Way Station Inc.

Benefit Guide

July 1, 2019 through June 30, 2020

www.waystationbenefits.org

Table of Contents

Important Contact Information

PRODUCTS		
MEDICAL **Group #: SPHS** Allegeant / CareFirst PPO (in MD, DC, N. VA)	www.myallegeant.com (after you have enrolled) To find a doctor (see "Medical/Rx Plan" section for detailed instructions): CareFirst www.carefirst.com	1-800-553-8635
RX **Group #: SPHS** Magellan Rx	www.magellanrx.com	1-800-424-0472
DENTAL **Group #: TM 05548141-G** MetLife	www.metlife.com/mybenefits.com	1-800-275-4638
VISION **Group #: 6107517** VSP	www.vsp.com	1-800-877-7195
Flexible Spending and Dependent Care Accounts **Group #: 34961** Discovery Benefits	www.discoverybenefits.com	1-866-451-3399 Participant Services Fax: 1-866-451-3245
BASIC LIFE / AD&D, SUPP LIFE / AD&D, STD **Group #: 0215096** MetLife	https://mybenefits.metlife.com/	1-800-GET-MET8 (438-6388)
CRITICAL ILLNESS, ACCIDENT Unum	www.unum.com	1-800-635-5597
EAP KEPRO	www.EAPHelplink.com Company Code: SPHS	1-800-765-0770
ENROLLMENT Kelly Benefit Services	www.waystationbenefits.org	1-877-290-9580

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MEMORANDUM

To: All Benefit-Eligible Employees of Way Station, Inc.

From: Lori Martin, Director of Human Resources

Date: April 25, 2019

Subject: Benefits Guide for the July 1, 2019 – June 30, 2020 Plan Year

Way Station, part of the Sheppard Pratt Health System, is committed to providing our employees with the very best benefits at an affordable cost.

Highlights of the benefits for the 2019-2020 plan year include:

- A decrease in the combined medical and prescription plan deductible and out of pocket maximums
- Partnering with Discovery Benefits who will handle the administration of the Flexible Spending and Dependent Care accounts
- Introducing Livongo, a platform that provides support for those with Diabetes

To encourage a healthy lifestyle, employees who enroll in the medical plan and participate in wellness activities have an opportunity to earn a $5.00 per pay discount by participating in the Healthy Incentive program.

Please read this guide thoroughly as it contains important information which will assist you in making the best possible benefit choices for you and your family.

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.

How to Enroll for Coverage

First Time www.waystationbenefits.org Users (New employees must enroll within 31 days after hire.)

1. Go to https://www.waystationbenefits.org. (We strongly recommend the most recent version of Internet Explorer or Firefox).
2. Click on the "**Register**" link located on the right-hand side of your screen.
3. When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes, you will also be asked to type a randomly generated security code. Click "**Continue**".
4. Follow the directions provided on the site to complete your registration and setup your online account.

Returning www.waystationbenefits.org Users

1. Go to https://www.waystationbenefits.org. (We strongly recommend the most recent version of Internet Explorer or Firefox).
2. Enter your Username and Password within the Secure Benefits Login section and then click "**Login"**.

Forgot Password

The link will provide you with either the option to enter the email address that is currently on file for your account or the option to enter your date of birth and social security number. Either option will allow for the login information to be sent to your current email address on file.

Register

If you do not have an email address on file, click the "Register" link. When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes you will also be asked to type a randomly generated security code. Click "Continue".

You will be asked to enter your previously saved security question as you have already been identified as having a login for your account. Click "Continue". If at this point, you do not know your security answer, please contact Kelly Tech Support at 877-290-9580.

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. You must complete your enrollment within 31 days 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.

Benefit Changes

The benefit elections you make during Open Enrollment will remain in effect for the Plan Year 2019-2020. 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 or 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 31 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

The Sheppard Pratt Health System (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.

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.

Medical Plan Rates per Pay Period (deductions are taken out of 24 pay periods)

ELECTION	40+ hrs/wk	30-39 hrs/wk
Employee only	$51.78	$103.56
Employee & child	$177.04	$295.07
Employee & spouse	$238.18	$357.09
Family	$310.49	$465.50

Summary of Medical Benefits

Claim Administrator:	Allegeant LLC
Member Services:	Allegeant LLC
PPO Network(s):	CareFirst BCBS Regional Provider Network (MD, DC, N. VA) and/or PHCS (outside of MD, DC, N. VA)

This Summary of Benefits is an overview only. Refer to actual summary plan document (SPD) for full description, rules and/or exceptions.

	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
PLAN YEAR DEDUCTIBLE	$700 Individual / $1,400 Family	$2,700 Individual / $5,400 Family
PLAN YEAR OUT-OF-POCKET MAXIMUM	$2,700 Individual / $5,400 Family	$6,700 Individual / $13,400 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

*** The In-Network deductible will apply to an Out-of-Network ambulance when billed with emergency services.

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	$700	$2,700
Per Family	$1,400	$5,400
Combined Medical and Rx Out-of-Pocket Maximum, Per Plan Year		
Per Individual	$2,700	$6,700
Per Family	$5,400	$13,400
	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.

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. Some features include:

- 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 – CareFirst network to find a doctor, access the wellness portal, view prescription claims on Magellan Rx, manage your FBA/HRA/FSA on Discovery Benefits.

How to Sign Up for myAllegeant

Go To: ***www.myallegeant.com***.

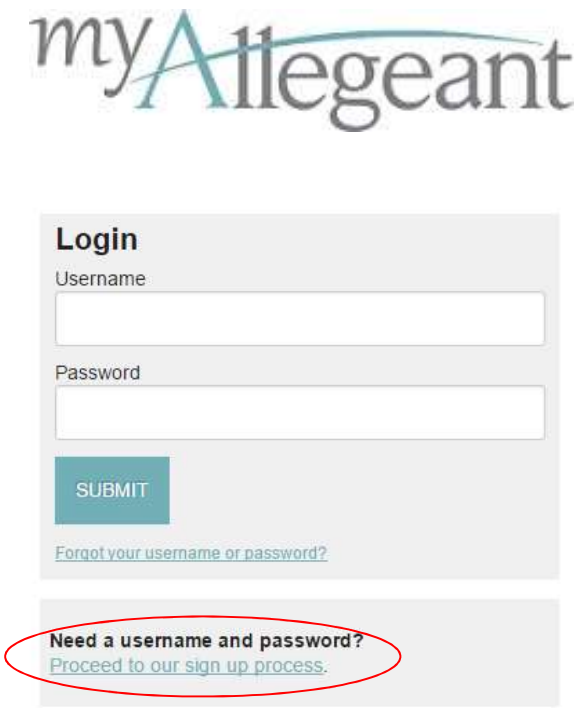
Click the ***Proceed to our sign up process*** link.

1. **Read the License Agreement** and ***Agree*** to proceed.

2. **Fill out the form.** You will need to enter your Member ID (exactly how it appears on your ID card), First Name, Last Name, Date of Birth, and Zip Code in order to establish a user account. Click on ***Next*** to continue the Sign-up process.

3. **Create your user name and password.** An email address is required. Click on ***Next*** to proceed.

4. **Click on *Finish* to complete the Sign-up process.**



Dental Plan

Dental Plan Rates per Pay Period (deductions are taken out of 24 pay periods)

ELECTION	Employees on The Health Plan			
	40+ hrs/wk		30-39 hrs/wk	
	High	Low	High	Low
Employee only	$17.38	$8.50	$17.38	$8.50
Employee & child(ren)	$43.81	$28.33	$43.81	$28.33
Employee & spouse	$37.51	$18.43	$37.51	$18.43
Family	$63.68	$38.19	$63.68	$38.19

ELECTION	Employees Not on The Health Plan			
	40+ hrs/wk		30-39 hrs/wk	
	High	Low	High	Low
Employee only	$0.00	$0.00	$4.18	$2.05
Employee & child(ren)	$25.41	$19.07	$29.59	$21.11
Employee & spouse	$19.36	$9.55	$23.54	$11.59
Family	$44.52	$28.55	$48.70	$30.59

Dental Plan Summary of Benefits

Carrier:	MetLife
Network:	Participating Dental Provider (PDP) Plus
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	$50	$50	$50	$75
Per Family	$150	$150	$150	$225
PLAN YEAR BENEFIT MAXIMUM Per person per plan year	$1,500	$1,500	$1,500	$1,500
COINSURANCE				
Preventive *(deductible waived for in-network)*	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

Vision Plan

Vision Plan Rates per Pay Period (deductions are taken out of 24 pay periods)

ELECTION	40+ hrs/wk	30-39 hrs/wk
Employee only	$4.30	$4.30
Employee & child	$6.45	$6.45
Employee & spouse	$7.16	$7.16
Family	$8.58	$8.58

Carrier:	Vision Service Provider (VSP)
Contribution:	100% employee paid
ID Card:	No ID card – just tell your doctor that you have VSP

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

Discovery Benefits:

Even with health insurance, you still have out of pocket expenses to cover if you need to utilize healthcare. To help you budget for these expenses, Way Station offers you the option to enroll in a Flexible Spending Account that allows you to set aside money and pay for eligible expenses tax-free.

Health Flexible Spending Account (FSA)

Contribution:	**100% employee paid**
Maximum:	**$2,700**
What is it used for?	A Health FSA allows you to pay for ALL of your qualified IRS 213(d) qualified expenses for medical, prescription, dental, orthodontia, vision, and over-the-counter expenses, by using money funded through pre-tax payroll deductions.
Uniformity Rule:	When electing the FSA, the total amount you elected is available for use on your first day of eligibility. However, you will be paying for the elected amount over the course of the year through pre-tax payroll deductions. EXAMPLE: At Open Enrollment, you elect $1,200 for the FSA. On the first day of the plan year, July 1, you will have $1,200 ready for use. However, you will be paying for the $1,200 throughout the plan year through payroll deductions. Even though you are paid bi-weekly, Way Station takes deductions twice per month (24 pay periods in a year), which means that you will have $50 (=$1,200/24) deducted from each paycheck.
Use it or Lose it:	If you have money remaining in your account on June 30, Way Station allows you an additional 75 days after the end of the Plan Year to incur expenses and spend the remaining FSA money on any qualified Medical and Rx expense. The 75-day Grace Period begins on July 1, 2020 and ends on September 15, 2020. All claims incurred during the plan year through June 30, or during the 75 day Grace Period, must be submitted to Discovery by September 30, 2020. All money that goes "unused" at the end of the plan year will be forfeited.
How to use it:	You have two ways to pay for expenses with your FSA: 1) Pay up front – submit claims to Discovery Benefits for reimbursement OR 2) Discovery Benefits Debit Card – **Discovery requires substantiation in order to confirm that transactions are eligible expenses. Substantiation requires either receipt and/or an Explanation of Benefits (EOB).**
Helpful tips:	❖ Save your receipts & EOBs for substantiation! You will be notified by Discovery to substantiate your transaction. ❖ Download the Discovery Benefits Mobile App from the Apple App Store or from Google Play to file and substantiate your claims.

Dependent Care Flexible Spending Account (DCA)

Contribution:	**100% employee paid**
Maximum:	**$5,000** ($2,500 if married filing separately)
What is it used for?	A DCA allows you to pay for custodial care of dependents while you are at work by using money funded through pre-tax payroll deductions.
How to use it:	DCAs are not pre-funded accounts like the FSA, so funds for those accounts will become available as they are deducted from your paycheck each pay period - the entire annual amount is not available at once. Because DCA funds accumulate over time, it is possible that you may incur expenses before funding is available to pay your entire claim. In this case, Discovery Benefits will reimburse you for the current available balance in your DCA and place the remaining claim amount "on-hold". The remaining on-hold claim amount will be automatically reimbursed to you as payroll contributions are transferred to your DCA. All claims must be submitted by September 30, 2020.

How to Use the Accounts

Flexible Spending Accounts assist you in budgeting and paying for out of pocket expenses.

Your Health FSA can be used for any eligible out of pocket medical/Rx expenses. The Health FSA would cover your deductible, copays and coinsurance amounts. Your Health FSA can also cover dental and vision out of pocket expenses and certain over-the-counter products.

How to Pay for your medical expenses with the FSA:

At the Doctor's Office

- Give them your Allegeant ID card
- Pay your copay (if requested) with your Discovery Benefits Debit Card
- See your doctor
- The doctor's office will send a claim to Allegeant
- Allegeant will send you an EOB (Explanation of Benefits) outlining the approved cost of the service, how much the plan will pay, and how much you may owe. Your provider will send you a bill. Make sure the amount he is billing you for matches the amount you may owe on your EOB.
- Pay the provider with your Discovery Benefits Debit Card
- Upload the bill from your provider or EOB to your online portal or mobile app with Discovery Benefits.

At the Pharmacy

- Give them your Allegeant ID card
- They'll tell you the cost of your prescription
- Pay with your Discovery Benefits Debit Card
- Upload the receipt from the pharmacy to your online portal or mobile app with Discovery Benefits.

Like anything tax-free with the IRS, there are strict guidelines and rules that you must comply with to maintain the tax-free status. As a general rule, every claim paid with the Discovery Benefits Debit Card must be reviewed and substantiated. The IRS guidance allows automatic adjudication for certain card transactions, meaning that receipts do not need to be submitted for verification of expenses for which the Discovery Benefits Debit Card is used. This applies in three situations at medical providers and at "90-percent pharmacies" (drug stores and pharmacies where at least 90 percent of the store's gross receipts during the prior taxable year consisted of medical expenses):

1. When the total cost of the transaction is equal to the standard copayment for the service(s) received,
2. When the transaction is for recurring expenses that have previously been approved (for instance: an orthodontia monthly financing plan), or
3. When the merchant provides expense verification to Discovery Benefits when the transaction takes place.

If you forget to substantiate a claim, Discovery Benefits will send you a notice via email or letter after a Discovery Benefits Debit Card swipe. You must provide itemized receipts or an EOB within the time requested by Discovery or the transaction will be deemed ineligible and you will be required to refund the amount of the transactions.

If you fail to submit receipts within 45 days, your card will be deactivated. **Please note, if your card is deactivated due to a hold for substantiation, you can still access your funds through the reimbursement method. You will have to pay upfront and then submit for reimbursement from Discovery.**

If you fail to reimburse the account, the amount of eligible expenses may be added to your W-2 or withheld from your pay.

Substantiation

Substantiation is essential to keep you and Way Station in compliance with the IRS. To stay on top of substantiation, download the Discovery Benefits Mobile App and upload all receipts and/or EOBs to the App.

Discovery Benefits Mobile App

Available for iOS (Apple) and Android-enable mobile devices and tablets, the Discovery Benefits app can be downloaded free of charge. Members can check account balances, view recent transactions, submit claims and upload a receipt or supporting documentation.

Useful Links from Discovery Benefits:

BENEFITS MOBILE APP VIDEO
www.DiscoveryBenefits.com/mobileappvideo

EASY SUBSTANTIATION VIDEO
www.DiscoveryBenefits.com/easysubstantiation

LIVE CHAT WITH DISCOVERY:
www.discoverybenefits.com/contact

ELIGIBLE EXPENSES REFERENCE:
https://www.discoverybenefits.com/employees/eligible-expenses

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 the SPHS High Deductible Health Plan. 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 health 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" (see chart below) are eligible to receive this discount.
- Employees must earn five (5) "Healthy Incentives" in order to receive the $5 per pay incentive.
- See the chart below for the list of "Healthy Incentives" from which you can choose.
- Employees need to provide proof of completion to WSI HR in order to receive the incentives. See chart below for details. Due to HIPAA 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 "Healthy Incentives" earned.
- Upon enrolling in the SPHS High Deductible Health Plan, an employee has up to 90 days to earn "Healthy Incentives" in a given plan year.

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 & Conditions 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.

Employer Paid Life and Disability Benefits

Basic Life / AD&D

Carrier:	MetLife
Contribution:	100% employer paid

BENEFIT / BENEFIT DETAILS	DEFINITION
Amount (Life / AD&D)	1.5x employee annual earnings Up to $200,000
Guarantee Issue	Lesser of 1.5x annual earnings or $200,000 with no medical underwriting
Age Reduction Formula	• 65% at age 65 • 50% at age 70
Accelerated Benefit	12 months or less to live, up to 80% of coverage, to a maximum of $500,000

Long Term Disability (LTD)

Carrier:	MetLife
Coverage:	100% employer paid
Max Monthly Benefit:	$4,000
Min Monthly Benefit:	Greater of $100 or 10% of monthly benefit
Max Benefit Duration:	To age 65, if disability occurs less than age 60. See benefit summary if disability occurs after age 60
Elimination Period:	90 Days or until the end of the STD Maximum Benefit Period

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.

Supplemental Life

Carrier:	MetLife
Contribution:	100% employee paid
Dependent Children:	Must be between 6 months and 19 yrs. Extended to 26 years if child is a full-time student.

Supplemental Life Summary

	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, not to exceed 100% of Employee Basic Life	$10,000 per child
Guarantee Issue Amount	Up to $100,000	Up to $50,000	Up to full amount

At Open Enrollment, if you are currently enrolled in the Supplemental Life insurance, you can increase your Supplemental Life insurance benefit by one increment of $10,000, not to exceed the Guaranteed Issue of $100,000, without submitting a Statement of Health. All increases to employee Supplemental Life over the Guarantee Issue or new elections, if previously eligible, require submission of the Statement of Health.

For spouses at Open Enrollment, all Supplemental Life elections, whether an increase to existing coverage or a new election when previously eligible, will require submission of the Statement of Health.

For child(ren) at Open Enrollment, any increase to Supplemental Life over $2,000 or new election of coverage, if previously eligible, requires submission of the Statement of Health.

Supplemental Life Rates

How to calculate your monthly premium: Your total elected amount / $1,000 * your age banded rate

Employee Rates		Spouse Rates	
Age	**Rate**	**Age**	**Rate**
0-24	$ 0.050	0-24	$ 0.070
25-29	$ 0.060	25-29	$ 0.070
30-34	$ 0.070	30-34	$ 0.081
35-39	$ 0.090	35-39	$ 0.100
40-44	$ 0.100	40-44	$ 0.142
45-49	$ 0.120	45-49	$ 0.203
50-54	$ 0.180	50-54	$ 0.324
55-59	$ 0.290	55-59	$ 0.515
60-64	$ 0.380	60-64	$ 0.791
65-69	$ 0.438	65-69	$ 1.234
70-74	$ 0.970	70-74	$ 2.143
75+	$ 0.970	75+	$ 3.820

Dependent Rate	
Age	**Rate**
5 days to 19 years	$ 0.365

Supplemental AD&D

Carrier:	MetLife
Contribution:	100% employee paid
Dependent Children:	Must be between 6 months and 19 yrs. Extended to 26 years if child is a full-time student.

Supplemental AD&D Summary

	EMPLOYEE	SPOUSE
Minimum	$10,000	$5,000
Maximum	Lesser of $500,000 or 5x salary (this election is not limited by the amount of Supplemental Life benefit)	$250,000, not to exceed 100% of Spouse Supplemental Life benefit
Guarantee Issue Amount	Up to $100,000	Up to $50,000

At Open Enrollment, if you are currently enrolled in the Supplemental Life insurance, you can increase your Supplemental AD&D insurance benefit by one increment of $10,000 for an employee, not to exceed the Guaranteed Issue of $100,000. All increases to employee Supplemental Life over the Guarantee Issue or new elections, if previously eligible, require submission of the Statement of Health.

For the spouse at Open Enrollment, all increases to existing coverage or new elections, if previously eligible, require submission of the Statement of Health.

Supplemental AD&D Rates

How to calculate your monthly premium: Your total elected amount / $1,000 * rate

Employee Rates		Spouse Rates	
All Employees	$ 0.031	All Spouses	$ 0.029

Employee Paid STD

No one likes to think about life's unexpected events. But it is important to face the facts so you can begin to plan ahead. It might surprise you to learn that:

- Just over 1 in 4 of today's 20-year-olds will likely become disabled before reaching age 67
- 1 in 8 workers will be disabled for 5 years or more during their working careers

Disability insurance helps you to maintain a steady stream of income when you can't work due to illness or injury. It is important to know what coverage your employer pays for you and what coverage you would need to buy. Short-term disability covers the first 90 days of your disability. Way Station does **not** give you STD coverage as part of your employment. Instead, Way Station gives you long-term disability (LTD) insurance as part of your employment. LTD covers the period after 90 days from disability and up to 5 years. Remember, if you want STD coverage, you must purchase it.

STD Summary

Carrier: MetLife
Contribution: 100% employee paid

Way Station offers employees the opportunity to purchase Short Term Disability (STD) Insurance through MetLife. 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. You must complete the Benefit Waiting Period, which is the first 7 calendar days of disability for injury or sickness before disability benefits begin. If you still satisfy the plan's definition of disability after the waiting period, the STD plan will replace 50% of your wages up to $500 per week, as long as you continue to be disabled for up to 13 weeks. Below is a summary of the benefits available to you through MetLife's individual STD products.

BENEFIT OVERVIEW	
Benefit Period	13 weeks is the maximum amount of time you can receive disability benefits.
Elimination Period	7 calendar days
Benefit Amount	50% of Weekly Earnings Maximum benefit amount per week: $500

Voluntary Short-Term Disability (STD)

STD Rates

Age	Rate per $10 of covered weekly benefit	How to Calculate Your Monthly Premium
< 25	$1.172	If *Your Weekly Salary * 50% >$500*, Then your monthly premium is *$500 / $10 * Age Rate* If *Your Weekly Salary * 50% <$500*, Then your monthly premium is *Your Weekly Salary * 50% / $10 * Age Rate*
25-29	$1.605	
30-34	$1.687	
35-39	$1.177	
40-44	$1.079	
45-49	$1.073	
50-54	$1.338	
55-59	$1.455	
60-64	$1.594	
65+	$1.753	

Voluntary Critical Illness

Carrier:	Unum Life Insurance Company of America (Unum)
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 enroll in 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 – Benefit Based on the Initial Diagnosis	PERCENTAGE OF COVERAGE AMOUNT
Benign Brain Tumor	100%
Blindness	100%
Coma as the Result of Severe Traumatic Brain Injury	100%
Coronary Artery Bypass Surgery	25%
End Stage Renal (Kidney) Failure	100%
Heart Attack (Myocardial Infarction)	100%
Major Organ Failure	100%
Occupational HIV	100%
Permanent Paralysis as the result of a Covered Accident	100%
Stroke	100%
CANCER CONDITIONS	
Cancer	100%
Carcinoma in Situ	25%
ADDITIONAL CRITICAL ILLNESS FOR DEPENDENT CHILDREN	
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Spina Bifida	100%

Voluntary Accident Insurance

Carrier:	Unum Life Insurance Company of America (Unum)
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

EAP

Way Station uses Sheppard Pratt's EAP plan through KEPRO. As part of this plan, all employees and/or their dependents have access to 5 counseling sessions per year. Individuals may speak with a professional counselor by phone, and the EAP will provide a referral to see a local counselor at no cost for issues such as: Anxiety and stress, depression, grief, parenting, drug or alcohol abuse, transition and change, and relationships.

KEPRO also offers Family Caregiving Services, Legal Services, Financial Services, Convenience Services and Online Tools and Information. Access KEPRO benefits online via www.EAPHelplink.com or call 1-800-765-0770 and use Company Code: SPHS.

403b Plan

Maximum Contribution:	The maximum contribution of eligible pre-tax pay is up to $19,000/year (2019). 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,
Lori Martin, MBA, SHRM-SCP
(301) 662-0099; ext. 1015
lmartin@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 January 31, 2019. Contact your State for more information on eligibility –

PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
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 January 31, 2019, 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

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 SPHS High Deductible 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. 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).

Date:	April 30, 2019
Name of Entity / Sender:	Way Station Inc.
Contact Position/Office:	Human Resources
Address:	210 Abrecht Place Frederick, MD 21701
Phone Number:	(301) 662-0099

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).

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 9.86% for 2019), 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 **210 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? **LORI MARTIN, MBA, SHRM-SCP**		
11. Phone number (if different from above)	12. Email address LMARTIN@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

SPHS Health Plan Summary of Benefit Coverage (SBC)

MetLife Benefit Plan Summaries

UNUM Benefit Plan Summaries

KEPRO Summary of Services

Appendices

Information About Your Health Plan

SPHS Health Plan Summary of Benefit Coverage (SBC)

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Allegeant℠
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).
    - **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.

Allegeant℠
Accountable Care Solutions

Sheppard Pratt
HEALTH SYSTEM

Information About Your Health Plan

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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- Benefit Information
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- 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.

Sheppard Pratt Health System Health Plan: Way Station PPO Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the PPO Plan) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (301) 662-0099. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (301) 662-0099 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$700** individual/**$1,400** family Out-of-Network Providers **$2,700** individual/**$5,400** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription In-Network Providers **$2,700** individual/ **$5,400** family Out-of-Network Providers **$6,700** individual/ $**13,400** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Network providers see **www.carefirst.com** for MD, DC & No. VA only or **www.multiplan.com** click PHCS for all other areas.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; 0% coinsurance	40% coinsurance	None
	Specialist visit	$40 copay/visit; 0% coinsurance	40% coinsurance	None
	Specialist visit • Renal Dialysis • Chemotherapy • Radiation Therapy • Chiropractic Care • Acupuncture • Physical, Speech & Occupational Therapy	0% coinsurance	40% coinsurance	Prenotification required for Renal Dialysis, Chemotherapy and Radiation Therapy; Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com.	Generic drugs (Tier 1)	$5 copay per retail prescription and $10.00 copay per mail order prescription	$5 copay per retail prescription and $10.00 copay per mail order prescription	Retail prescriptions are limited to a 34 day supply. Mail order prescriptions are limited to a 90 day supply. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay.
	Preferred brand drugs (Tier 2)	$30 copay per retail prescription and $60.00 copay per mail order prescription	$30 copay per retail prescription and $60.00 copay per mail order prescription	
	Non-preferred brand drugs (Tier 3)	$60 copay per retail prescription and $120.00 copay per mail order prescription	$60 copay per retail prescription and $120.00 copay per mail order prescription	
	Specialty drugs (Tier 4)	20% coinsurance up to a $100 maximum per prescription	20% coinsurance up to a $100 maximum per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	No charge for Well Women contraceptive services. Prenotification for Organ Biopsies.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	The in-network deductible will apply to the out-of-network emergency medical transportation.
	Urgent care	$40 copay/visit; 0% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	40% coinsurance	Deductible and Coinsurance waived if care is provided by SPHS, SPPPA, Family Services Inc., Mosaic Community Services or Way Station, Inc. mental health providers. Prenotification required for intensive outpatient services.
	Inpatient services	0% coinsurance	40% coinsurance	
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	0% coinsurance	40% coinsurance	Maximum 10 visits per plan year for Chiropractic Care and maximum 10 visits for Acupuncture; Maximum 60 visits per plan year combined for Physical, Speech and Occupational Therapy.
	Habilitation services	0% coinsurance	40% coinsurance	
	Skilled nursing care	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	0% coinsurance	40% coinsurance	No charge for breast feeding equipment. Prenotification required after $2,500 per plan year.
	Hospice services	0% coinsurance	40% coinsurance	Precertification required. $1,000 penalty for non-precertification; Maximum 30 days during 12 consecutive months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Vision Plan available

For more information about limitations and exceptions, see Summary Plan Description at www.waystationbenefits.org.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (unless mother's life/health is at risk)
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Holistic or Homepathic medicine
- Infertility Treatment
- Long Term Care
- Maternity care for dependent children/adults
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Insurance Department or the Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Allegeant, (800) 553-8635. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al (800) 553-8635.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 553-8635.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** (800) 553-8635.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 553-8635.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$700
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$820**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$700
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1540**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$700
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$820**

Way Station, Inc.
Plan Benefits

Explore the coverage that helps you give yourself and your loved ones more security today…and in the future.

Basic Life and Accidental Death and Dismemberment Insurance (AD&D)

Your employer provides you with Basic Life insurance coverage and Accidental Death and Dismemberment insurance in the amount of 1.5 times your base annual earnings to a maximum of $200,000.

Basic Life reduction schedule: 35% at Age 65, 50% at Age 70

Once Enrolled, You have Access to MetLife Advantages℠ - Services to Help Navigate What Life May Bring

This insurance offering from your employer and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Grief Counseling[1]

To help you, your dependents, and your beneficiaries cope with loss

You, your dependents, and your beneficiaries have access to grief counseling[1] sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet[1]. In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-888-319-7819 855-609-9989 or log on to www.metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

Download this helpful Funeral Planning Guide at www.metlife.com/funeralguide.

Funeral Discounts and Planning Services[2]

Ensuring your final wishes are honored

As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using a Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you and your family in making confident decisions when planning ahead as well as

bereavement travel services - available 24 hours, 7 days a week, 365 days a year - to assist with time-sensitive travel arrangements to be with loved ones.

Beneficiary Claim Assistance[3]

For support when beneficiaries need it most

This program is designed to help beneficiaries sort through the details and serious questions about claims and financial needs during a difficult time. MetLife has arranged for Massachusetts Mutual Life Insurance Company (Mass Mutual) financial professionals to be available for assistance in-person or by telephone to help with filing life insurance claims, government benefits and help with financial questions.

Life Settlement Account[4]

For immediate access to death proceeds

The Total Control Account® (TCA) settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accidental death and dismemberment claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. TCA death claim payments relieve beneficiaries of the need to make immediate decisions about what to do with a lump-sum check and enable them to have the flexibility to access funds as needed while earning a guaranteed minimum interest rate on the proceeds as they assess their financial situations. Call 1-800-638-7283 for more information about options available to you.

WillsCenter.com[5]

Self-service online legal document preparation

Employees and spouses/domestic partners have access to WillsCenter.com, an online document service to prepare and update a will, living will, power of attorney, funeral directive, memorandum of wishes or HIPAA authorization form in a secure 24/7 environment at no additional cost. This service is available with all life coverages. Log on to www.willscenter.com to register as a new user.

Retirement Planning[3]

A four-part workshop series that offers you comprehensive retirement education. You also have the option to meet with a local financial professional to discuss your specific circumstances and individual goals.

Transition Solutions[3]

Assistance identifying solutions for your financial situations

Transition Solutions is a service designed to help provide assistance in making financial decisions based on the major events in your life including changes in employment or your benefits status or your retirement. Contact your employer or plan administrator for more information. Call 1-877-275-6387 to get in touch with a MassMutual Transition Solutions Specialist.

Additional Features

This insurance offering from your employer and MetLife comes with additional features that can provide assistance to you and your family.

Accelerated Benefits Option[6]

For access to funds during a difficult time

If you become terminally ill and are diagnosed with 12 months or less to live, you have the option to receive up to 80% of your life insurance proceeds. This can help your family meet medical and other expenses at a difficult time. Amounts not accelerated will continue under your employer's plan for as long as you remain eligible per the certificate requirements and as long as the group policy remains in effect.

The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C.Sec 101(g)).[9]

Accelerated Benefits Option is not the same as long term care insurance (LTC).

Conversion

For protection after your coverage terminates

You can generally convert your group term life insurance benefits to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or change in employee class. Conversion is available on all group life insurance coverages. Please note that conversion is **not** available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, please call 1-877-275-6387 to begin the conversion process. Please contact your employer for more information.

Waiver of Premiums for Total Disability (Continued Protection)

Offering continued coverage when you need it most

If you become Totally Disabled, you may qualify to continue certain insurance. You may also be eligible for waiver of your basic term life insurance premium until you reach age 60, die, or recover from your disability, whichever is sooner.

Total Disability or Totally Disabled means you are unable to do your job and any other job for which you are fit by education, training or experience due to injury or sickness. The Total Disability must begin before age 60, and your waiver will begin after you have satisfied a 9-month waiting period of continuous disability. The waiver of premium will end when you reach age 65, die, or recover.

If you return to work after completing part or all of the 9-month waiting period and later cease active work due to the same or a related Total Disability while your coverage is being continued, you will be given credit for the prior partial or total completion of the waiting period and it will be considered a continuation of the original Total Disability. This means that if you completed the waiting period of continuous disability in the original period of disability, you will not need to complete another one.

- You must notify MetLife of the later period of cessation of active work within 12 months of when that period began.
- The amount of insurance being continued will be the same as during the original period of disability, subject to any reductions in coverage amount due to age.

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Accidental Death & Dismemberment (AD&D) coverage complements your Basic Life insurance coverage and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage

This valuable coverage is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for losses due to covered accidents — while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

Coverage Amounts for You

Your employer provides you with Accidental Death and Dismemberment insurance in an amount equal to your Basic Life coverage amount of 1 times your base annual earnings to a maximum of $200,000 at no additional cost to you.

Table of Covered Losses

This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of your AD&D coverage is called the “Full Amount” and is equal to the benefit payable to the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and are listed in the following table of covered losses. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100% of the Full Amount.

Covered Losses	Percent of Full Amount
Life	100% of Full Amount
Hand	50% of Full Amount
Foot	50% of Full Amount
Arm	75% of Full Amount
Leg	75% of Full Amount
Sight of one eye	50% of Full Amount
Thumb & index finger of same hand	25% of Full Amount
Speech & hearing	100% of Full Amount
Speech or hearing	50% of Full Amount
Paralysis of both arms and both legs	100% of Full Amount
Paralysis of both legs	75% of Full Amount
Paralysis of the arm & leg on either side of the body	50% of Full Amount
Paralysis of one arm or leg	25% of Full Amount
Brain Damage	100% of Full Amount
Coma	1% monthly up to 60 months

Standard Additional Benefits Include

The following benefits are payable in addition to the covered losses listed in the above table:

- Air Bag
- Seat Belt
- Common Carrier

What Is Not Covered?

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Who Can Be A Designated Beneficiary?

You can select any beneficiary(ies) other than your employer, and you may change your beneficiary(ies) at any time. You can also designate more than one beneficiary.

About Your Coverage Effective Date

You must be Actively at Work on the date your coverage is scheduled to become effective.

If Actively at Work requirements are met, coverage will become effective on eligibility effective date or the first of the month following the receipt of your completed application for all requests that do not require additional medical information. A request for an amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of: (1) the date that MetLife approves the coverage or increase if you meet Actively at Work requirements on that date, or (2) the date that Actively at Work requirements are met after MetLife has approved the coverage or increase.

1 Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.

2 Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.

3 The financial professionals involved in the programs Delivering the Promise, Transition Solutions and Retirewise were affiliated with MetLife until July 2016, when Massachusetts Mutual Life Insurance Company (MassMutual) acquired MSI Financial Services Inc. MetLife continues to administer these programs, but has arranged with MassMutual for specially-trained financial professionals associated with MassMutual to offer financial education and provide personal guidance to employees and former employees of firms providing this program through MetLife..

4 Subject to state law, and/or group policyholder requests, the Total Control Account (TCA) is provided for all Life and AD&D benefits of $5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCAs are maintained in MetLife's general account and are subject to claims of MetLife's creditors. MetLife bears the investment risk of the assets backing TCAs, and expects to receive a profit. Regardless of the investment experience of such assets, the interest credited to TCAs will never fall below the guaranteed minimum rate. Guarantees are subject to the financial strength and claims paying ability of MetLife.

5 WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. is not affiliated with MetLife and the WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters.

6 The Accelerated Benefits Option is subject to state availability and regulation. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable federal tax treatment. If the accelerated benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation.

This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Way Station, Inc. and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Like most group insurance policies, insurance policies offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases when your Life and AD&D contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

Way Station, Inc. Plan Benefits

Explore the coverage that makes it easy to give yourself and your loved ones more security today…and in the future.

Supplemental Term Life Insurance Coverage Options

For You	$10,000 increments to a maximum of the lesser of 5.00 times pay or $500,000. Medical Evidence Level: $100,000
For Your Spouse	$5,000 increments to a maximum of $250,000, not to exceed 100% of employee's Basic Life Benefit Medical Evidence Level: $50,000
For Your Dependent Children*	For child from 15 days to 6 months: $1000 Child from 6 months to 1 year: $2,000 increments to a maximum of $10,000

*Child(ren)'s Eligibility: Dependent children ages from 15 days to 19 years old are eligible for coverage. In TX, regardless of student status, child(ren) are covered until age 25.

Monthly Costs* for Supplemental Term Life and Accidental Death and Dismemberment Insurance

You have the option to purchase Supplemental Term Life Insurance. Listed below are your monthly rates (based on your age as of your last birthday) as well as those for your spouse. Rates to cover your child(ren) are also shown.

Age	Monthly Cost Per $1,000 of Employee Coverage	Monthly Cost Per $1,000 of Spouse Coverage
Under 25	$0.048	$0.070
25 - 29	$0.048	$0.070
30 – 34	$0.070	$0.081
35 – 39	$0.090	$0.100
40 – 44	$0.100	$0.142
45 – 49	$0.120	$0.203
50 – 54	$0.180	$0.324
55 – 59	$0.290	$0.515
60 – 64	$0.380	$0.791
65 – 69	$0.438	$1.234
70 – 74	$0.970	$2.143
75 +	$0.970	$3.820
Cost for your Child(ren)†	$0.365	

† Covers all eligible children

*Note: rates are subject to the policy's right to change premium rates, and the employer's right to change employee contributions.

Use the table below to calculate your premium based on the amount of life insurance you will need.
Example: $100,000 Supplemental Life Coverage

1. Enter the rate from the table (example age 36)	$0.090	$ _____
2. Enter the amount of insurance in thousands of dollars (Example: for $100,000 of coverage enter $100)	100	_____
3. Monthly premium (1) x (2)	$9.00	$ _____

Repeat the three easy steps above to determine the cost for each coverage selected.

Once Enrolled, You have Access to MetLife Advantages[SM] - Services to Help Navigate What Life May Bring

Grief Counseling[1] *To help you, your dependents, and your beneficiaries cope with loss*

You, your dependents, and your beneficiaries have access to grief counseling[1] sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet.[1] In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-888-319-7819 855-609-9989 or log on to www.metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

Download this helpful Funeral Planning Guide at www.metlife.com/funeralguide.

Funeral Discounts and Planning Services[2]

Ensuring your final wishes are honored

As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using a Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you.

Beneficiary Claim Assistance[3]

For support when beneficiaries need it most

This program is designed to help beneficiaries sort through the details and serious questions about claims and financial needs during a difficult time. MetLife has arranged for Massachusetts Mutual Life Insurance Company (Mass Mutual) financial professionals to be available for assistance in-person or by telephone to help with filing life insurance claims, government benefits and help with financial questions.

Life Settlement Account[4]

For immediate access to death proceeds

The Total Control Account® (TCA) settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accidental death and dismemberment claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. TCA death claim payments relieve beneficiaries of the need to make immediate decisions about what to do with a lump-sum check and enable them to have the flexibility to access funds as needed while earning a guaranteed minimum interest rate on the proceeds as they assess their financial situations. Call 1-800-638-7283 for more information about options available to you.

Will Preparation [5]

To help ensure your decisions are carried out

When you enroll for supplemental term life coverage, you will automatically receive access to Will Preparation Services at no extra cost to you. Both you and your spouse will have unlimited in-person or telephone access to one of Hyatt Legal Plans' nationwide network of 14,000+ participating attorneys for preparation of or updating a will, living will or power of attorney.* When you use a participating plan attorney, there will be no charge for the services.* Like life insurance, a carefully prepared will (simple or complex), living will and power of attorney are important.

- A will lets you define your most important decisions, such as who will care for your children or inherit your property.
- A living will ensures your wishes are carried out and protects your loved ones from having to make very difficult and personal medical decisions by themselves. Also called an "advanced directive," it is a document authorized by statutes in all states that allows you to provide written instructions regarding use of extraordinary life-support measures and to appoint someone as your proxy or representative to make decisions on maintaining extraordinary life-support if you should become incapacitated and unable to communicate your wishes.
- Powers of attorney allow you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated

Call 1-800-821-6400 and a Client Service Representative will assist you.

* You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

Estate Resolution Services[SM7] (ERS)

Personal service and compassion assistance to help probate your and your spouse's estates.

MetLife Estate Resolution Services [SM] provides probate services in person or over the phone to the representative (executor or administrator) of the deceased employee's estate and the estate of the employee's spouse Estate Resolution Services include preparation of documents and representation at court proceedings needed to transfer the probate assets from the estate to the heirs and completion of correspondence necessary to transfer non-probate assets. ERS covers participating plan attorneys' fees for telephone and face-to-face consultations or for the administrator or executor to discuss general questions about the probate process.

WillsCenter.com[6]

Self-service online legal document preparation

Employees and spouses have access to WillsCenter.com, an online document service to prepare and update a will, living will, power of attorney, funeral directive, memorandum of wishes or HIPAA authorization form in a secure 24/7 environment at no additional cost. This service is available with all life coverages. Log on to www.willscenter.com to register as a new user.

Retirement Planning[3]

A four-part workshop series that offers you comprehensive retirement education. You also have the option to meet with a local financial professional to discuss your specific circumstances and individual goals.

Portability

So you can keep your coverage even if you leave your current employer

Should you leave Sheppard Pratt Health System for any reason, and you Supplemental and Dependent Term Life and Accidental Death and Dismemberment insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly. Rates may be higher than your current rates.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please see your employer or certificate for specific details.
Please note that if you experience an event that makes you eligible for portable coverage, please call a MetLife representative at 1-888-252-3607 or contact your employer for more information.

Transition Solutions[3]

Assistance identifying solutions for your financial situations

Transition Solutions provides assistance for important, time-sensitive benefit and financial decisions due to change in benefits including:

- Group Life Insurance Continuation Options
- Lump-sum distributions
- Reduction in benefits for active or retired employees
- Benefits coordination due to layoffs, merger, acquisition or bankruptcy
- Define Contribution Plan termination
- Retiree Group Life elimination

Additional Features

This insurance offering from your employer and MetLife comes with additional features that can provide assistance to you and your family.

Accelerated Benefits Option[7]

For access to funds during a difficult time

If you become terminally ill and are diagnosed with 12 months or less to live, you have the option to receive up to 80% of your life insurance proceeds. This can go a long way towards helping your family meet medical and other expenses at a difficult time. Amounts not accelerated will continue under your employer's plan for as long as you remain eligible per the certificate requirements and the group policy remains in effect.

The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C.Sec 101(g)).[10]

Accelerated Benefits Option is not the same as long term care insurance (LTC). LTC provides nursing home care, home-health care, personal or adult day care for individuals above age 65 or with chronic or disabling conditions that require constant supervision.

The Accelerated Benefits Option is also available to spouses insured under Dependent Life insurance plans.

This option is not available for dependent child coverage.

Conversion

For protection after your coverage terminates

You can generally convert your group term life insurance benefits to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or change in employee class. Conversion is available on all group life insurance coverages. Please note that conversion is **not** available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, please call 1-877-275-6387 to begin the conversion process. Please contact your employer for more information.

Waiver of Premiums for Total Disability (Continued Protection)

Offering continued coverage when you need it most

If you become Totally Disabled, you may qualify to continue certain insurance. You may also be eligible for waiver of your supplemental and dependent term life AD&D insurance premium until you reach age 60, die, or recover from your disability, whichever is sooner.

Total Disability or Totally Disabled means you are unable to do your job and any other job for which you are fit by education, training or experience due to injury or sickness. The Total Disability must begin before age 60, and your waiver will begin after you have satisfied a 9-month waiting period of continuous disability. The waiver of premium will end when you reach age 65, die, or recover. Please note that this benefit is only available after you have participated in the supplemental term life plan for one year and it is not available on dependent coverage.

If you return to work after completing part or all of the 9-month waiting period and later cease active work due to the same or a related Total Disability while your coverage is being continued, you will be given credit for the prior partial or total completion of the waiting period and it will be considered a continuation of the original Total Disability. This means that if you completed the waiting period of continuous disability in the original period of disability, you will not need to complete another one.

- You must notify MetLife of the later period of cessation of active work within 12 months of when that period began.
- The amount of insurance being continued will be the same as during the original period of disability, subject to any reductions in coverage amount due to age

What's Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance does not provide payment of benefits for death caused by suicide within the first two years (one year for group policies issued in Missouri, North Dakota and Colorado) of the effective date of the certificate or an increase in coverage. This exclusionary period is one year for residents of Missouri and North Dakota. If the group policy was issued in Massachusetts, the suicide exclusion does not apply to dependent life coverage. The suicide exclusion does not apply to residents of Washington, or to individuals covered under a group policy issued in Washington.

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Accidental Death & Dismemberment (AD&D) coverage complements Supplemental Life insurance coverage and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage Options

This valuable coverage benefits beyond your disability or life insurance for losses due to covered accidents — including while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

Supplemental AD&D Coverage Amounts for You

Your Supplemental AD&D amount is $10,000 increments to a maximum of the lesser of 5.00 times pay or $500,000.

Supplemental/ AD&D Coverage Amounts for Spouse

You can choose to cover your dependent spouse with AD&D coverage. Your Spouse will be eligible for coverage amounts of $5,000 increments to a maximum of $250,000, not to exceed 100% of Spouse's Supplemental Life Benefit.

Monthly Cost for Accidental Death & Dismemberment (AD&D) Insurance

Supplemental Coverage	Monthly Cost Per $1,000 of Coverage
Employee	$0.031
Dependent Spouse	$0.029

Covered Losses

This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the "Full Amount" and is equal to the benefit payable for the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and will be listed in your coverage in a table of Covered Losses. Such losses include loss of limbs, sight, speech and hearing, various forms of paralysis, brain damage and coma. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100% of the Full Amount.

Standard Additional Benefits Include

Some of the standard additional benefits included in your coverage that may increase the amounts payable to you and/or defray additional expenses that result from accidental injury or loss of life are:

- Air Bag
- Seat Belt
- Common Carrier
- Child Care Center
- Child Education
- Spouse Education

What Is Not Covered by AD&D?

AD&D insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained or; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or

sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or active participation in a riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

About Your Coverage Effective Date

You must be Actively at Work on the date your coverage becomes effective. Your coverage must be in effect in order for your spouse and eligible children's coverage to take effect. In addition, your spouse and eligible child(ren) must not be home or hospital confined or receiving or applying to receive disability benefits from any source when their coverage becomes effective.

If Actively at Work requirements are met, coverage will become effective on eligible effective date or the first of the month following the receipt of your completed application for all requests that do not require additional medical information. A request for your amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of the date that notice is received that MetLife has approved the coverage or increase if you meet Actively at Work requirements on that date, or the date that Actively at Work requirements are met after MetLife has approved the coverage or increase. The coverage for your spouse and eligible child(ren) will take effect on the date they are no longer confined, receiving or applying for disability benefits from any source or hospitalized.

Who Can Be A Designated Beneficiary?

You can select any beneficiary(ies) other than your employer for your Supplemental coverage, and you may change your beneficiary(ies) at any time. You can also designate more than one beneficiary. You are the beneficiary for your Dependent coverage.

[1] Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.

[2] Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.

[3] The financial professionals involved in the programs Delivering the Promise, Transition Solutions and Retirewise were affiliated with MetLife until July 2016, when Massachusetts Mutual Life Insurance Company (MassMutual) acquired MSI Financial Services Inc. MetLife continues to administer these programs, but has arranged with MassMutual for specially-trained financial professionals associated with MassMutual to offer financial education and provide personal guidance to employees and former employees of firms providing this program through MetLife.

[4] The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCAs are maintained in MetLife's general account and are subject to claims of MetLife's creditors. MetLife bears the investment risk of the assets backing TCAs, and expects to receive a profit. Regardless of the investment experience of such assets, the interest

credited to TCAs will never fall below the guaranteed minimum rate. Guarantees are subject to the financial strength and claims paying ability of MetLife.

[5] Will Preparation and MetLife Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio, a MetLife company. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and affiliates, Warwick, Rhode Island. For New York sitused cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

[6]WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. is not affiliated with MetLife and the WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters.

[7]The Accelerated Benefits Option is subject to state availability and regulation. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable federal tax treatment. If the accelerated benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation.

This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Way Station, Inc. and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Life and AD&D coverages are provided under a group insurance policy issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates, when your employment ceases, when your Life and AD&D contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

Way Station
Disability Plan Benefits

Original Plan Effective Date: July 1, 2018
Date Prepared: 4/27/2018

Explore the coverage that helps you protect your income and your lifestyle.

What is Short Term Disability insurance?

Short Term Disability (STD) insurance can help you replace a portion of your income during the initial weeks of a Disability.

How is "Disability" defined under the Plan?

Generally, you are considered disabled and eligible for short term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation for any employer.

For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance provided by your Employer or contact your MetLife benefits administrator with any questions.

What is the benefit amount?

Short Term Disability:

The Short Term Disability benefit replaces a portion of your predisability earnings, less the income that was actually paid to you during the same Disability from other sources[1] (e.g., state disability benefits, no-fault auto laws, sick pay, vacation pay, etc.).

The Benefit amount is 50% of your predisability weekly earnings; subject to the plan's maximum weekly benefit of $500.

When do benefits begin and how long do they continue?

Short Term Disability:

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. The elimination periods are/is as follows:

For Injury: 7 days.
For Sickness (includes pregnancy): 7 days.

Benefits continue for as long as you are disabled up to a maximum duration of 13 weeks of Disability.

Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance provided by your Employer.

Additional Disability Plan Benefits:

Coverage with Your Best Interests in Mind…

When you are ill or injured for a long time, MetLife believes you need more than a supplement to your income. That's why we offer return-to-work services, and financial.

Services to Help You Get Back to Work Can Include:

Financial Incentives:

Allow you to receive Disability benefits or partial benefits while attempting to return to work

Answers to Some Important Questions…

Q. ***Can I still receive benefits if I return to work part time?***

A. Yes. As long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Your plan offers financial and Rehabilitation incentives designed to help you to return to work when appropriate, even on a part-time basis when you participate in an approved Rehabilitation Program. While disabled, you may receive up to 100% of your predisability earnings when combining benefits, Rehabilitation Incentives, other income sources such as state disability benefits, and part-time earnings.

With the Rehabilitation Incentive you can get a 10% increase in your weekly benefit.

If you work or participate in a rehabilitation program while disabled,following the 4th weekly benefit payment, the Family Care Incentive provides reimbursement up to $100 per week for eligible expenses, such as child care.

You may be eligible for the Moving Expense Incentive if you incur expenses in order to move to a new residence recommended as part of the Rehabilitation Program. Expenses must be approved in advance.

Q. Are there any exclusions for pre-existing conditions?

A. Yes. For the first 12 months your plan may not cover a sickness or accidental injury that arose in the months prior to your participation in the plan. Thereafter, provided you remain disabled, the sickness or accidental injury may be covered. A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance provided by your Employer or contact your MetLife benefits administrator with any questions.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability which results from or is caused or contributed to by:

- Elective treatment or procedures, such as cosmetic surgery, sex-change surgery, reversal of sterilization, liposuction, visual correction surgery, in-vitro fertilization, embryo transfer procedure, artificial insemination or other specific procedures.
  However, pregnancies and complications from any of these procedures will be treated as a sickness.
- War, whether declared or undeclared, or act of war, insurrection, rebellion;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

The “Plan Benefits” provides only a brief overview of the STD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Short Term Disability (“STD”) coverage is provided under a group insurance policy (Form GPNP99) issued to your employer by MetLife. This STD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your STD contributions cease (if applicable) or upon termination of the group contract by your employer. Like most group insurance policies, MetLife’s group policies contain certain exclusions, elimination periods, reductions, limitations and terms for keeping them in force. State variations may apply.

1 Under certain circumstances, MetLife may estimate the amount of income you may receive from other sources.

Way Station
Disability Plan Benefits

Original Plan Effective Date: July 1, 2018
Date Prepared: 4/27/2018

Explore the coverage that helps you protect your income and your lifestyle.

What is Long Term Disability insurance?
Long Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time.

How is "Disability" defined under the Plan?
Generally, you are considered disabled and eligible for long term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your local economy.

Following the Own Occupation period, you are considered disabled if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of treatment and you are unable to earn 80% of your predisability earnings from any employer in their local economy at any gainful occupation for which you are reasonably qualified taking into account your training, prior education and experience
.
For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance provided by your Employer or contact your MetLife benefits administrator with any questions.

What is the benefit amount?
Long Term Disability:
The Long Term Disability benefit replaces a portion of your predisability monthly earnings, less other income you may receive from other sources[1] during the same Disability (e.g., Social Security, Workers' Compensation, vacation pay etc.).

The Benefit amount is 50% of your predisability monthly earnings subject to the plan's maximum monthly benefit.

What is the maximum monthly benefit?
The amount of the Long Term Disability 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.

When do benefits begin and how long do they continue?
Long Term Disability:
Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period for Long Term Disability is 90 days.

Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance provided by your Employer.

Additional Disability Plan Benefits:

Coverage with Your Best Interests in Mind…
When you are ill or injured for a long time, MetLife believes you need more than a supplement to your income. That's why we offer return-to-work services, and financial incentives and assistance in obtaining Social Security Disability Benefits to help you get the maximum benefits from your coverage.

Services to Help You Get Back to Work Can Include:

Nurse Consultant or Case Manager Services:
Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis:
Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accommodations:
Adjustments (e.g., redesign of work station tools) that enable you to return to work.

Retraining:
Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives:
Allow you to receive Disability benefits or partial benefits while attempting to return to work.

Answers to Some Important Questions…

Q. *Can I still receive benefits if I return to work part time?*

A. Yes. As long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Your plan offers financial and Rehabilitatio incentives designed to help you to return to work when appropriate, even on a part-time basis when you participate in an approved Rehabilitation Program.

While disabled, you may receive up to 100% of your predisability earnings when combining benefits, Rehabilitation Incentives,] other income sources such as Social Security Disability Benefits and state disability benefits, and part-time earnings.

With the Rehabilitation Incentive you can get a 10% increase in your monthly benefit.

The Family Care Incentive provides reimbursement up to $400 per month for eligible expenses, such as child care, during the first 24 months of Disability.

You may be eligible for the Moving Expense Incentive if you incur expenses in order to move to a new residence recommended as part of the Rehabilitation Program. Expenses must be approved in advance.

Q. Are there any exclusions for pre-existing conditions?

A. Yes. For the first 12 months your plan may not cover a sickness or accidental injury that arose in the months prior to your participation in the plan. Thereafter, provided you remain disabled, the sickness or accidental injury may be covered. A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance provided by your Employer or contact your MetLife benefits administrator with any questions.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability which results from or is caused or contributed to by:

- War, whether declared or undeclared, or act of war, insurrection, rebellion;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

Q. Are there any limitations to my coverage?

A. For Long Term Disability, limited benefits apply for specific conditions:
If you are disabled due to alcohol, drug or substance abuse or addiction, we will limit your disability benefits to a lifetime of Disability for 24 months. During Your Disability, we require you to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a physician.
Benefits will end at the earliest of

- The date you receive 24 months of disability benefit payments;
- The date you cease or refuse to participate in the recovery program referred above; or
- The date you complete such recovery program.

If you are disabled due to mental or nervous disorders or diseases, we will limit your Disability benefits to a lifetime maximum equal to the lesser of:

- 24months; or
- The Maximum Benefit Period.

Other limitations or exclusions to your coverage may apply. Please review your Certificate of Insurance provided by your Employer for specific details or contact your benefits administrator with any questions.

The "Plan Benefits" provides only a brief overview of the LTD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the Certificate of Insurance/Summary Plan Description. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Long Term Disability ("LTD") coverage is provided under a group insurance policy (Form GPNP99) issued to your employer by MetLife. This LTD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your LTD contributions cease (if applicable) or upon termination of the group contract by your employer. Like most group insurance policies, MetLife's group policies contain certain exclusions, elimination periods, reductions, limitations and terms for keeping them in force. State variations may apply.

1 Under certain circumstances, MetLife may estimate the amount of income you may receive from other sources.

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

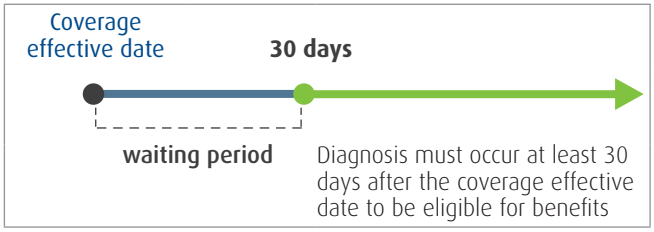
Available family coverage

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

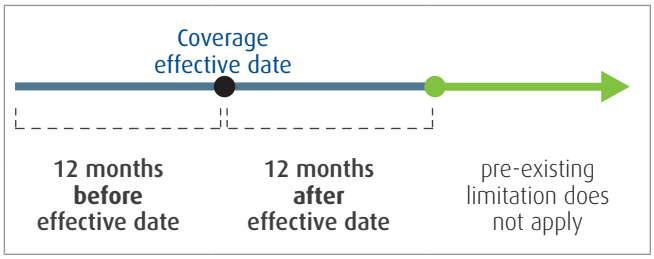
Waiting period



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.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

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.

unum.com

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).

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

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

unum.com

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)

The information is not intended to be a complete description of the insurance coverage available. 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. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

unum.com

EMPLOYEE ASSISTANCE PROGAM

KEPRO INTELLIGENT VALUE

Summary of Services: Way Station

COUNSELING SERVICES Up to five (5) counseling sessions are available for issues affecting employees and their dependents. Individuals may speak with a professional counselor by phone, and the Employee Assistance Program will provide a referral to see a local counselor at no cost for issues such as:	• Anxiety and stress • Depression • Grief • Parenting • Drug or alcohol abuse	• Transition and change • Relationships – individual, marital, and family
FAMILY CAREGIVING SERVICES Confirmed referrals and information are available on a variety of family matters, including:	*CHILD CARE AND PARENTING* • Prenatal care • Daycare/summer camps • Special needs services • Preparing students for college	*ELDERCARE* • Assisted living • In-home care • Transportation services • Adult daycare
LEGAL SERVICES A 30 minute phone or in-person consultation is available to help answer basic legal questions and simplify the process of obtaining legal help. Some common legal concerns include:	• Adoption • Bankruptcy • Child custody • Criminal issues • Divorce	• Estate Planning • Immigration • Real estate • Tenant's rights • Mediation
FINANCIAL SERVICES A telephonic consultation with a qualified financial consultant is available to assist with a variety of financial concerns such as:	• Bankruptcy alternatives • Budgeting and cash flow • Credit issues • Identity theft	• Education funding • Income taxes • Mortgages • Retirement planning
CONVENIENCE SERVICES The Employee Assistance Program includes complimentary referrals to convenience services to help members make the most of their money and free time.	• Repairs • Moving and relocation services • Cleaning services • Car and hotel reservations • Sightseeing tours	• Destination guides • Dining • Personal shopping • Gift Recommendations
ONLINE TOOLS AND INFORMATION EAPHelplink.com is an interactive web-based self-service solution. The site provides a wide array of life management tools to help members with a variety of personal and/or work related issues in a private and convenient manner.	• Research articles • Wellness articles • Online trainings • Monthly webinars	• Self-search locators for child, academic and adult care resources • And much more!

CONFIDENTIALITY: All discussions between you and your EAP professional are confidential. Information regarding your contact with the EAP cannot be released without your written consent, except by court order, imminent threat of harm to self or others, or in situations of abuse (such as child or elder abuse).

NO OUT-OF-POCKET COST: Your EAP is offered at no cost. Most concerns can be resolved directly with your EAP professional, but in the case that additional services are needed, your EAP professional will work with you to identify the most appropriate and affordable community resource to help meet your needs. Please note that referrals to services outside the EAP benefit may require out-of-pocket cost.

For more information about your Employee Assistance Program please contact us as listed below.

Phone: 800-765-0770 **Website: www.EAPHelplink.com** **Company Code: SPHS**

WAY STATION
Part of the Sheppard Pratt Health System