger or toe	$750
CATASTROPHIC ACCIDENTAL DISMEMBERMENT	
loss of both hands or both feet; or loss of one hand and one foot	

	Prior to age 65	Age 65 - 69	Age 70 and over
Employee	$100,000	$50,000	$25,000
Spouse	$50,000	$25,000	$12,500
Dependent Child(ren)	$50,000	$25,000	$12,500

ACCIDENTAL LOSS	
INITIAL ACCIDENTAL LOSS	
Permanent Paralysis; or	$15,000
loss of sight of both eyes; or	$15,000
loss of sight of one eye; or	$7,500
loss of the hearing of one ear	$7,500
CATASTROPHIC ACCIDENTAL LOSS	
Permanent Paralysis; or loss of sight of both eyes; or loss of the hearing of both ears; or loss of the ability to speak	

	Prior to age 65	Age 65 - 69	Age 70 and over
Employee	$100,000	$50,000	$25,000
Spouse	$50,000	$25,000	$12,500
Dependent Child(ren)	$50,000	$25,000	$12,500

403b Plan

Maximum Contribution:	The maximum contribution of eligible pre-tax pay is up to $18,000/year (2018). The maximum catch-up provision (for those age 50 and over) is an additional $6,000/year.
Company Match	If profitable, WSI will match 25% of the employee's contribution
Vesting Schedule	Years of Service — Vesting % Less than 1 — 0 1 — 20% 2 — 40% 3 — 60% 4 — 80% 5 — 100%
Eligibility:	FTE's (over 21) are eligible on the 1st day of the month following 30 days after hire. Employee's must work 1,000 or more hours in the plan year.
Investment Info:	Refer to www.principal.com for all additional information and resources
Account Number:	Way station's account number is 809673

Paid Time Off (PTO)

Full-time (40 hour) employees are granted paid time off at the following rate:

Years of Employment	Paid Time Off (Days)	Accrual Per Pay Period (Hours)
1st year of employment	26	8
2nd and 3rd year (after 1 year)	29	8.93
4th and 5th year (after 3 years)	33	10.16
6th – 10th year (after 5 years)	36	11.08
11th year + (after 10 years)	40	12.31

Staff working in the capacity of a licensed mental health professional (20-29 hours per week) are eligible for 50% Paid Time Off.

Part-time staff (30 hours or more) receive 75% Paid Time Off.

Paid time off also includes holiday, personal, snow, and sick leave, as well as vacation.

Tuition Reimbursement

Tuition reimbursement for college courses which are job related. To qualify you must apply for course reimbursement by April 1st each year, obtain a grade of "B" or better and turn in the necessary paperwork when course is completed. See the Tuition Reimbursement Policy.

State Employee's Credit Union

Contributions are taxed. You can enroll at any time. Employees regularly scheduled for 20 hours or more per week are eligible to participate.

Mandatory Notices

Notice Regarding Special Enrollment Rights

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage

For more details about these special enrollment opportunities, please consult your Summary Plan Description (SPD).

To request special enrollment, contact:

Way Station HR,
Kimberly Lundy
(301) 662-0099; ext. 1015
klundy@waystationinc.org

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid

	Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please contact the Plan Administrator or refer to your Summary Plan Description for more detailed information regarding deductibles and coinsurance for these benefit under the Plan.

Important Notice from Way Station Inc About Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Way Station Inc has determined that the prescription drug coverage offered by the (Insert Name of Plan) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Sheppard Pratt Health System coverage will not be affected. Your current prescription coverage with Sheppard Pratt group health plan will coordinate with Part D coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription drug coverage in your area.

Your current Sheppard Pratt Health System coverage pays for health expenses including hospital, medical and prescription drugs. If you do decide to join a Medicare drug plan and drop your current Sheppard Pratt Health System coverage, be aware that you and your dependents will be able to get this coverage back provided that you satisfy the current eligibility rules of the Sheppard Pratt Health System Medical Plans.

If you do decide to join a Medicare drug plan and drop your current Sheppard Pratt Health System coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Way Station Inc and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information [or call (Insert Alternative Contact) at (XXX) XXX-XXXX]. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Way Station Inc changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	November 16, 2017
Name of Entity / Sender:	Way Station Inc.
Contact Position/Office:	Human Resources
Address:	204 Abrecht Place Frederick, MD 21701
Phone Number:	(301) 662-0099

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 9.56% for 2018), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name **WAY STATION INC.**		4. Employer Identification Number (EIN) **52-1162749**
5. Employer address **204 ABRECHT PLACE**		6. Employer phone number **(301) 662-0099**
7. City **FREDERICK**	8. State **MD**	9. ZIP code **21701**
10. Who can we contact about employee health coverage at this job? **KIMBERLY LUNDY**		
11. Phone number (if different from above)	12. Email address KLUNDY@WAYSTATIONINC.ORG	

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

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

  Please refer to the Summary Plan Description for full eligibility information.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  ☐ Please refer to the Summary Plan Description for full eligibility information.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Appendices

Information About Your Health Plan

Group Health Insurance: Self-funded Health Plans

Understanding a HRA

Flexible Spending Accounts

Health Insurance Terms You Need to Know

myAllegeant

The Hartford

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Accountable Care Solutions

Sheppard Pratt
HEALTH SYSTEM

Information About Your Health Plan

In addition to being the broker, Allegeant is Sheppard Pratt's health plan claims and service administrator.

A good way to avoid unexpected medical bills is to know how your plan works. Certain choices you make can affect what you'll pay out of pocket.

Medical Plan

- Your health insurance is self-funded through Sheppard Pratt Health System (SPHS). Allegeant is the health plan claims and service administrator.
- Allegeant Customer Service is available 8:00 a.m. to 5:00 p.m. EST Monday through Friday to assist you with questions regarding your medical plan or claims payment. The Allegeant Customer Service telephone number (1-800-553-8635) is on the ID card or you can e-mail customercare@allegeant.net with any questions.
- To help you save money, your health plan provides access to a network of providers. Your network is the CareFirst BlueCross BlueShield (CFBCBS) Regional Provider Network in MD/DC/Northern VA and PHCS for outside the CFBCBS service area.
  - To find a participating CareFirst provider (within MD/DC/Northern VA): go to www.carefirst.com; under "Find a Doctor", click "Search Now"; under "Other Sites", select "CareFirst – Network Leasing"; under "Type of Care", choose "Medical" or "Mental Health"; then enter your search parameters.
  - To find a Wrap Network PHCS provider (providers outside of the CFBCBS service area): go to www.multiplan.com; click "Search for a Doctor or Facility"; click on the PHCS logo that corresponds with the back of your ID card, click "continue"; then enter your search parameters.
- Providers that are not participating with CFBCBS or PHCS (outside of the CFBCBS service area) are paid under the out-of-network benefits. If you choose to use an out-of-network provider:
  - You may be responsible for paying your provider in full at the time services are rendered.
  - Out-of-network claims are reimbursed based on the Usual and Customary (U&C) allowance for services rendered.
  - You may be billed for the difference between the doctor's billed amount and what your plan has paid.
  - When you use a doctor or facility that is out-of-network, your deductible and other out-of-pocket costs may be much higher than the in-network cost.
  - Out-of-network costs can add up quickly, so we encourage you to use an in-network provider for your health care needs.
- The provider may collect applicable copayments, deductibles and/or coinsurance that are due at the time of service.
  a.) A **copayment** (or "copay") is a fee that you owe a doctor for certain services. The fee is a flat dollar amount.
    - **Example:** You go to your Primary Doctor (PCP) that is in-network for a non-routine office visit. Your benefit plan has a $20 PCP copayment, you must pay $20 for that visit.

  b.) A **deductible** is the amount of money you must pay over 1 plan year before the plan will pay for some covered services (i.e. physical therapy). For the short plan year effective 1/1/2018 through 6/30/2018, Way Station will be covering your full in-network deductible. After you pay your deductible, the SPHS plan will start paying for covered expenses. Please note that Way Station will be funding the HRA accounts for individuals ($2,000) and families ($4,000) to cover the in-network deductible.
    - **Example:** If you are an individual, you have a $2,000 deductible. You must spend a total of $2,000 on your health care within 1 plan year before your plan will start paying for certain health services. Your deductible resets once every plan year.

  c.) **Coinsurance** is a percentage (i.e. 0%, 40%, etc) of covered charges you owe a doctor for your care after your deductible (if applicable) is satisfied.
- SPHS is providing prescription coverage through Magellan Rx which provides national retail coverage as well as mail order and specialty pharmacy.
- Show your ID card with each visit to a provider or pharmacy.

Member Information

Go to our website myAllegeant.com to obtain:

- Benefit Information
- Eligibility Information
- ID Cards
- Paid Claim Information
- Prescription Drug Coverage
- Claim Forms, HIPAA Documents
- Electronic Explanation of Benefits (EOBs) - eEOBs

Questions?

Please call Customer Service
1.800.553.8635
For your convenience, this number is also on the back of your ID card.

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Billing

- Your provider should bill all medical claims directly to Allegeant using the SPHS group and member ID as well as the claim submission information on your ID card:

  EDI (electronically): Payer ID 52193

  Mail: Allegeant
  PO Box 981801
  El Paso TX 79998-1801

- If your provider draws blood or collects a specimen for testing at an outside lab, make sure they send it to Quest Diagnostic or Lab Corp (both are network participating providers). You should also ask them to include a copy of your ID card with the lab request paperwork so the bill can be submitted correctly.
- If you are being seen for Wellness/Preventative services, the provider should bill with a Wellness/Screening diagnosis to include any lab/x-ray related services.

Precertification/Prenotification

- Certain services require precertification/prenotification to confirm whether a proposed service or procedure is approved or disapproved for benefits based on Medical Necessity. A verbal or written authorization is provided. Allegeant has partnered with Conifer to provide Utilization Management services. Call Conifer at 866-397-1698 to precertify/prenotify if you will be receiving one of the following services:
  - All Inpatient Hospital Admissions (planned or emergency)
  - Partial hospitalization
  - Outpatient Renal Dialysis
  - Extended care facility
  - Hospice care
  - Private duty nursing
  - Residential rehabilitation for substance abuse
  - Organ Biopsy or Organ Transplant
  - Radiation Therapy
  - Chemotherapy
  - Durable medical equipment that costs $2,500 or more per plan year
  - Intravenous Infusion Therapy
  - Intensive Outpatient Mental Health or Substance Abuse treatment

Case/Care Management

- When you or a dependent are diagnosed with a serious illness or a catastrophic condition a Nurse Care Manager can help you understand and use your benefits more effectively, arrange for treatment ordered by your Physician, answer questions, and refer you to Network participating Physicians. Allegeant can assist you with obtaining a Nurse Care Manager as soon as you are aware of a serious condition so the case manager can begin assisting you.

Member Information

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- Electronic Explanation of Benefits (EOBs) - eEOBs

Questions?

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KNOW YOUR BENEFITS.

From Way Station Inc

Group Health Insurance: Self-funded Health Plans

This past October, the Way Station received a 35% premium increase from Cigna. There was no way that Way Station or its employees could afford that much of an increase. Luckily, through Way Station's affiliation with the Sheppard Pratt Health System, we are able to join the Sheppard Pratt Health and Vision plans starting on January 1, 2018. This will allow Way Station to keep premiums relatively flat while also providing slightly better benefits.

The Sheppard Pratt Health Plan that Way Station is offering you is called a self-funded health plan. You need to know how this type of health plan works, and what it means for the way you receive health care benefits.

What Is Self-funding?
An employer has a self-funded (or self-insured) group health plan if the employer assumes the financial risk associated with providing health care benefits to its employees.

Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk— Sheppard Pratt Health System pays for medical claims out of pocket as they are incurred. As part of Sheppard Pratt's Health Plan, Way Station pays Sheppard Pratt a premium to account for the added number of people.

Why Do Employers Choose Self-funding?
An employer may choose to offer a self-funded health plan for a number of reasons.

- Instead of trying to purchase a "one size fits all" health plan, self-funded plans can be customized to fit the needs of an employer's workforce.
- Employers can contract with the providers or a particular provider network that will best meet the needs of its employees. Way Station (through the Sheppard Pratt Health Plan) contracts with **CareFirst BlueCross BlueShield Regional Provider Network** in Maryland, Washington DC and Northern Virginia. For all other areas, they contract with **PHCS.**

Because your employer assumes the financial risk of providing you with health care benefits, it's important to be a wise health care consumer.

How Self-funded Benefits Work
Imagine you make an appointment with your doctor because you are sick. When you arrive at your doctor's office, you are asked to provide your insurance card to your physician's office personnel. Your insurance card tells the doctor's office what type of health plan you have and how it is administered, including to whom your claim should be sent (see sample to the right).

After you have seen your doctor, a claim for payment for the office visit is generated. Someone in your doctor's office prepares the claim and submits it to the administrator—the entity that will determine how your claim will be paid—listed on the insurance card you provided. Some employers administer employee health care claims in-house, while some use a third-party administrator (TPA). **Sheppard Pratt uses Allegeant as its TPA**.

Allegeant then adjudicates your claim. Adjudication is the process of paying health care claims according to your health plan's contract. Allegeant will determine how your health benefits work and what payment is required for your doctor. Your plan may require you to pay coinsurance or a deductible before your health plan pays its

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Group Health Insurance: Self-funded Health Plans

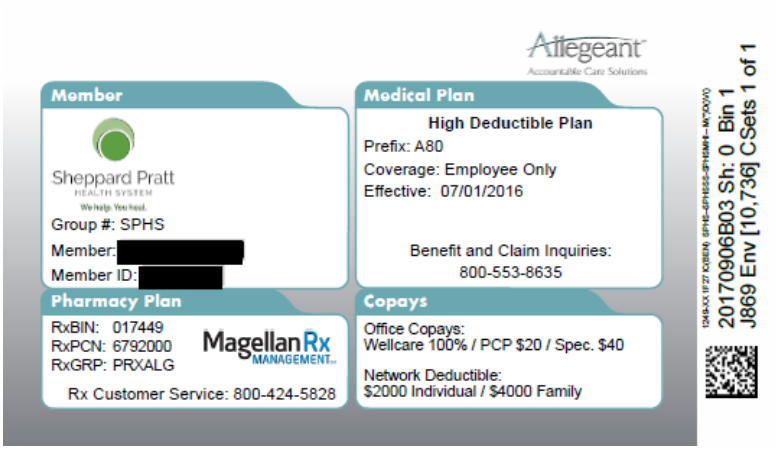
portion of your bill. Or, your doctor may participate in a Preferred Provider Organization (PPO) or another type of managed care plan and therefore will charge discounted fees to your plan. These and other factors determine how much of the claim the plan will pay, how much you will pay, and how much the doctor will eventually receive.

Once all of the payment issues are cleared up and it is determined that your expense will be covered by the plan, Allegeant contacts Sheppard Pratt for approval of your claim's payment (and any other current claims). Sheppard Pratt approves payment of the claim.

After approving payment, Sheppard Pratt will wire the appropriate funds to Allegeant, who will then send payment to your physician. Your claim is paid.

This payment process generally takes two to four weeks.

Front:



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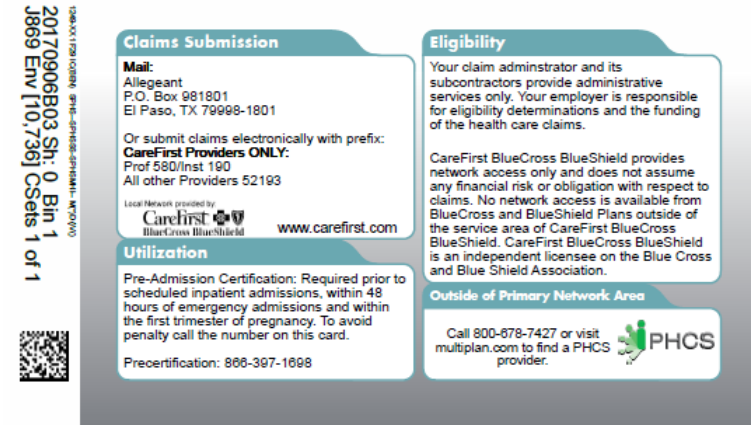

Group Health Insurance: Self-funded Health Plans

The Explanation of Benefits
After your visit with your physician, you will receive an informational statement from Allegeant. This is the explanation of benefits, or EOB. An EOB summarizes your claim, the payments you must make, the payments your health plan (Sheppard Pratt) must make, and any other payment information regarding your claim. This statement is not a bill or request for payment, it is simply informational.

Do Your Part
Because Sheppard Pratt & Way Station assumes the financial risk of providing you with health care benefits, we can either save or lose money depending on the level of claims incurred by our employees.

We want to be able to provide you with high quality health benefits, but as the cost of providing health care rises, you too must do your part to keep benefits high and costs low.

Some ways that you can help save money for yourself and our company are:

- Eliminate unnecessary visits to your doctor.
- Discuss healthy living and preventive care with your doctor.
- Follow prescription drug directions precisely, and be sure to take all of your medication, even if you feel better.
- Use in-network providers.

To help keep your health care costs down, do your best to be a wise health care consumer and always ask questions if you do not understand the benefits available to you. Contact HR if you would like more information on our self-funded health plan.

Understanding a HRA

Carrier	**Choice Strategies** https://www.choice-strategies.com/where-would-you-like-to-go-.html 888-278-2555 Option 2
Plan year	1/1/2018 – 6/30/2018
Employer Contribution	$2,000 individual $4,000 family
Choice MasterCard	One debit card for your Health FSA, Dependent Care FSA and HRA
Helpful tip:	Save your receipts!

What is a Health Reimbursement Arrangement?
A Health Reimbursement Arrangement (HRA) is an **employer-funded** account that is designed to reimburse employees for qualified medical expenses that are paid for out-of-pocket. There are no annual contribution limits on HRAs; however, *Way Station will set the contribution at the annual in-network deductible, which is **$2,000** for individual and **$4,000** for family*. HRAs are often designed to operate with a high deductible health plan (HDHP), thereby reducing premium costs while encouraging employees to spend wisely.

Your employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period, and establishes the types of expenses the funds can be used for.

What are the benefits of an HRA?
You may enjoy several benefits from having an HRA:

- Contributions made by your employer can be excluded from your gross income.
- Reimbursements may be tax-free if used to pay for qualified medical expenses.

Who is eligible for an HRA?
HRAs are employer-established benefit plans. These may be offered in conjunction with other employer-provided health benefits. Employers have complete flexibility to offer various combinations of benefits in designing their plan. You do not have to be covered under any other health care plan to participate. Self-employed persons are not eligible for an HRA. Certain limitations may apply if you are a highly-compensated participant.

An HRA may reimburse medical care expenses only if they are incurred by employees or former employees (including retirees) and their spouses and tax dependents. HRA coverage must be in effect at the time the expense is incurred.

Are HRAs really best only for the young and healthy?
No. HRAs and other HDHPs are well-suited for a very wide demographic of people. According to Aetna, the average age of its HRA plan members is 42, the same average age as those who opted for more traditional plans.

What is an HDHP?
An HDHP has:

- A higher annual deductible than typical health plans; and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

Understanding a Health Reimbursement Arrangement

An HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible. Preventive care includes, but is not limited to, the following:

1. Periodic health evaluations
2. Routine prenatal and well-child care
3. Child and adult immunizations
4. Tobacco cessation programs
5. Obesity weight-loss programs
6. Screening services (e.g., cancer, heart and vascular diseases, infectious diseases)

Contributions to an HRA
Your employer funds the account, so it costs you nothing out-of-pocket. There is no limit on the amount of money your employer can contribute to the accounts. Additionally, the maximum reimbursement amount credited to the HRA in the future may be increased or decreased at your employer's discretion. The maximum annual contribution is determined by your employer's plan document. There may also be a cap amount for the HRA. Way Station will fund your HRA monthly to fund your deductible.

Distributions from an HRA
Distributions from an HRA must be paid to reimburse you for qualified medical expenses you have incurred. The expense must have been incurred on or after the date you are enrolled in the HRA.

The *Choice Mastercard* given to you by your employer can be used to reimburse participants in an HRA. If the use of the card meets certain substantiation methods, you may not have to provide additional information to the HRA.

If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income. For example, if an unused reimbursement is payable to you in cash at the end of the year, or upon termination of your employment, any distribution from the HRA is included in your income. This also applies if any unused amount upon your death is payable in cash to your beneficiary or estate, or if the HRA provides an option for you to transfer any unused reimbursement at the end of the year to a retirement plan.

If the plan permits amounts to be paid as medical benefits to a designated beneficiary (other than the employee's spouse or dependents), any distribution from the HRA is included in income.

Reimbursements under an HRA can be made to the following persons:

1. Current and former employees
2. Spouses and dependents of those employees
3. Employees' covered tax dependents
4. Spouses and dependents of deceased employees

Qualified Medical Expenses
Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. Examples include amounts paid for doctors' fees, prescription medicines* and necessary hospital services not paid for by insurance. You can use your HRA funds for deductibles, copayments and coinsurance. An extensive list can be found in the Internal Revenue Service (IRS) document, Publication 502 at www.irs.gov.

Balance in an HRA
Amounts that remain at the end of the year may be carried over to the next year depending on your employer's plan design. Your employer is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses.

Understanding a Health Reimbursement Arrangement

What if I terminate my employment during the Plan Year?
If you cease to be an Eligible Employee (i.e., you die, retire or terminate employment), your participation in the HRA Plan will end unless you elect COBRA continuation coverage. You will be reimbursed for any medical care expenses incurred prior to your termination date, up to your account balance in the HRA, provided that you comply with the plan reimbursement request procedures required under the plan. Any unused portions will be unavailable after termination of employment. The rules regarding COBRA are contained within your Summary Plan Description.

Will I have any administrative costs under the HRA plan?
Generally, no. Your employer bears the entire cost of administering the HRA plan while you are an employee.

How long will the HRA plan remain in effect?
Although your employer expects to maintain the HRA plan indefinitely, it has the right to terminate the HRA plan at any time. Your employer also has the right to amend the HRA plan at any time and in any manner that it deems reasonable, in its sole discretion.

Are my benefits taxable?
The HRA plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan generally are not taxable to you. Your employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results.

What is the difference between an HRA and FSA?
HRAs are employer-funded, which means your employer determines the amount that goes into the HRA account. FSAs can be funded by employee and employer contributions. FSA contributions are deducted from your salary, usually on a pre-tax basis. You determine how much to contribute to your FSA account.

What does the IRS require me to report on my taxes concerning my HRA?
Nothing. Your HRA is a health benefit.

**Over-the-counter medications are considered to be qualified expenses only if purchased with a prescription (except for insulin, which is considered to be a qualified expense even without a prescription).*

Flexible Spending Accounts

Information for About FSAs

Flexible spending accounts, or FSAs, provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Essentially, the Internal Revenue Service (IRS) set up FSAs as a means to provide a tax break to employees and their employers. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes—effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you incur, your spendable income will increase.

The example that follows illustrates how an FSA can save money. **Please note, this example is not representative of Way Station's FSA for the short plan year**.

Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in medical expenses in the next plan year, they decide to direct a total of $2,650 (the maximum allowed amount per individual, for that taxable year) into their FSAs. (See table)

	Without FSA	With FSA
Gross income	**$30,000**	**$30,000**
FSA contributions	$0	-$2,650
Gross income	$30,000	$27,350
Estimated taxes		
Federal	-$2,550*	-$1,776*
State	-$900**	-$750**
FICA	-$2,295	-$1,913
After-tax earnings	**$24,255**	**$22,911**
Eligible out-of-pocket medical and dependent care expenses	-$3,000	-$350
Remaining spendable income	**$21,255**	**$22,561**
Spendable income increase	**--**	**$1,306**

** Assumes standard deductions and four exemptions*

*** Varies, assumes 3 percent*

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

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Flexible Spending Accounts

Way Station Inc Flexible Spending Accounts

About Way Station's FSA

Carrier	**Choice Strategies** https://www.choice-strategies.com/where-would-you-like-to-go-.html 888-278-2555 Option 2
Plan year	1/1/2018 – 6/30/2018 (contribution maximums are prorated)
Health FSA max	$1,325
Dependent care FSA max	$2,500 ($1,250 for married filing separately)
Choice MasterCard	One debit card for your Health FSA, Dependent Care FSA and HRA
Substantiation	Be sure to substantiate your purchases within 90 days, otherwise, your debit card will be deactivated. If you fail to substantiate, any unsubstantiated amounts will be either added to your W-2 or withheld from pay.
Helpful tip	Save your receipts!

The Health Care Reimbursement FSA
The health care reimbursement FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. For example, cash that you now spend on deductibles, copayments or other out-of-pocket medical expenses can instead be placed in the health care reimbursement FSA pre-tax. **Since Way Station is doing a short plan year, the FSA maximum contribution is prorated for six months**. The prorated maximum contribution to the health care reimbursement FSA is **$1,325.**

Health FSAs employ a "use-it-or-lose-it" model. If you do not use the funds that you contribute to your FSA within the end of the year, you will have to forfeit those funds.

Eligible Expenses
Eligible health care expenses for the health care reimbursement FSA include more than just your deductible and copayments. You can also reimburse items such as prescription drugs, dental expenses, eye glasses and contacts, certain medical equipment and many more items. For more information about eligible medical expenses, please refer to IRS Publication 502, Medical and Dental Expenses, available at www.irs.gov/publications/p502/index.html.

Over-the-counter drugs used to be eligible expenses, but a law effective Jan. 1, 2011, only allows claims for over-the-counter medication or drug expenses (other than insulin) to be reimbursed **if the patient has a prescription**. This new rule does not apply to items for medical care that are not considered medication or drugs. Equipment such as crutches, supplies such as bandages and diagnostic devices such as blood sugar test kits still qualify for reimbursement without a prescription.

The Dependent Care FSA
The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care. The prorated maximum amount that you may contribute is **$2,500** (or $1,250 if married and filing separately) per calendar year.

If you elect to contribute to the dependent care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Eligible Expenses
In order for dependent care services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care

Flexible Spending Accounts

must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours (instances such as Saturday night babysitting does not qualify) and cannot be provided by another of your dependents.

Is the FSA program right for me?
The flexible spending accounts offered by Way Station Inc are beneficial for anyone who has out-of-pocket medical (in excess of the HRA amounts funded by Way Station), dental, vision, hearing or dependent care expenses beyond what his or her insurance plan covers.

Please note that Way Station is funding $2,000 for individuals and $4,000 for families through the HRA. Your Health FSA will be useful for remaining out-of-pocket health costs, dental or vision claims. Budget accordingly.

It's easy to determine if an FSA will save you money. At enrollment time, you will need to determine your annual election amount. Estimate the expenses that you know will occur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you had $100 or more in recurring or predictable expenses, the accounts can help you stretch your dollars.

How do the accounts work?
If you decide to enroll in one or both of the accounts, your election amount(s) is availble to you on January 1, 2018. Your contributions are taken out of each paycheck—before taxes—in equal installments throughout the plan year. When you have an eligible health care or dependent care expense, You can either you must submit a claim form along with an itemized receipt to be reimbursed from your account.

The health care reimbursement FSA will reimburse you for the full amount of your annual election (less any reimbursement already received), at any time during the plan year, **regardless of the amount actually in your account**. The dependent care FSA will only reimburse you for the amount that is in your account at the time you make a claim.

KNOW YOUR BENEFITS.

From Way Station Inc

Health Insurance Terms You Need To Know

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Ambulatory Care – Health care services that do not require a hospital stay, such as those provided in a doctor’s office, clinic or day surgery center.

Annual Limit – A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Assignment of Benefits – A document you sign that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

Benefits – The amount of money payable by an insurance company to a claimant under the insurance policy.

Brand-name Drugs – Prescription drugs sold by a drug company under a specific name or trademark and protected by a patent. Brand-name drugs may be available by prescription or over the counter.

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers.

Broker – An independent insurance agent who works with many insurance companies to find insurance policies for his or her clients.

Case Management – A technique that insurance companies and HMOs use to ensure that individuals receive appropriate, timely and reasonable health care services.

Children’s Health Insurance Program (CHIP) – A government insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families that earn too much income to qualify for Medicaid but can’t afford to purchase private health insurance coverage.

Claim – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

Coinsurance – The money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.

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Health Insurance Terms You Need to Know

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event.

Copayment – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. Copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim – Refusal by an insurance company to pay a submitted request for health care services obtained.

Dental Insurance – Insurance that helps pay for dental care and usually includes regular checkups, cleanings, X-rays and certain services required to promote general dental health. Some plans will provide broader coverage than others, and some will require a greater financial contribution from you when services are rendered. Some plans may also provide coverage for certain types of oral surgery, dental implants or orthodontia.

Dependent – Any individual, adult or minor whom a parent, relative or other person may choose to cover on his or her insurance plan.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

Essential Health Benefits – A set of health care service categories that must be covered by certain plans.

Exclusions and Limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

Flexible Spending Account (FSA) – An individual arrangement set up through employers to pay for many of out-of-pocket medical expenses with tax-free dollars. The FSA account holder sets aside a pre-tax dollar amount for the year which he or she can use to pay medical expenses. Unused FSA funds can expire, depending on the policy of the account holder's employer.

Generic Drugs – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Group Health Plan – A health plan offered by an employer or employee organization that provides health coverage to a large group of people at a discounted rate.

Health Insurance – A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Insurance Marketplace (Marketplace) – A state or federal resource where individuals, families, and small businesses can shop for health insurance plans based on costs, benefits and other important features, and enroll in coverage. Individuals who enroll in a health insurance plan through the Marketplace may be eligible for Advance Premium Tax Credits and other assistance in paying for coverage. Also known as Exchanges.

Health Reimbursement Arrangement (HRA) – Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses. Like health savings accounts (HSAs), unused amounts may be rolled over to be used in subsequent years. Unlike HSAs, the employer funds and owns HRA accounts. The employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period and establishes the types of expenses the funds can be used for.

Health Savings Account (HSA) – A medical savings account available to people who are enrolled in an HSA-compliant high-deductible health plan. The account is employee-owned, and money may be contributed by both the employer and employee. If the employee leaves the company, he or she remains in control of the

Health Insurance Terms You Need to Know

account. The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds for non-qualified expenses. Funds roll over year to year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no cap on how much money can be in the account.

High Deductible Health Plan (HDHP) – A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with an HSA or an HRA to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

In-network –Typically refers to physicians, hospitals or other health care providers who contract with an insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Lifetime Limit – A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits or limits on specific benefits, or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Managed Care – A system of health care delivery that is characterized by arrangements with selected providers, ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific procedure or service or during a specified period of time.

Medicaid – A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid varies state by state and may have a different name in your state.

Medical Loss Ratio (MLR) – A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has an MLR of 80 percent. With an 80 percent MLR, the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs and agent commissions. The ACA sets minimum MLRs for different markets, as do some state laws.

Medically Necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

Medicare – A federal health insurance program for people who are age 65 or older and for certain younger people with disabilities. It also covers people with End-stage Renal Disease (ERSD)—permanent kidney failure requiring dialysis or a transplant.

Medicare Part D – A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Minimum Essential Coverage – The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Open Enrollment Period – A period of time, usually but not always occurring once per year, when employees of companies and organizations may make changes to their health insurance and other benefit options.

Health Insurance Terms You Need to Know

Out-of-network – Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan to provide services to its members. Depending on the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-pocket Maximum (OOPM) – The total amount paid each year by the member for the deductible, coinsurance, copayments and other health care expenses, excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.

Pre-admission Certification –Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary. Also called "precertification" or "pre-admission review."

Pre-existing Condition – Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which health care providers and insurers agree to offer substantially discounted fees for covered health care services and to lower copays and deductibles for in-network services. The plan's payment ratio (what your insurance company pays compared to what you pay) may be high—for example, it could be 90/10, with the insurance company paying 90 percent of medical costs and you paying 10 percent after the copay and deductible.

Premium – The amount of money charged by an insurance company for coverage.

Prescription Insurance – Insurance that helps pay for prescription drugs and medications. Prescription insurance is often offered as part a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who have no health insurance. Eligibility for specific medications and the cost of insurance varies among health plans. Also known as drug coverage.

Preventive Care – Any medical checkup, test, immunization, or counseling service used to prevent chronic illnesses from occurring.

Primary Care Physician (PCP) – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Qualified Health Plan – An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualified Medical Expense – The costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges are the responsibility of the patient.

Self-insured – A health benefits plan in which the employer is responsible for the cost of its employees' health care. Typically, a third party provides administrative services for the plan to the employer group.

Summary of Benefits and Coverage (SBC) – An outline of a health insurance plan that allows somebody to evaluate costs and coverage and compare against other health plans.

Vision Insurance – Insurance that covers specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other

Health Insurance Terms You Need to Know

procedures, and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery.

Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Wellness Program – A program intended to improve and promote health and fitness, usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

myAllegeant

myAllegeant – an online portal where you and your dependents can have easy access to self-service tools that allow you to take an active role in your health plan's benefits.

To register, go to www.myallegeant.com, click on "*Proceed to our sign up process*", and have your ID card ready.

Features:

- eEOBs – go paperless and sign up for eEOBs
  - When an EOB/claim is ready to be viewed, you will get an email notification alerting you that your EOB is ready to be viewed on myAllegeant.
- Eligibility – effective dates, demographic information, summary of benefits and coverage.
- Claims – summary of all claims, claims status, paid date, explanation of benefits (EOB).
- Out-of-pocket and deductible amounts – see where you stand year-to-date.
- Secure messaging – send questions to customer service about claims, eligibility, address changes, or request a new ID card.
- ID card – view or print a temporary ID card.
- Notifications – an email notification is sent to you when there is a secure message from customer service.
- Announcements and information – new features or processes at Allegeant, FAQs, plan information.
- Links to other tools – find a network provider, access the wellness portal, view prescription claims, manage your FSA/HSA/HRA.

If you need help registering, click on "*Sign Up Instructions*" underneath the login field. For continued assistance or if have a question about eligibility or claims, please contact Allegeant Customer Service at 1-800-793-9403.

ABILITY ASSIST® COUNSELING SERVICES

For employees covered under The Hartford's Disability insurance, Critical Illness insurance or Leave Management Services.

GETTING SUPPORT SHOULD BE EASY.

Life presents complex challenges. If the unexpected happens, you want to know that you and your family have simple solutions to help you cope with the stress and life changes that may result. That's why the Hartford's Ability Assist Counseling Services, offered by ComPsych®,[1] can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES.

From the everyday issues like job pressures, relationships, retirement planning or personal impact of grief, loss, or a disability, Ability Assist can be your resource for professional support.

You and your family, including spouse and dependents, can access Ability Assist, at any time, as long as you are covered under The Hartford's **Disability insurance, Critical Illness insurance or Leave Management Services.**

ABILITY ASSIST COUNSELING SERVICES

Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your family members may face. It's staffed by GuidanceExperts℠ – highly trained master's and doctoral level clinicians – who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include: • Job pressures. • Relationship/marital conflicts. • Stress, anxiety and depression. • Work/school disagreements. • Substance abuse. • Child and elder care referral services.
Financial Information and Resources	Provides support for the complicated financial decisions you or your family members may face. Speak by phone with a Certified Public Accountant and Certified Financial Planner ™ Professionals on a wide range of financial issues. Topics may include: • Managing a budget. • Retirement. • Getting out of debt. • Tax questions. • Saving for college.

continued

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ABILITY ASSIST COUNSELING SERVICES *con't.*

Legal Support and Resources	Offers assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your family members. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include: • Debt and bankruptcy. • Guardianship. • Buying a home. • Power of attorney. • Divorce.
Health Champion℠	A service that supports you through all aspects of your health care issues by helping to ensure that you're fully supported with employee assistance programs and/or work-life services. HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include: • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/tests/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan provider(s) • An easy-to-understand explanation of your benefits–what's covered and what's not • Cost estimation for covered/non-covered treatment • Guidance on claims and billing issues • Fee/payment plan negotiation

A CASE IN POINT.[3]

"The initial counselor I spoke with was so comforting and easy to communicate with. She put me right at ease and empowered me to follow through with the program. She was wonderful."

– Hartford Customer, Ability Assist User

SERVICE FEATURES.

The service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won't have to share visits. Each individual can get counseling help for his/her own unique needs. Legal and financial counseling are also available by telephone during business hours. HealthChampion℠ offers unlimited access to services.[2]

GETTING IN TOUCH IS EASY.

On the phone: Just one simple call.
For access over the phone, simply call toll-free **1-800-96-HELPS (1-800-964-3577).**

Online: The point is simplicity.
You'll also have 24/7 access to GuidanceResources® Online (offered by ComPsych).[1] This resource provides trusted information, resources, referrals and answers to everyday questions right from your desktop or the privacy of your home. It includes:

- Chat sessions with professional moderators.
- Access to hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

Visit **WWW.GUIDANCERESOURCES.COM** to create your own personal username and password. If you're a first-time user, you'll be asked to provide the following information on the profile page:

1. In the **Company/Organization** field, use: **HLF902**
2. Then, create your own confidential user name and password.
3. Finally, in the Company Name field at the bottom of personalization page, use: **ABILI**

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[1] Ability Assist®, The GuidanceResources® Program, and HealthChampionSM services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych. ComPsych and GuidanceResources are registered trademarks and HealthChampion is a service mark of ComPsych Corporation.

[2] HealthChampion℠ specialists are only available during business hours. Inquiries outside of this time frame can either request a call-back the next day or schedule an appointment.

[3] This case illustration is fictitious and for illustrative purposes only.

ADDED PEACE OF MIND WHEN IT'S NEEDED THE MOST.

The death of a loved one is one of life's most stressful situations. Quick, often costly decisions must be made while emotions are at their peak. Yet, how many people know how to plan a funeral? That's why your employer offers a funeral planning and concierge service through The Hartford's **Group Life Insurance program** – provided by Everest,[1] the first to offer this service nationwide.

THE RESOURCES TO HELP YOU MAKE CONFIDENT, INFORMED DECISIONS.

Everest's advisors help families understand all of their options and put them into action while staying within their budget. Here are the services they offer you, your spouse/partner and children under the age of 26.

EVEREST SERVICES	
24/7 Advisor Assistance	• Round-the-clock access to Everest Advisors. • Assistance with all funeral planning issues.
PriceFinder℠ Research Reports	• The only nationwide database of funeral home prices. • Detailed local funeral home price comparisons. • Unlimited access to reports available on demand via the Web site.
Online Planning Tools	• Unlimited use of Everest's online planning, research, and knowledge tools. • Create simple or detailed funeral plans using various reference materials, including 10 key decisions everyone should make. • Information can be stored, updated, retrieved and printed on demand.

continued

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CASE ILLUSTRATION: A SHOULDER TO LEAN ON.[2]

April had always thought that she and her husband would spend their golden years together. So when he began to lose his battle with pancreatic cancer, she was completely unprepared. However, April had a knowledgeable and trusted resource: Everest services were included as part of her insurance program.

Her Everest advisor assisted with every aspect of the funeral planning process, giving April peace of mind during this stressful time. And she received an expedited life insurance payment within a week of her husband's death, which helped ease many of the family's financial pressures. Everest's services relieved April of some of the stress that comes with loss, allowing her to focus on her family.

EVEREST SERVICES *con't*

At-Need Family Support	• Concierge services at or near the time of death provided by Everest's licensed funeral directors, who offer as much or as little assistance as the family desires. • Communication of the plan with the funeral home of choice, removing the family from a sales-focused environment. • Pricing information presented to the family in an easy-to-understand format. • Negotiation of the funeral costs with the funeral home, often resulting in significant financial savings.
Express Claim Processing	• Includes Express Pay, an innovative claims payment service that can deliver benefits in as little as 48 hours. • Allows your beneficiary to use the insurance proceeds to pay for immediate funeral expenses.

A TRUSTED ADVISOR DURING THE WORST OF TIMES.

We can't always predict, but we can prepare. Find out more about The Hartford's Funeral and Concierge Services by calling **1-866-854-5429**.

Or visit **WWW.EVERESTFUNERAL.COM/HARTFORD** and use this code: **HFEVLC**.

Prepare. Protect. Prevail.®

Visit us at **THEHARTFORD.COM/EMPLOYEEBENEFITS**

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[1] Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. PriceFinder is a service mark of Everest Information Services, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials.

[2] This case illustration is fictitious and for illustrative purposes only.

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES.

EVEN THE BEST PLANNED TRIPS CAN BE FULL OF SURPRISES.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.[1]

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

GOOD TO GO: MULTILINGUAL ASSISTANCE 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.[2,3]

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to $1 million in covered services.[4]

SERVICES FROM HERE TO THERE.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

IDENTITY THEFT ASSISTANCE, TOO.

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year.[5] Europ Assistance USA helps protect you and your family from its consequences 24/7,[2] at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

continued

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TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

EMERGENCY MEDICAL ASSISTANCE[6]	PRE-TRIP INFORMATION	EMERGENCY PERSONAL SERVICES[7]	IDENTITY THEFT ASSISTANCE
• Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Traveling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains	• Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals	• Medication and eyeglass prescription assistance • Emergency travel arrangements[9] • Emergency cash[9] • Locating lost items • Bail advancement	• Prevention Services - Education - Identity Theft Resolution Kit • Detection Services - Fraud alert to three credit bureaus • Resolution Guidance and Assistance - Credit information review - ID Theft Affidavit Assistance - Card replacement • Personal Services - Translation - Emergency cash advance*

* Cash advance available when theft occurs 100 miles or more from your primary residence. Must be secured by a valid credit card.

CASE ILLUSTRATION: HELP A WORLD AWAY.[8]

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance medical referral, medical monitoring, and repatriation services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

What to have ready: Your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and your company policy number, which can be obtained through your Human Resources department.

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.
Call: 1-800-243-6108 Collect from other locations: 202-828-5885 Fax: 202-331-1528
Travel Assistance Identification Number: GLD-09012

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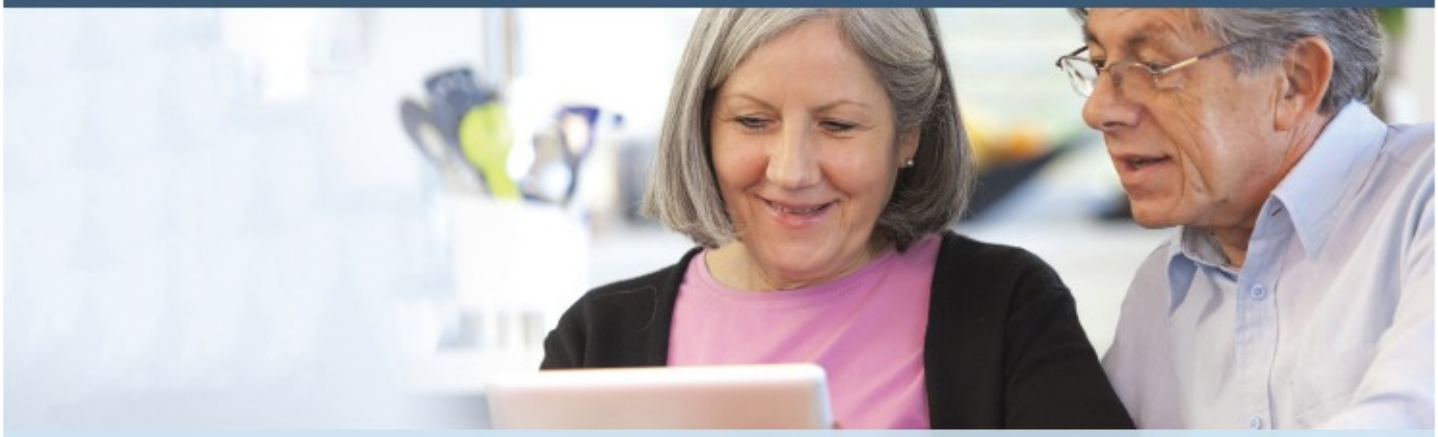

CREATE A SIMPLE WILL FROM THE CONVENIENCE OF YOUR DESKTOP.

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

AN EASY AND EMPOWERING SOLUTION.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®.[1] It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.
- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

QUICK ANSWERS TO KEY QUESTIONS.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

" **Isn't will preparation complicated?"** Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

" **What if I have questions as I'm creating my will?"** The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

" **What about my privacy?"** All information is kept secure and confidential with the latest encryption technology.[2]

continued

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CASE ILLUSTRATION: THE FINAL WORD.[3]

Laura was the single parent of a six-year-old daughter, Amy. She worried that if she were to die, her modest but hard-earned assets would not be available to her daughter.

The cost of a legal will seemed beyond her means until she discovered EstateGuidance® through her group life insurance provider. With it, she was able to appoint her older sister as executor of her will and name her brother and sister-in-law as Amy's legal guardians. She felt better knowing that she would have the final word in protecting her daughter's best interests.

" So, what happens if I don't create a will?" The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

GOOD INTENTIONS AREN'T ENOUGH.

You might have the best of intentions, but without a will, they aren't legally binding. Take this opportunity to put your intentions into action.

Visit **WWW.ESTATEGUIDANCE.COM/WILLS** today. Use this code: **WILLHLF**. Then follow the easy steps below:

1. Access The Hartford's EstateGuidance® Will Services online.
2. Sign in to the secure site by entering the access code.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

Prepare. Protect. Prevail.®

Visit us at **THEHARTFORD.COM/EMPLOYEEBENEFITS**

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

[1] EstateGuidance® is offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

[2] The EstateGuidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on the site are protected with up to 256-bit Secure Sockets Layer encryption.

[3] This case illustration is fictitious and for illustrative purposes only.

Services may not be available in all states.

Better benefits at work.

Way Station, Inc.

Group critical illness insurance

Could your bank account survive a serious illness?

Get protected with group critical illness insurance from Unum.

Lisa's story

Lisa was planning her daughter's wedding when a stroke disrupted her plans. Thanks to her critical illness coverage, Lisa was able to afford the treatment her medical insurance didn't cover. So she was able to focus on her goal for recovery: to dance at her daughter's wedding.

Who's at risk?

- The odds of developing cancer during a lifetime are one in two for men and one in three for women.[1]
- Every 34 seconds someone in America will have a coronary event.[2]

Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis and be medically unrelated. Each condition is payable once per lifetime.

How to apply

To learn more, watch for information from your employer.

GetBenefitSmart.com
Finally, benefits made simple

Three reasons to buy this coverage at work

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

How can critical illness insurance help?

Critical illness insurance can pay a lump sum benefit at the diagnosis of a critical illness. You can choose to purchase $5,000, $10,000 or $15,000 of coverage. — and you can use the money any way you see fit.

Covered conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	

Covered conditions with time limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident

Optional cancer conditions	
If selected by your employer, you may choose to select this benefit for an additional premium.	
Cancer	Carcinoma in situ;[3] pays 25% of lump sum benefit

Please see policy definitions for complete details about these covered conditions.

Group critical illness insurance

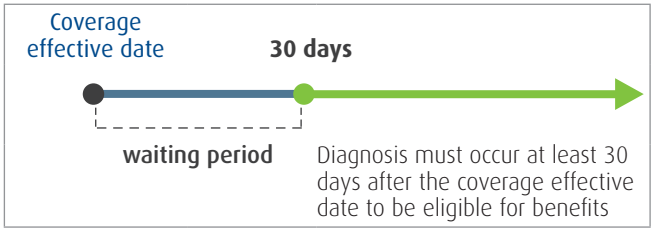
Available family coverage

Who can have it?	Benefit
Employees who are actively at work	You can choose to purchase $5,000, $10,000 or $15,000 of coverage.
Dependent children newborn until their 26th birthday, regardless of marital or student status All eligible children are automatically covered at 25% of the employee benefit amount (no additional cost)	Eligible children are covered for the same conditions as employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
Spouse ages 17 through 64 with purchase of employee coverage	You can choose to purchase $5,000 or $10,000 of coverage.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage. Employees and spouses may be covered under a policy or the Spouse Rider, but not both.

Provisions

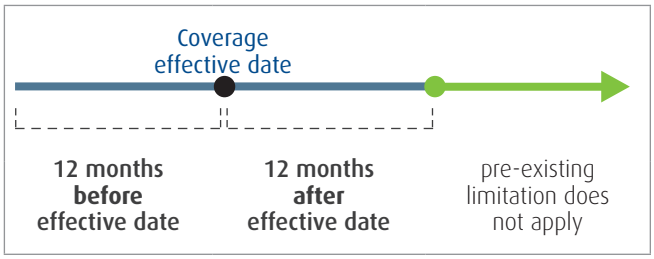
Waiting period



Does not apply to coma, occupational HIV and permanent paralysis or the specific childhood conditions listed in the chart to the left.

Pre-existing condition** limitation

Unum will not pay benefits for a claim that is caused by, contributed to or occurs as a result of a pre-existing condition. Please refer to information provided in your certificate or consult with your benefit counselor to determine what would be considered a pre-existing condition.



** A pre-existing condition is a condition for which symptoms existed (within 12 months before your coverage effective date) that would cause a person to seek treatment from a physician or for which a person was treated or received medical advice from a physician, or took prescribed medicine. The determination on whether your condition qualifies as pre-existing will be based on the date of disability and not the date you notify Unum.

Reduction of benefits

The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary date after the insured individual's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

My critical illness coverage

Amount I applied for: $ _____

Cost per pay period: $ _____

Date deductions begin: ___/___/____

(For your records — complete during your enrollment)

THIS INSURANCE PROVIDES LIMITED BENEFITS.

1 American Cancer Society, Cancer Facts & Figures 2013 (2013).
2 American Heart Association, "Heart Disease and Stroke Statistics — 2013 Update: A Report from the American Heart Association," Circulation (Jan. 1/8, 2013).
3 Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.

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The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.

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Better benefits at work.

Group accident insurance benefit schedule

Be sure to review this schedule of benefits

It shows the many ways this coverage can pay a benefit if you are injured

Covered injuries	Benefit amount
Fractures	
Open	Up to $7,500
Closed	Up to $3,750
Chips	25% of closed amount
Dislocations	
Open	Up to $6,000
Closed	Up to $3,000
Burns	
At least 10 square inches, but less than 20 square inches	2nd degree – $0 3rd degree – $2,500
At least 20 square inches, but less than 35 square inches	2nd degree – $0 3rd degree – $5,000
35 or more square inches of the body surface	2nd degree – $1,000 3rd degree – $10,000
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit
Skin graft for any other accidental traumatic loss of skin	
At least 10 square inches, but less than 20 square inches	$150
At least 20 square inches, but less than 35 square inches	$250
35 or more square inches of the body surface	$500
Concussion	$150
Coma	$10,000
Ruptured disc	$800
Knee cartilage	
Torn	$750
Exploratory	$150
Laceration	$25 – $600
Tendon/ligament and rotator cuff	
Repair of one	$800
Repair of two or more	$1,200
Exploratory only	$150
Dental work, emergency	
Extraction	$100
Crown	$300
Eye injury	$300

Emergency and hospitalization benefits	Benefit amount
Ambulance (ground, once per accident)[1]	$400
Air ambulance	$1,500
Emergency room treatment	$150
Emergency treatment in physician office/urgent care facility Either ER room or Primary Care/Specialist/Urgent Care benefit is payable once per covered accident	
Primary Care Physician	$75
Specialist	$75
Urgent Care Facility	$75
Hospital admission (admission or intensive care admission once per covered accident)	$1,500
Intensive care admission (same as above)	$2,250
Hospital confinement (per day up to 365 days)	$200
Intensive care confinement (per day up to 15 days)	$400
Medical imaging test (once per accident)	$200
Outpatient surgery facility service (once per accident)	$300
Pain management (epidural, once per accident)	$100

Treatment and other services	Benefit amount
Surgery benefit	
Open abdominal, thoracic	$1,500
Exploratory (without repair)	$150
Hernia repair	$150
Physician follow-up visit (up to 2 visit(s) per accident)	
Primary care physician	$75
Specialist	$75
Urgent care facility	$75
Chiropractic visit (up to 3 visits per calendar year)[2]	$25
Therapy services (up to 10 per accident)	
Occupational therapy	$25
Speech therapy	$25
Physical therapy	$25
Prosthetic device or artificial limb	
One	$750
More than one	$1,500
Appliance (once per accident)	$100
Blood, plasma and platelets	$400
Travel (due to covered accident)	
Lodging (per day up to 30 days per covered accident)[3]	$150
Transportation more than 50+ miles from residence (up to three trips per covered accident; benefit for injured insured individual only; max 1200 miles per round trip)[4]	$0.40
Transportation maximum	$1,440
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	$100

Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
***The accidental death benefit triples** if the insured individual is injured as a fare-paying passenger on a common carrier: Employee – $150,000; spouse – $60,000; child – $30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	$15,000
Loss of one hand and one foot; or	$15,000
Loss of one hand or one foot;	$7,500
Loss of two or more fingers, toes or any combination; or	$1,500
Loss of one finger or toe	$750
Catastrophic accidental dismemberment — once per lifetime, not payable with catastrophic loss[5]** Loss of both hands or both feet, or loss of one hand and one foot	
Employee (prior to age 65)	$100,000
– Spouse and child	$50,000
Employee (ages 65–69)	$50,000
– Spouse and child	$25,000
Employee (70+ years old)	$25,000
– Spouse and child	$12,500
Accidental loss — paralysis, sight, hearing and speech[6] Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	$15,000
Loss of sight of both eyes; or	$15,000
Loss of sight of one eye; or	$7,500
Loss of the hearing of one ear	$7,500
Catastrophic accidental loss — once per lifetime, not payable with catastrophic dismemberment** Permanent paralysis, or loss of hearing in both ears, or loss of the ability to speak, or loss of sight of both eyes	
Employee (prior to age 65)	$100,000
– Spouse and child	$50,000
Employee (ages 65–69)	$50,000
– Spouse and child	$25,000
Employee (70+ years old)	$25,000
– Spouse and child	$12,500

THIS IS A LIMITED POLICY.

In CT, there is a $500 benefit payable for outpatient emergency room medical care for accidental ingestion of a controlled substance.

** Catastrophic accidental benefit — payable after fulfilling a 365 day elimination period.

1 In CA and CT, no ground or air ambulance benefit is payable.
2 In KS, no chiropractic benefit is payable.
3 In NJ, no lodging benefit is payable.
4 In NJ, no transportation benefit is payable.
5 In ME, catastrophic benefits amounts vary. In PA, no catastrophic accidental dismemberment benefit is payable.
6 In PA, no paralysis benefit is payable.

EN-1669 (10-12)

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Better benefits at work.

Way Station, Inc.

Group accident insurance with wellness benefit

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Life can take a tumble.

With a full-time job and three active kids, Marsha has a lot of demands on her time — and her pocketbook. So if her kids break something other than a window, she doesn't want an injury to break her bank account as well.

Benefits that pay for covered accidents while you are on the road to recovery

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- cuts repaired by stitches
- coma due to a covered injury
- eye injuries
- ruptured discs
- concussion

Some covered expenses include:

- emergency room treatment
- outpatient surgery facility
- doctor office visit
- hospitalization
- occupational therapy
- speech therapy
- chiropractic visit
- physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Who's at risk?

- Every 10 minutes, over 700 Americans suffer an injury severe enough to seek medical help.[1]
- About two-thirds of disabling injuries suffered by American workers are not work-related, and therefore not covered by workers' compensation.[2]

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at home

Injury: Broken toe and ACL tear (knee ligament injury)

Out-of-pocket expenses incurred:

$100 emergency room copay
$500 deductible
$875 coinsurance for surgery ($3,500 x 25%)
$90 copay for six physical therapy visits

Total out-of-pocket expenses: $1,565

Benefits paid:

$150 emergency room visit
$100 appliance (knee brace)
$150 fractured toe
$800 surgical ligament tear repair
$75 follow-up appointment
$150 for six physical therapy sessions

Total benefit paid under policy: $1,425

*Costs of treatment and benefit amounts may vary. Example is based on the level 2 schedule of benefits.

How to apply

To learn more, watch for information from your employer.

Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur on and off the job. Accident insurance is offered to all eligible employees who are actively at work. You decide if it's right for you and your family.

The following benefits are automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Stress tests
- Colonoscopies
- Chest X-rays
- Mammograms

There is an additional charge for this feature. A full list of covered tests will be provided in your certificate.

Catastrophic Benefit

This pays an additional sum if a covered individual has a serious injury — such as loss of sight, hearing or a limb.

Four reasons to buy this coverage at work:

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are conveniently deducted from your paycheck.

Available family coverage

Who can have it?	
Spouse coverage	Ages 17 to 64
Child coverage	Dependent children newborn until their 26th birthday, regardless of marital or student status.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

My accident coverage

Coverage plan chosen: _____

Cost per pay period: $ _____

Date deductions begin: ___/___/____

(For your records — complete during your enrollment)

GetBenefitSmart.com
Finally, benefits made simple

THIS IS A LIMITED POLICY.

* If you have purchased both enhanced group critical illness and group accident coverage with $50 wellness benefits, Unum will pay wellness benefits for both policies (maximum benefit: $100). This does not apply to policies with $75 or $100 wellness benefit amounts.

1,2 National Safety Council, *Injury Facts* (2013).

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Unum complies with all state civil union and domestic partner laws when applicable.

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