Area Agency on Aging of Western Arkansas
and Visiting Nurses Agency

"Our heart is in your home."

EMPLOYEE BENEFITS PLAN YEAR 2017-2018

Arthur J. Gallagher & Co.

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This Benefit and Cost Summary summarizes the Area Agency on Aging of Western Arkansas, Inc. benefits program. Complete descriptions of each benefit are available in the actual plan documents. Every effort has been made to ensure this summary accurately describes these benefits. However, if there is a conflict between this information and the plan documents, the plan documents will govern. In addition, participation in the benefits program does not constitute a right to continued employment with the company. Nothing in this guide should be construed as a contract or offer to contract for employment for any specific time or under any particular terms and conditions. While it is the company's intent to continue these programs, we reserve the right to amend or terminate them at any time.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 38 for more details.

This handout is for illustrative purposes only. If there is a discrepancy between this handout and the contract, the contract will prevail.

ELIGIBILITY INFORMATION YOU NEED TO KNOW

OPEN ENROLLMENT / NEWLY ELIGIBLE

Open Enrollment is during the month of September / October each year. If you wish to sign up for coverage for either yourself or your eligible dependent(s) or drop coverage for yourself or a dependent—open enrollment is the time to do so; otherwise you will have to wait until the next open enrollment period (during September / October 2018) to enroll, unless you have a qualifying event. *If you experience a qualifying event, you must submit a change form to your human resources department within 30 days of the qualifying event.* If you are a new hire, you must sign up for coverage within 30 days of your eligibility date.

WHO IS ELIGIBLE

Employee Eligibility

All full time employees working 30 hours per week (as determined during our measurement period) will be eligible for benefits the first of the month following the 60 day waiting period. The effective date of most changes made will be the 1st of the month following the change. The effective date for medical, dental and vision termination will be the last day of the month following the termination. The effective date for all life coverage terminations will be the date of termination. Please contact Colonial for your coverage end date for these specific benefits.

Dependent Eligibility

You may also cover your eligible dependents, including:

* Your legal spouse
* Your natural children, stepchildren, legally adopted children and children under your legal guardianship until their 26th birthday.

If your child or spouse is no longer eligible, you must notify Area Agency on Aging of Western Arkansas, Inc. by contacting your human resources office.

TO ADD A DEPENDENT AFTER YOUR INITIAL ELIGIBILITY PERIOD

If you decline enrollment for yourself or your dependents because you are covered by another health insurance plan, you are eligible to enroll in this plan if you have a loss of the other insurance coverage. Your completed form must be turned in to the human resources department within 30 days of the loss of coverage. If your form is not received within 30 days, you will not be able to enroll until the next open enrollment period.

Coverage for a new dependent acquired by court or administrative order or marriage will take effect the first of the month following the event date. Coverage for a newborn or adopted newborn will be effective the date of birth. Coverage for a new dependent acquired by legal adoption or placement for adoption will take effect on the date placed for adoption or the date of petition for adoption is filed.

Coverage is effective only if the enrollment form is received within the 90 days of the birth, 60 days of the adoption or placement for adoption, or 30 days of the court or administrative order or marriage.

If the human resources department does not receive your form within the required time period, you will not be able to enroll until the next open enrollment period.

CHANGING YOUR BENEFIT ELECTIONS—Medical / Dental / Vision

Please remember that since your premium contributions are deducted on a pre-tax basis, according to the IRS regulations, you are "locked in" to your benefit election for the next year unless you have a change in family status. Changes may NOT be made during the year unless there is a change in family status. Some examples of this would include:

*Marriage or Divorce
*Birth or Adoption of a child
*Death of a Dependent
*Loss or Gain of Spouse's Employment
*Loss or Gain of other coverage
* Legal Guardianship
* Loss of a Dependent
* Court or Administrative Order

You must notify the human resources department about any qualifying Life Events as soon as possible and before 30 days have passed. You also must provide proof of the event (a marriage license, birth certificate, death certificate, etc.). If you wait longer than 30 days, you will not be allowed to make any coverage changes until the next annual open enrollment, per IRS regulations.

CHANGING YOUR BENEFIT ELECTIONS—Voluntary Life

Voluntary Life—If you are enrolling during this initial enrollment or are a new hire and enrolling within 30 days of your eligibility date, you may enroll in the life insurance and receive up to a $150,000 life insurance benefit for yourself, $25,000 for your spouse and $10,000 for each eligible child without evidence of insurability. Any purchase or increase in benefits that does not take place within 30 days of your or your dependent's eligibility effective date is subject to evidence of insurability and coverage is not guaranteed and is subject to Guardian's approval.

POLICY CERTIFICATE BOOKLET

Your certificate booklets are available on your personal member site for each carrier. The member sites are shown in the back of this booklet. You may find information on how to access these sites in this booklet. If you are unable to access this information, please contact your human resources department and request a copy of the certificates.

THE FOLLOWING PAGES CONTAIN A BRIEF OUTLINE OF THE BENEFITS OFFERED. MORE DETAILED SUMMARY INFORMATION MAY BE FOUND AT THE FOLLOWING MEMBER SITES:

Medical Coverage - www.myblueprint.arkansasbluecross.com

Dental / Vision / Basic Life / Voluntary Life/ Voluntary Accidental Death and Dismemberment — www.guardiananytime.com

Voluntary Worksite: www.coloniallife.com

H S A Administrator—www.discoveryBenefits.com

Cobra Administrator— www.discoverybenefits.com

Arkansas Blue Cross Blue Shield / MEDICAL—HDHP / H S A PLAN

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	(IN and OUT of Network Deductible are separate and do not cross accumulate) Deductible Type: Aggregate—There is one family deductible to satisfy, and no individual deductibles to meet. With an aggregate deductible, either one family member or a combination of family members can satisfy the family deductible amount.	
Individual Maximum	$3,000	$6,000
Family Maximum	$6,000	$12,000
Payment Level/ Coinsurance	100% after deductible until out of pocket maximum is met; then 100%	80% after deductible until out of pocket maximum is met; then 100%
Annual Out-of-Pocket Maximum	(Out of pocket maxes do not cross accumulate)	
	Annual Out of Pocket Maximum In Network INCLUDES Deductible and Coinsurance	Annual Out of Pocket Maximum Out of Network INCLUDES Deductible and Coinsurance
Individual Maximum	$3,000	Unlimited
Family Maximum	$6,000	Unlimited
Primary Care and Specialist Doctor Office Visits	100% after Deductible has been met	80% after Deductible has been met
Preventive Care Services	100% - Deductible does not apply. You pay $0	80% after Deductible has been met
Diagnostic Test (X-ray, Bloodwork)	100% after Deductible has been met	80% after Deductible has been met
Imaging (CT/PET scans, MRIs)	100% after Deductible has been met	80% after Deductible has been met
Emergency Health Services—Outpatient	100% after Deductible has been met	100% after Deductible has been met
Urgent Care	100% after Deductible has been met	80% after Deductible has been met
Prescription Drug Coverage— Participating Retail Pharmacies	Preventive Maintenance Medications that are generic are covered 100% with no deductible or copay. You pay $0 All Other Prescriptions are Subject to the Deductible and Coinsurance	
	Mail Order—Not Available	
Lifetime Maximum	Unlimited	
Dependent Age Limit: Up to age 26 Regardless of Student, Marital or Tax Status		

MONTHLY PREMIUM				
Annual Salary	**Employee Only**	**Employee + Children**	**Employee + Spouse**	**Employee + Family**
Up to $34,999	**$73.82**	**$451.06**	**$562.00**	**$917.03**
$35,000 to $49,999	**$147.64**	**$524.88**	**$635.82**	**$990.85**
$50,000 and Over	**$221.90**	**$599.14**	**$710.08**	**$1,065.11**

*The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to uou can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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Arkansas Blue Cross Blue Shield / MEDICAL—PPO PLAN

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	(IN and OUT of Network Deductible is shared) Accumulated Deductible Type: Once one person in the family meets the individual deductible, the remaining family members are combined to satisfy the family deductible.	
Individual Maximum	$3,000	
Family Maximum	$6,000	
Payment Level/ Coinsurance	80% after deductible until out of pocket maximum is met; then 100%	60% after deductible until out of pocket maximum is met; then 100%
Annual Out-of-Pocket Maximum	(Out of pocket maxes do not cross accumulate)	
	Annual Out of Pocket Maximum In Network INCLUDES Deductible, Coinsurance and Copays	Annual Out of Pocket Maximum Out of Network INCLUDES Deductible and Coinsurance
Individual Maximum	$6,000	Unlimited
Family Maximum	$12,000	Unlimited
Physician's Office Service	100% after $30 Copay per visit	60% after Deductible has been met
Specialist's Office Service	100% after $50 Copay per visit	60% after Deductible has been met
Preventive Care Services	100%, copayments and deductibles do not apply; You pay $0	80% after Deductible has been met
Diagnostic Test (X-ray, Bloodwork)	80% after Deductible has been met	60% after Deductible has been met
Imaging (CT/PET scans, MRIs)	80% after Deductible has been met	60% after Deductible has been met
Emergency Health Services—Outpatient	$100 Copay per visit + Deductible + 20%	$100 Copay per visit + Deductible + 20%
Urgent Care	$50 Copay per visit + 20%	$50 Copay per visit + 20%
Prescription Drug Coverage— Participating Retail Pharmacies **(Prior Authorization, Step Therapy or Quantity Limits May Apply)**	Retail—Up to 31- Day Supply Generic—$10 / Brand —$35 / Non Preferred Brand—$60 / Specialty—$60 / Non Covered Medications— you pay 100%	
	Mail Order—Up to 90-Day Supply Generic —$20 / Preferred Brand —$70 / Non Preferred Brand —$120 / Specialty Not Covered as Mail Order / Non Covered Medications— you pay 100%	
Lifetime Maximum	Unlimited	
Dependent Age Limit: Up to age 26 Regardless of Student, Marital or Tax Status		

MONTHLY PREMIUM				
Annual Salary	**Employee Only**	**Employee + Children**	**Employee + Spouse**	**Employee + Family**
Up to $34,999	**$89.58**	**$574.01**	**$716.47**	**$1,172.39**
$35,000 to $49,999	**$179.14**	**$663.57**	**$806.03**	**$1,261.95**
$50,000 and Over	**$269.24**	**$753.67**	**$896.13**	**$1,352.05**

*The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to uou can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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Deductible Types / Alternative Prescription Drug Program

HOW YOUR DEDUCTIBLE WORKS ON YOUR PLAN:

The Summary of Benefits and Coverage does not clearly explain the types of deductibles on your plans. Although the individual and family deductible amounts shown are accurate, the way the deductible is accumulated needs to be clarified. The deductible and out of pocket is based on a calendar year basis from January 1st through December 31st each year.

PPO PLAN: Effective 11/01/2017, the deductible type on the PPO PLAN is *changing* from Accumulated to Fulfillment. Below is the definition of the deductible types and an example of how each is administered by Arkansas Blue Cross Blue Shield.

Accumulated:
One person must meet the individual deductible before the family can accumulate.
Fulfillment:
Two family members must fully satisfy their individual deductible in order to meet the family deductible.

EXAMPLE:
John, Jane, and Jimmy have family coverage, which has a $575 individual deductible and a $1150 family deductible.

Accumulated Deductible Type (Prior Type) —*Example*

⇒ John has outpatient surgery in January. He meets $500 of his individual deductible. Nothing is applied to the family deductible so far.
⇒ Jimmy has to go to the ER in September. His claim is $300 and is applied to his individual deductible.
⇒ Jane has inpatient surgery in May. She meets her full $575 individual deductible. The family deductibles can now be accumulated because one person reached the full individual deductible.

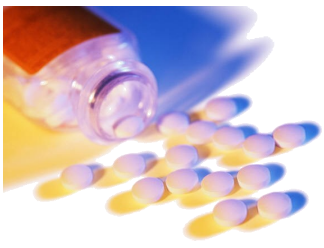
Family deductible required: $1150
Total deductible applied: $1375

Fulfillment Deductible Type (New Type)—*Example*

⇒ John has outpatient surgery in January. He meets $500 of his individual deductible. Nothing is applied to the family deductible so far.
⇒ Jane has inpatient surgery in May. She meets her full $575 individual deductible. The family deductible can now reflect $575 met since one person has fully satisfied their individual deductible.
⇒ Jimmy has to go to the ER in August. His claim is $200. $200 is applied to his individual deductible.
⇒ John has additional outpatient services in August and meets the last $75 of his individual deductible. Because he is the second person to meet the individual deductible, the family deductible is now considered satisfied.

Family Deductible: $575, 2X = $1150
Total deductible applied: $1350

HSA PLAN: The deductible type on the HSA plan is not changing. The deductible type is Aggregate. An aggregate deductible type means there is one family deductible to satisfy and no individual deductibles to meet. With an aggregate deductible, either one family member or a combination of family members can satisfy the family deductible amount.



ALTERNATIVE PRESCRIPTION DRUG PROGRAM

$4 Prescriptions
Choose from hundreds of generic drugs
and over the counter medications
$4 for 30-day supply / $10 for a 90-day supply

Instead of the applicable pharmacy copay under your Arkansas Blue Cross Blue Shield plan, you may participate in the Pharmacy $4 Prescription Program. This program is available to everyone, no membership is required.

You may ask your local Pharmacist if the medication you are taking is included on the list of available medications or check online at your participating pharmacy website. Simply ask for the $4 program and do not give them your Arkansas Blue Cross Blue Shield ID card.

***Please check with your local retail chain pharmacy. ***

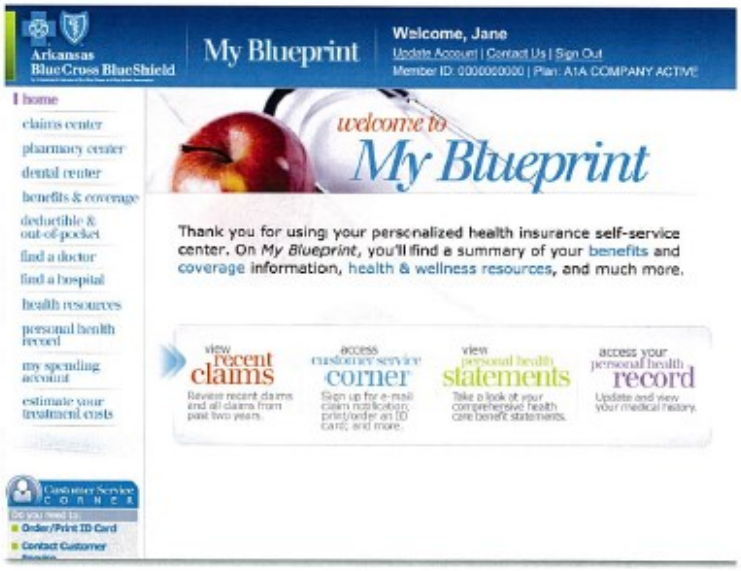
Connect to your health plan FROM ANYWHERE

The *free* Arkansas Blue Cross and Blue Shield mobile app lets you:

- Pay your bill
- Look up in-network doctors, hospitals and dentists
- Find locations and stores for face-to-face help
- View recent claims securely at your fingertips
- Review coverage information and dependents
- See a digital member ID card
- Contact your health plan

HOW TO USE MY BLUEPRINT

My Blueprint is an online, self-service center for the health plan members of Arkansas Blue Cross and Blue Shield. It gives you access to your health plan information 24 hours a day, 7 days a week.



MY BLUEPRINT FUNCTIONS

- Order replacement ID card
- Check status of claims and claims history
- Check deductible
- Access health information
- Find a doctor or hospital
- Estimate your treatment costs
- Review a recent doctor visit

HOW TO LOCATE MY BLUEPRINT

Go to our website at
arkansasbluecross.com

In the "Log In" box at the top of the screen, use the drop-down box to select "Member" and register for this free service.

Arkansas **BlueCross BlueShield**
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LEARN HOW TO REGISTER

HOW TO REGISTER

You, your covered spouse and covered dependents can register for *My Blueprint*.

To register, select the "Register" link in the log-in box and follow the instructions. You will need the following information as it appears on your health plan ID card:

- Member ID number
- Name
- Date of birth

You will create your own **log-in ID** and **password** which will allow you immediate access to the health tools.

To access your **personal health information** (Personal Health Record, claims or pharmacy data or other personal information), you must have your **activation code**. Your activation code will be mailed to your home address within five days after you have registered.

Members can get *immediate* access to *My Blueprint* by entering a claim number from the past six months or physician's last name and date of an office visit from the past six months or by calling Customer Service.

WELCOME TO *MY BLUEPRINT!*

Arkansas
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MPI 3224 11/14

Health Education & Disease Management PROGRAMS

HEALTHIER LIVING THROUGH Disease Management

WHAT IS DISEASE MANAGEMENT?

The Arkansas Blue Cross and Blue Shield disease management program helps employees and their dependents manage their health with evidence-based healthcare guidelines and national standards of care.

Make the most of our *no-cost* disease management program so that you and your family can live a healthier lifestyle.

WHY ENROLL?

Discover new, achievable ways to improve your health.

- Health education
- Help managing a condition
- Support for a chronic condition
- Information regarding local healthcare resources
- Tools to live a healthier life

When you enroll, a registered nurse will help you set goals and manage your condition, whether it's diabetes, heart disease, asthma, congestive heart failure, or chronic obstructive pulmonary disease.

HOW DO I ENROLL?

Enrollment is easy. Call and talk to one of our registered nurses at 800-285-6652.

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Health Advantage
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BlueAdvantage Administrators of Arkansas
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Please note: Health Education Programs are for health education purposes only. We do not offer medical advice or medical services. Always consult your treating physician(s) for any medical advice or services you may need. You, as a member, are responsible for selecting providers, services or products. Please check your member benefits for coverage of services. All information provided by you is kept strictly confidential and is only used to provide us with information necessary for participation in the Health Education Programs.

Another Way to Buy Diabetes Supplies

Visit your local in-network pharmacy for your testing supplies

Arkansas Blue Cross and Blue Shield and Health Advantage have added another way for members with diabetes to purchase certain supplies. You now can buy diabetes testing supplies at your local pharmacy at a preferred copayment or the cost will count toward your overall deductible or HSA out-of-pocket maximum *(depending on your coverage)*.

You can fill your prescriptions and get the supplies you need at the local pharmacy in one simple stop. Testing supplies covered at the pharmacy include:

- **Diabetes meters (OneTouch Brand only)**
- **Test strips (OneTouch Brand only)**
- **Lancets**
- **Needles**
- **Syringes**

Your local pharmacist is a good resource for medicine and supply questions. Next time you need to refill your supplies, fill a prescription or ask a question about your medication, remember to visit your local pharmacy and bring your health insurance card.

New, no-cost diabetes meter

OneTouch offers a no-cost diabetes meter, too. Visit the OneTouch website at **www.onetouch.com** to find out if you qualify for a free meter.

Happy with how you get supplies?

Other options for diabetes supplies still are available to you! Nothing changes if you order diabetes supplies from a durable medical equipment provider and if you're a member of the Diabetes Health Education program your deductible is waived. You can continue to get your strips, lancets and other supplies the same way. The option to purchase at your local pharmacy is just another outlet to make buying diabetes testing supplies more convenient for Arkansas Blue Cross and Health Advantage members.

Questions? Call 1-800-863-5561

Arkansas BlueCross BlueShield
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Health Advantage
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OneTouch is owned by Johnson & Johnson, an independent company that provides diabetic meters to Arkansas Blue Cross and Health Advantage members who qualify.

HEALTH SAVINGS ACCOUNT (HSA)

EMPLOYEE HANDOUT

THE FASTEST-GROWING HSA ON THE MARKET

- ONE PORTAL, ONE MOBILE APP AND ONE DEBIT CARD FOR ALL OF YOUR BENEFITS
- ABILITY TO CHECK BALANCE AND REQUEST DISTRIBUTIONS OR CONTRIBUTIONS ON THE GO
- A LOW INVESTMENT THRESHOLD AND ENHANCED INVESTMENT EXPERIENCE
- NO SURPRISE PARTICIPANT FEES
- TOOLS AND RESOURCES FOR SPENDERS, SAVERS AND INVESTORS

Health Savings Account Overview

A Health Savings Account (HSA) lets you make the most of your earnings by setting aside tax-free dollars for medical, dental and vision expenses. HSAs are individually owned and provide a triple-tax advantage. You can deposit money tax-free it will grow tax-free until you use it, and your withdrawals are tax-free when used on eligible expenses.

Eligibility

You must be enrolled in a High-Deductible Health Plan (HDHP) to get an HSA, which can be used to pay for out-of-pocket expenses until you've met your deductible, at which point your health plan kicks in. While you can't be enrolled in a general purpose Flexible Spending Account and an HSA at the same time, you can pair an HSA with a Limited FSA.

Spending

The HSA covers qualifying medical, dental and vision expenses. To find out which specific expenses are eligible, view our searchable eligibility list at www.DiscoveryBenefits.com/eligibleexpenses.

Discovery Benefits makes it easy to access your HSA funds with:

- The Discovery Benefits debit card, which can be used to pay for eligible expenses, so you'll reduce your out-of-pocket costs.
- Claims Sync, which syncs insurance claims directly into your consumer portal dashboard so you can easily track your expenses.
- Our mobile app, which provides a fast and secure way to check your balance, track expenses and move funds between your HSA and your bank account.

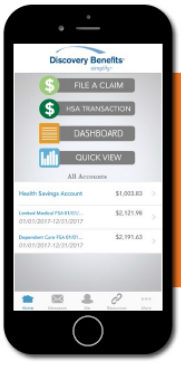
Saving

To take the guesswork out of election decisions, we offer a free savings calculator to help you decide how much to set aside. Calculate your savings today at www.DiscoveryBenefits.com/hsacalculator.

Investing

We make it easy to invest by offering a low HSA investment threshold of $1,000. Once your HSA reaches that amount, you're able to invest in interest-bearing accounts or mutual funds without ever leaving your consumer portal.

We also offer an Investment Guidance Tool on the consumer portal to help you determine which investments are right for you. And, since all of your HSA dollars carry over from year to year, HSAs are a valuable long-term investment option.



DOWNLOAD THE APP FOR FREE ON APPLE AND ANDROID DEVICES

Download on the App Store | GET IT ON Google Play

RESOURCES

- **ELIGIBLE EXPENSE LIST** www.DiscoveryBenefits.com/eligibleexpenses
- **HSA CALCULATOR** www.DiscoveryBenefits.com/hsacalculator
- **MOBILE APP VIDEO** www.DiscoveryBenefits.com/mobileappvideo
- **HSA VIDEOS** www.DiscoveryBenefits.com/hsavideos

Discovery Benefits®
www.DiscoveryBenefits.com

08/01/17

Health Savings Account (HSA) FAQ — Participants

What is a Health Savings Account (HSA)?

HSAs are individually owned accounts that work similar to Individual Retirement Accounts and allow you to set aside pre-tax dollars for medical expenses. With an HSA, you can deposit money tax-free and it will grow tax-free until you use it. Interest or dividends accumulate tax-free and payment of qualified medical expenses have no additional tax consequences. You decide how to invest and grow your HSA.

To open an HSA, you must be enrolled in a High-Deductible Health Plan (HDHP). Then, you can use the money in your HSA to pay for the plan's deductible, co-insurance and other non-covered expenses. Once your deductible is met, the HDHP kicks in to pay for major health costs. Even if an HDHP no longer covers you, your account will remain active and you can use the remaining balance for medical expenses — you just won't be able to make contributions once your HDHP coverage ends. The assets in your HSA account always belong to you and funds will remain in your account from year to year unless they are used.

When you set up an HSA, you are required to set it up with a qualified custodian or trustee. Discovery Benefits' custodian is HealthcareBank.

Who can participate in an HSA?

Any individual covered by a High-Deductible Health Plan (HDHP) can participate in an HSA.

Individuals may be excluded from an HSA if they are:

- Covered under a spouse's or a dependent's employer's health plan that is not an HDHP.
- Claimed on someone's taxes.
- Covered by any Medicare Benefit.
- Covered under an MSA or HRA, unless the coverage under the MSA or HRA is limited to permitted benefits or specific benefits not provided by the HDHP.

If an HSA is offered through an employer's cafeteria plan, the eligibility requirements of the cafeteria plan apply. Sub S-corporation owners, their spouses and dependents employed by the company may not participate in an HSA. Neither can sole-proprietors, 2% or more owners in a partnership, limited-liability partnerships or limited-liability corporations.

Who can make contributions to an HSA?

HSAs allow contributions to be made by employers, eligible individuals or both. Employer contributions are subject to non-discrimination rules (also known as comparability rules).

How much can I contribute to my HSA?

You can contribute up to the annual statutory maximum as long as your HSA is established by December 1 of the calendar year. The maximums are as follows:

2017:
Single HDHP Coverage = $3,400
Family HDHP Coverage = $6,750
Catch-up Contribution (age 55 by the end of the year) = $1,000

2018:
Single HDHP Coverage = $3,450
Family HDHP Coverage = $6,900
Catch-up Contribution (age 55 by the end of the year) = $1,000

What is the contribution deadline?

The contribution deadline is April 15 following the year for which the contributions were made.

Health Savings Account (HSA) FAQ — Participants, continued

What are the tax advantages of owning an HSA?

Triple Tax Savings:

- Contributions are tax-free*
  - Employee contributions that are deductible over-the-line (i.e. deductible even by non-itemizers)
  - Employer contributions that are excluded from income and employment taxes
  - Salary reduction contributions made through a Section 125 cafeteria plan
- Earnings are tax-free
- Withdrawals are tax-free when made for eligible medical care expenses

*All three forms of contributions are exempt from federal income taxes. Employer and salary reduction contributions (Section 125 cafeteria plan) are exempt from FICA and FUTA as well. For specific tax advantages, please consult your tax advisor.

When is my HSA effective?

The account will be established when we receive your HSA enrollment and you log in to the Discovery Benefits Consumer Portal and agree to the online HSA agreements. The account then becomes effective on the first of the month following the setup. For example, if your HSA application is sent to Discovery Benefits on January 15 and your account was established on January 17, your HSA would be effective February 1st — the first of the month following the date the account was established. Eligible expenses would be those incurred on or after February 1st. The effective date of your HSA cannot be backdated to the date your HDHP was established.

What is the USA PATRIOT Act?

Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an HSA. This means that when you open an HSA with Discovery Benefits, we will ask for your name, street address, date of birth and other information that will allow us to identify you.

This process takes approximately two days, during which time your account will be blocked. Once this process is completed and your identity has been verified, access to your HSA will be unblocked and made available to you. If your identity is not verified (e.g. if you moved recently and your new address is not on file with the appropriate government agency), you may be asked to provide proof of your identity by providing a copy of your utility bill to verify your address or a copy of your Social Security card if the number does not match the verifying source's records.

Can an individual have more than one HSA?

An individual may contribute to more than one HSA; however, the total contribution of all HSA contributions cannot exceed the annual limit. You and your spouse may both have an HSA if you both have high-deductible health insurance coverage.

Can an individual participate in both an HSA and a Medical Spending Account (MSA) or Health Reimbursement Arrangement (HRA)?

If the MSA or HRA through your employer or your spouse's employer is unlimited, you are not eligible for an HSA. If the MSA or HRA is limited to dental, vision and/or preventive care expenses, you can have it with the HSA. Ultimately, it is the responsibility of participants to maintain IRS compliance within their plans.

Can an individual participate in both an HSA and a Dependent Care FSA?

Yes.

What do I need to consider if I'm moving from an FSA to an HSA?

Before you are eligible to use your HSA, your FSA needs to be spent down to a $0 balance prior to the start of the new plan year. If an FSA balance is carried over into the new plan year, you will need to wait until the end of the run-out period to be eligible to participate in the HSA.

What expenses are eligible for reimbursement from an HSA?

The Medical FSA and HSA Eligibility List is a summary of common expenses claimed against Medical Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs). Due to frequent updates to the regulations governing FSAs and HSAs, this list does not guarantee reimbursement but is intended to be utilized as a guide for the submission of claims.

How and when can money be taken out of an HSA?

Account holders can make a withdrawal (also known as a distribution) at any time. Distributions received for qualified medical expenses not covered by the High-Deductible Health Plan (HDHP) are distributed tax-free. Distributions can be requested via your online account. Unless individuals are disabled, age 65 or older or die during the year, they must pay income taxes plus an additional 20% on any amount not used for qualified medical expenses. An individual who is disabled or who reaches age 65 can receive non-medical distributions without penalty but must report the distribution as taxable income.

Health Savings Account (HSA) FAQ — Participants, continued

Why do I need to designate beneficiaries?

After the death of an account holder, the tax treatment of an HSA depends on whether a spouse or non-spouse is designated as a beneficiary of the account. If there is no designated death beneficiary, the fair market value of the account will be included in the account holder's final income tax return and estate tax return.

Spouse Beneficiary: If the deceased account holder's designated beneficiary is a spouse, the HSA will be treated as the surviving spouse's own HSA. Distributions to the surviving spouse for qualified medical expenses would be tax-free.

Non-spouse Beneficiary: If a non-spouse beneficiary is named as a beneficiary, the HSA will cease to be an HSA as of the date of death. The non-spouse beneficiary would include the balance of the HSA in his or her income for the year of death.

Can I roll over funds from another account?

Rollover contributions to an HSA are permitted as long as the source of the rollover funds is another HSA or Archer MSA. You cannot rollover funds from a Medical FSA. A rollover of HSA or Archer MSA funds must be completed within 60 days from the date of constructive receipt to avoid taxation. Only one rollover every 12 months is permitted. When account holders make a rollover contribution, they must certify to the custodian or trustee in writing that they are making a rollover contribution. Once made, the certification is irrevocable.

Are there any fees associated with my HSA account?

Typically, employers will cover fees that are associated with your HSA while you are an active employee. If you leave your current employer but keep your HSA open with Discovery Benefits, there may be maintenance fees assessed to your account.

How do I report HSA activity on my tax return?

The IRS has stated that HSA contributions and distributions are reportable transactions.

Contributions: Employer HSA contributions are reported on the W-2 as non-taxable wages for each employee that receives a contribution. Regardless of whether or not HSA contributions are made by the account holder or the employer, contributions must be reported on the individual tax return of the account holder. Contributions to and distributions from HSAs are reported by the account holder on Form 8889 and attached to Form 1040.

Distributions: Distributions from HSAs, if for qualified medical expenses, will avoid income tax consequences to the recipient. For this reason, the IRS requires the reporting of these distributions.

The account holder can access Form 1099-SA for reporting distributions made during the tax year and Form 5498-SA for reporting contributions made to the HSA during the tax year electronically through their consumer portal. 1099-SAs and 5498-SAs are made available on the portal by January 31st each year. It is the account holder's responsibility to keep records to support distributions and to complete Form 8889 and attach it to Form 1040.

The account holder will be responsible for reporting the contributions and distributions to the IRS and will ultimately be responsible for ensuring that account transactions are within the allowed regulations. If an error is made by Discovery Benefits or its custodian, Discovery Benefits will be responsible for that activity.

Should I keep my receipts for HSA-eligible items?

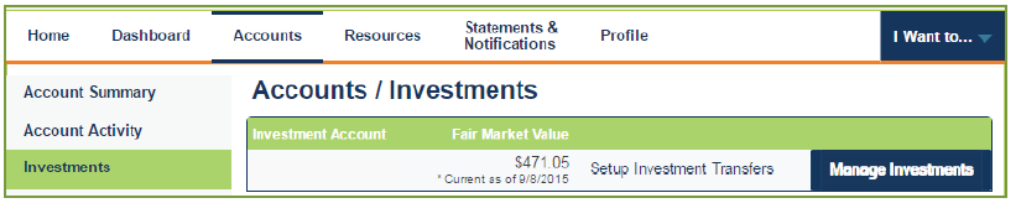
Yes. Discovery Benefits does not require you to submit substantiation for HSA reimbursements, but if the IRS chooses to audit you, the paperwork for your HSA claims may be requested.

Guide to Managing HSA Investments

Your fund balances will be automatically reallocated, consistent with your investment elections and at the frequency you select. Even as market conditions change, your overall investment mix will stay on target with your diversification strategy. The investment sweeps will automatically replenish your cash account when it goes below your investment threshold. Simply follow the below steps to manage your investments.

Step 1: Access your consumer portal by going to www.DiscoveryBenefits.com and entering your login credentials.

Step 2: From your homepage, select the "Accounts" tab, and in the left-hand column, choose "Investments."



Next, on the investment site:

Step 3: From the Investments screen, click on the Set up Investment Transfers link. A pop-up screen will appear asking you to establish your investment threshold. Make sure the "Define Investment Sweep Amount" box is checked. Enter an amount equal to or greater than $1,000 and click "Save." **Please note:** If you click the "Manage Investments" button, you will be prompted to answer a security question and then directed to the investment site.

Step 4: Use the toolbar on the left side of the screen to navigate through the site. In the "Account Information" section of this toolbar, select "Fund Performance" to view various investments and their return rates. This section will help with the investment decision-making process.

Step 5: In the "Manage My Account" section in the same toolbar, select "Investment Elections" to view your investment preferences, establish investments or reallocate investment funds. If you do make changes, be sure to click the "Submit Election Change" button at the bottom of the page to save your updates. **Please note:** Trades initiated after 1:30 p.m. CST will be processed the next business day. Trades require three business days to process.

Guide to Filing Claims

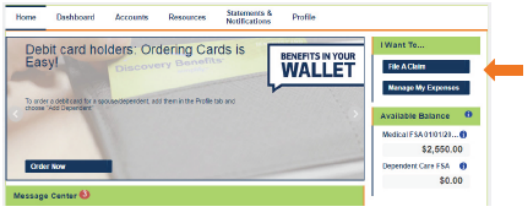
Claims for out-of-pocket expenses can be filed online, by mail or via fax.

Note: Don't file a claim if you have already used your benefits debit card. This could result in duplicate claims.

Online

Step 1: Log in.

Step 2: Select "File A Claim" in the "I Want To" section.



Step 3: Enter your claim information by selecting the appropriate options from the drop-down menus. (**Note:** A receipt must be uploaded to file a claim. Also, when submitting a claim, you have the option to send payment to yourself or someone else. If you choose "Someone Else," a paper check will be mailed to the designated payee. Please allow 10-14 business days for mailing time in addition to the two business days of claim processing time.)

Step 4: Select "Add Claim," agree to the Terms and Conditions and select "Submit."

Step 5: You will receive a confirmation that your claim was submitted. It will be processed within two business days. If further documentation is needed, you will be notified via email if you have an email address on file or via mail if you do not.

Fax or Mail

Submit the Out-of-Pocket Reimbursement Request Form with documentation via fax or mail.
Fax: 1-866-451-3245
Mail: Discovery Benefits, PO Box 2926, Fargo ND 58108-2926

Guide to the Benefits Debit Card — HSA

- Fewer out-of-pocket expenses at time of service
- No waiting for reimbursement
- Merchant is paid directly at the point of sale
- Card is valid for three years

How It Works

- Use the Discovery Benefits debit card to pay for eligible services and products. Payments are automatically withdrawn from your Health Savings Account (HSA), so there are fewer out-of-pocket costs. Your debit card will work at qualifying merchants and providers. For a list of eligible services and products you can go www.discoverybenefits.com/employees/eligible-expenses. This list will provide eligible medical, vision, dental and pharmacy items.
- Your benefits debit card will not need to be assigned a personal identification number (PIN). Cash back and automated teller machine (ATM) transactions will not be allowed.

Documentation/Receipts

- Your HSA is a consumer-directed account, which means you as the consumer are responsible for ensuring you are using your HSA funds for eligible expenses. Discovery Benefits does not require you to submit documentation to substantiate debit card transactions for your HSA. However, we do recommend that you keep your own record of documentation with receipts dating back seven years in the event of an Internal Revenue Service (IRS) audit. For ease of storing, you can import this documentation into the expense tracker in your consumer portal.

Contact Information

Participant Services Hours of Operation	6 a.m. to 9 p.m. CST (M-F)
Participant Services Toll-Free Phone Number	866-451-3399
Toll-Free Fax Number	866-451-3245
Participant Services Email Address	customerservice@discoverybenefits.com (This email is for inquiries only. Please do not submit documentation to this address.)
Mailing Address	Discovery Benefits PO Box 2926 Fargo, ND 58108

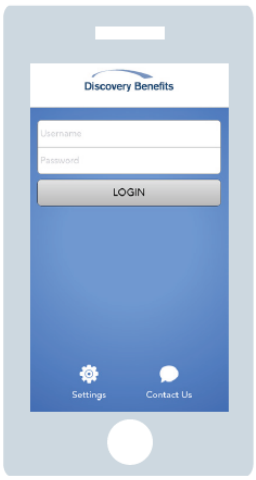
Guide to the Discovery Benefits Mobile Application

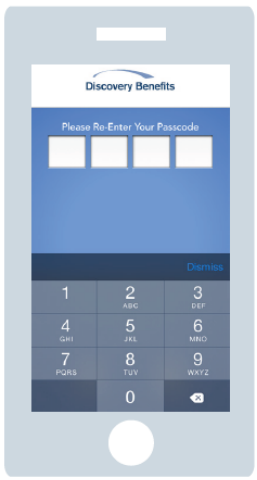
Downloading the Mobile Application

The Discovery Benefits mobile application can be downloaded for free on Android and Apple devices. Search for "Discovery Benefits" to locate the app in your phone's online store.

Logging In

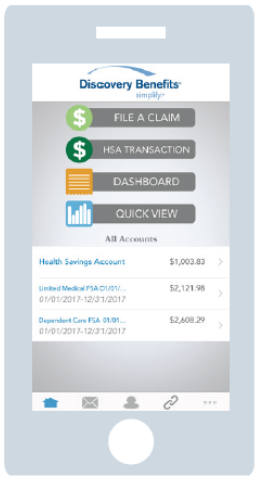
When the app is opened for the first time, you will need to enter the username and password for your Discovery Benefits portal. After you have successfully logged in to the mobile app for the first time, you will be prompted to set up a four-digit PIN. From that point forward, you'll be able to access the mobile app simply by entering this PIN.





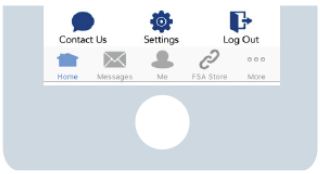
The Home Screen

From the app's home screen, you will see options to file a claim, review and pay expenses or get a quick view of your account information. You'll also see an "All Accounts" section that lists the plans you are currently enrolled in, along with plan dates and balance information. To access more details about individual plans, simply tap the name of the plan that you wish to learn more about. If you click on a plan from the home screen, you will be brought to the "Account Details" page, where you can access current plan balance, plan dates and claim history.



The Menu

The menu bar is located at the top of the screen on Android devices and the bottom of the screen on iOS systems, and it is visible from any page of the mobile app. From the menu, you can access your home screen, the message center, your personal profile, a quick link to the FSA Store, Discovery Benefits' contact information, app settings and logout capabilities.



GUARDIAN®

Area Agency On Aging of Western Arkansas, Inc.

Dental Benefit Summary

Group Number: 00493275

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Your Monthly premium	**$30.53**	
You and spouse	$64.95	
You and child(ren)	$77.98	
You, spouse and child(ren)	$112.38	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$100	$100
Family limit	Not Applicable	
Waived for	None	None
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	100%	100%
Major Care	60%	60%
Orthodontia	Not Covered	
Annual Maximum Benefit	$1000	$1000
Maximum Rollover	Yes	
Rollover Threshold	$500	
Rollover Amount	$250	
Rollover In-network Amount	$350	
Rollover Account Limit	$1000	
Lifetime Orthodontia Maximum	Not Applicable	
Dependent Age Limits	26	

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	100%	100%
	Fillings‡	100%	100%
	Periodontal Maintenance	100%	100%
	Frequency:	Once Every 6 Months (Enhanced)	
	Repair & Maintenance of Crowns, Bridges & Dentures	100%	100%
	Root Canal	100%	100%
	Scaling & Root Planing (per quadrant)	100%	100%
	Simple Extractions	100%	100%
	Surgical Extractions	100%	100%
Major Care	Bridges and Dentures	60%	60%
	Inlays, Onlays, Veneers**	60%	60%
	Perio Surgery	60%	60%
	Single Crowns	60%	60%

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00493275

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1000	$500	$250	$350	$1000
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,000 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

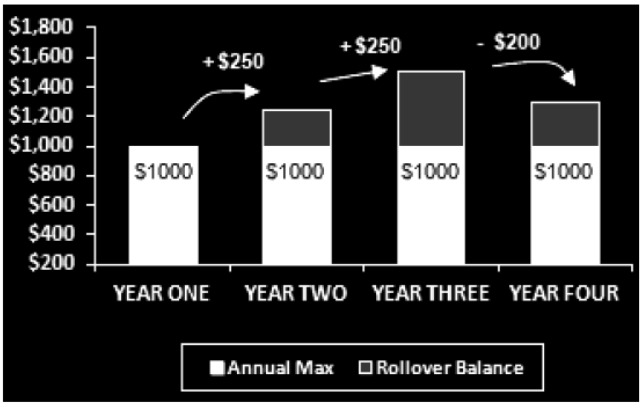
Here's how the benefits work:

YEAR ONE: Jane starts with a $1,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $500 Threshold, she receives a $250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,250. This year, she submits $50 in claims and receives an additional $250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $1,500. This year, she submits $1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,300 ($1,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply.

Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

GUARDIAN®

Area Agency On Aging of Western Arkansas, Inc.

Vision Benefit Summary

Group Number: 00493275

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Network Signature Plan	
Your Monthly premium	**$ 13.91**	
You and spouse	$ 23.41	
You and child(ren)	$ 23.88	
You, spouse and child(ren)	$ 37.78	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $46
Single Vision Lenses	$0	Amount over $47
Lined Bifocal Lenses	$0	Amount over $66
Lined Trifocal Lenses	$0	Amount over $85
Lenticular Lenses	$0	Amount over $125
Frames	80% of amount over $120	Amount over $47
Contact Lenses *(Elective)*	Amount over $120	Amount over $120
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 30% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price^	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every 12 months	
Lenses *(for glasses or contact lenses)*‡‡	Every 12 months	
Frames	Every 24 months	
Network discounts *(cosmetic extras, glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	

‡‡Benefit includes coverage for glasses or contact lenses, not both.

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

^ For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.

For VSP, only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Vision Provider

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and vision network, which can be found on the first page of your vision benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00493275.
Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

On average, 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to $1,800 per eye for LASIK and $1,500 per eye for PRK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

GUARDIAN

Area Agency On Aging of Western Arkansas, Inc.

Life Benefit Summary

Group Number: 00493275

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	VOLUNTARY TERM LIFE
Employee Benefit	$25,000 increments to a maximum of $500,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse‡ Benefit	Up to 100% of employee coverage to a max of $250,000
Child Benefit	Your dependent children age 14 days to 26 years. Up to 10% of employee coverage to a max of $10,000. Subject to state limits.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to: Employee $150,000. Spouse $25,000. Dependent children $10,000. An Additional $100,000 per employee, $25,000 for a spouse can be obtained with a "No" response to the Health question (on your enrollment form). Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue plus Additional amount.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment.	Yes, with age and other restrictions

Guardian / VOLUNTARY LIFE AND AD&D RATES

	VOLUNTARY TERM LIFE
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00493275

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and use our Life Insurance Explorer Tool.

Monthly premiums displayed.

Policy Election Amount	Policy Election Cost Per Age Bracket									
Employee	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$25,000	$1.58	$1.58	$1.93	$3.08	$6.40	$9.65	$14.60	$22.20	$38.68	$66.73
$50,000	$3.15	$3.15	$3.85	$6.15	$12.80	$19.30	$29.20	$44.40	$77.35	$133.45
$75,000	$4.73	$4.73	$5.78	$9.23	$19.20	$28.95	$43.80	$66.60	$116.03	$200.18
$100,000	$6.30	$6.30	$7.70	$12.30	$25.60	$38.60	$58.40	$88.80	$154.70	$266.90
$125,000	$7.88	$7.88	$9.63	$15.38	$32.00	$48.25	$73.00	$111.00	$193.38	$333.63
$150,000	$9.45	$9.45	$11.55	$18.45	$38.40	$57.90	$87.60	$133.20	$232.05	$400.35
$175,000	$11.03	$11.03	$13.48	$21.53	$44.80	$67.55	$102.20	$155.40	$270.73	$467.08
$200,000	$12.60	$12.60	$15.40	$24.60	$51.20	$77.20	$116.80	$177.60	$309.40	$533.80
$225,000	$14.18	$14.18	$17.33	$27.68	$57.60	$86.85	$131.40	$199.80	$348.08	$600.53
$250,000	$15.75	$15.75	$19.25	$30.75	$64.00	$96.50	$146.00	$222.00	$386.75	$667.25
$275,000	$17.33	$17.33	$21.18	$33.83	$70.40	$106.15	$160.60	$244.20	$425.43	$733.98
$300,000	$18.90	$18.90	$23.10	$36.90	$76.80	$115.80	$175.20	$266.40	$464.10	$800.70
$325,000	$20.48	$20.48	$25.03	$39.98	$83.20	$125.45	$189.80	$288.60	$502.78	$867.43
$350,000	$22.05	$22.05	$26.95	$43.05	$89.60	$135.10	$204.40	$310.80	$541.45	$934.15
$375,000	$23.63	$23.63	$28.88	$46.13	$96.00	$144.75	$219.00	$333.00	$580.13	$1,000.88
$400,000	$25.20	$25.20	$30.80	$49.20	$102.40	$154.40	$233.60	$355.20	$618.80	$1,067.60
$425,000	$26.78	$26.78	$32.73	$52.28	$108.80	$164.05	$248.20	$377.40	$657.48	$1,134.33
$450,000	$28.35	$28.35	$34.65	$55.35	$115.20	$173.70	$262.80	$399.60	$696.15	$1,201.05
$475,000	$29.93	$29.93	$36.58	$58.43	$121.60	$183.35	$277.40	$421.80	$734.83	$1,267.78
$500,000	$31.50	$31.50	$38.50	$61.50	$128.00	$193.00	$292.00	$444.00	$773.50	$1,334.50
Policy Election Amount Up to 100% of Employee Amount to a maximum $250,000										
Spouse										
$25,000	$1.58	$1.58	$1.93	$3.08	$6.40	$9.65	$14.60	$22.20	$38.68	$66.73
$50,000	$3.15	$3.15	$3.85	$6.15	$12.80	$19.30	$29.20	$44.40	$77.35	$133.45
$75,000	$4.73	$4.73	$5.78	$9.23	$19.20	$28.95	$43.80	$66.60	$116.03	$200.18
$100,000	$6.30	$6.30	$7.70	$12.30	$25.60	$38.60	$58.40	$88.80	$154.70	$266.90
$125,000	$7.88	$7.88	$9.63	$15.38	$32.00	$48.25	$73.00	$111.00	$193.38	$333.63
$150,000	$9.45	$9.45	$11.55	$18.45	$38.40	$57.90	$87.60	$133.20	$232.05	$400.35
$175,000	$11.03	$11.03	$13.48	$21.53	$44.80	$67.55	$102.20	$155.40	$270.73	$467.08
$200,000	$12.60	$12.60	$15.40	$24.60	$51.20	$77.20	$116.80	$177.60	$309.40	$533.80
$225,000	$14.18	$14.18	$17.33	$27.68	$57.60	$86.85	$131.40	$199.80	$348.08	$600.53

Voluntary Life Cost Illustration *continued*

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$250,000	$15.75	$15.75	$19.25	$30.75	$64.00	$96.50	$146.00	$222.00	$386.75	$667.25
Policy Election Amount Up to 10 % of Employee Amount to a maximum of $10,000										
Child(ren)										
$2,500	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42	$0.42
$5,000	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84
$7,500	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25
$10,000	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67

Guarantee Issue Amount: Employee $150,000; Spouse $25,000; Child $10,000

Guarantee Issue with Additional Amount: Employee $250,000; Spouse $50,000

Premiums for Voluntary Life Increase in five-year increments

‡**Spouse coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.**

†Benefit reductions apply.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

Accidental Death and Dismemberment Life Cost Illustration:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries. Election amount will equal 1 times the election amount for Voluntary life election.

Employee Policy Election Amount	Monthly Premiums displayed	Spouse Policy Election Amount	Monthly Premiums displayed	Child(ren) Policy Election Amount	Monthly Premiums displayed
$25,000	$0.75	$25,000	$0.75	$2,500	$0.08
$50,000	$1.50	$50,000	$1.50	$5,000	$0.15
$75,000	$2.25	$75,000	$2.25	$7,500	$0.23
$100,000	$3.00	$100,000	$3.00	$10,000	$0.30
$125,000	$3.75	$125,000	$3.75		
$150,000	$4.50	$150,000	$4.50		
$175,000	$5.25	$175,000	$5.25		
$200,000	$6.00	$200,000	$6.00		
$225,000	$6.75	$225,000	$6.75		
$250,000	$7.50	$250,000	$7.50		
$275,000	$8.25				
$300,000	$9.00				
$325,000	$9.75				
$350,000	$10.50				
$375,000	$11.25				
$400,000	$12.00				
$425,000	$12.75				
$450,000	$13.50				
$475,000	$14.25				
$500,000	$15.00				

Benefit reductions apply.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

Questions?

Call the Guardian Helpline (888) 600-1600
Call weekdays, 7:00 AM to 8:30 PM, EST. And refer to your plan number : 00493275

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.
Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.
We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al.
We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated.
The loss must occur within 365 days of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

Access helpful, secure information about your Guardian benefits instantly — at www.GuardianAnytime.com. You can do it 24/7, without picking up the phone.

- Review your benefits
- Look up coverage amounts, including deductible and co-insurance
- Check the status of a claim
- Find a specific provider or create a customized listing of providers
- Print forms and plan materials
- Access significant discounts on goods and services, from home office supplies to flowers*
- And so much more!

Register in two minutes at www.GuardianAnytime.com

GUARDIAN ANYTIME.

* Certain exclusions apply and availability may vary based on company location.

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2007 — 8489

The Guardian Life Insurance Company of America, New York, NY 10004

WorkLifeMatters℠

Your Confidential Employee Assistance Program

Balancing your work and home is not always easy. With **WorkLifeMatters℠**, your confidential employee assistance program through **Guardian** and **Integrated Behavioral Health (IBH)**, you don't have to face life's challenges alone. WorkLifeMatters provides support and guidance for matters that range from personal issues you might be facing, to providing information on everyday topics that affect your life.

WorkLifeMatters℠ can offer support with:

Education
- Admissions testing & procedures
- Adult re-entry programs
- College planning
- Financial aid resources

Dependent Care & Care Giving
- Adoption assistance
- Before/after school programs
- Day care & elder care
- In-home services
- Parenting support
- Senior housing options
- Special needs care

Legal & Financial
- Basic tax planning
- Credit & debt
- Immigration
- Legal forms and will making
- Personal legal
- Retirement planning

Working Smarter
- Balancing work and home life
- Career & training development
- Effective managing
- Relocation
- Workspace diversity

Lifestyle & Fitness Management
- Anxiety and depression
- Divorce and separation
- Relationship issues
- Drugs and alcohol
- Health and well-being
- Grief & loss
- Pet care

GUARDIAN®

The Guardian Life Insurance Company of America
7 Hanover Square, New York, NY 10004

GUARDIAN®

Support and guidance are just a phone call away

You have unlimited access to consult with a professional counselor via telephone. Face-to-face counseling sessions are available, if needed, with an IBH network provider — and up to three sessions are free of charge as part of **WorkLifeMatters℠**.

For legal and financial topics, you are eligible to receive a free initial 30 minute office or telephone consultation with an attorney or seasoned financial professional and certified public accountant (CPA). Local referrals are available for more complex legal or financial issues for a fee.

A variety of training resources — webinars, video and PowerPoint presentations — are also available to help you manage your quality of life.

Connect to a counselor for free support services:
1-800-386-7055 (Available 24 hours a day, 7 days a week)
Visit www.ibhworklife.com (User name: Matters Password: wlm70101)

WorkLifeMatters℠ Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.
2014-7557 Exp 6/16 Pub 3525 (6/14)

Cut here and save this convenient card for WorkLifeMatters

WorkLifeMatters℠

Your Employee Assistance Program through The Guardian Life Insurance Company of America and Integrated Behavioral Health

1-800-386-7055
www.ibhworklife.com

User name: Matters
Password: wlm70101

9am-8pm, M-F (EST)
Emergency access 24/7

GUARDIAN®

IBH
INTEGRATED BEHAVIORAL HEALTH

PATIENT PROTECTION DISCLOSURE NOTICE

The Area Agency on Aging of Western Arkansas, Inc., group health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Arkansas Blue Cross Blue Shield Customer Service.

For children, you may designate a pediatrician as a primary care provider.

You do not need prior authorization from Area Agency on Aging of Western Arkansas, Inc. group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Arkansas Blue Cross Blue Shield Customer Service.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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

- All states 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 physician complications of the mastectomy, including lymphedema.

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

Please refer to your chosen medical plan's summary of benefits for the applicable deductible and coinsurance.

If you would like more information on WHCRA benefits, call your plan administrator Holly Gray at 479-783-4500.

INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage: If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment ***within 30 days*** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption: If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment ***within 30 days*** after the marriage, birth, adoption or placement for adoption.

Termination of Medicaid or Children's Health Insurance Program (CHIP) Coverage: If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.

Eligibility for Employment Assistance under Medicare or CHIP: If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Group health plan and health insurance issuer generally may not, under Federal Law, restrict benefit for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours or 96 hours.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Group Administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

CONTINUATION COVERAGE RIGHTS UNDER COBRA—Cont.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

Area Agency on Aging of Western Arkansas, Inc.
Holly Gray
524 Garrison Avenue
Fort Smith, AR 72901
Phone: 479-783-4500

IMPORTANT: This Benefit Guide is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

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, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Important Notice from Area Agency on Aging of Western Arkansas, 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 Area Agency on Aging of Western Arkansas, 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. Arkansas Blue Cross Blue Shield has determined that the prescription drug coverage offered by the Area Agency on Aging of Western Arkansas, Inc's group health 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 15th to December 7th.

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

CMS Form 10182-CC **Updated April 1, 2011**

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 Area Agency on Aging of Western Arkansas, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Area Agency on Aging of Western Arkansas, Inc. group health plan coverage, be aware that you and your dependents will 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 Area Agency on Aging of Western Arkansas, 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 at 479-783-4500.

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 Area Agency on Aging on Western Arkansas, Inc. group health plan changes. You also may request a copy of this notice at any time. **CMS Form 10182-CC**

Updated April 1, 2011

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 14, 2016
Name of Entity/Sender: Area Agency on Aging of Western Arkansas, Inc.
CMS Form 10182-CC

Contact–Position/Office: Holly Gray
Address: 524 Garrison Avenue, Fort Smith, AR 72901
Phone Number: 479-783-4500

Updated April 1, 2011

OMB 0938-0990

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

3

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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, 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.

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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 Area Agency on Aging of Western Arkansas, Inc.		4. Employer Identification Number (EIN) 71-0523556
5. Employer address 524 Garrison Ave.		6. Employer phone number 479-783-4500
7. City Fort Smith	8. State AR	9. ZIP code 72901
10. Who can we contact about employee health coverage at this job? Holly Gray		
11. Phone number (if different from above)	12. Email address hgray@agingwest.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:

Full time employees working 30 hours or more per week and Variable Hour Employees that have met the measurement periods.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal Spouses and Dependent Children up to the age of 26.

☐ 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.

EMPLOYEE CONTACT DIRECTORY

MEDICAL **Arkansas Blue Cross Blue Shield** CUSTOMER SERVICE Claims, ID Cards, Prescriptions MEMBER WEBSITE NETWORK	**800-238-8379** **www.arkansasbluecross.com** **www.myblueprint.arkansasbluecross.com** **True Blue**
HEALTH SAVINGS ACCOUNT ADMINISTRATION **Discovery Benefits** CUSTOMER SERVICE MEMBER WEBSITE	**866-451-3399** **Fax: 866-451-3245** **www.discoverybenefits.com**
DENTAL / VISION / VOLUNTARY LIFE & AD&D **Guardian** CUSTOMER SERVICE MEMBER WEBSITE DENTAL NETWORK VISION NETWORK	**800-627-4200** **www.guardiananytime.com** **DentalGuard Preferred** **VSP Network—Signature Plan**
ACCIDENT / CANCER / DISABILITY / CRITICAL ILLNESS / HOSPITAL CONFINEMENT / WHOLE LIFE **Colonial Life** CUSTOMER SERVICE MEMBER WEBSITE	**800-325-4368** **www.coloniallife.com**
AREA AGENCY ON AGING OF WESTERN ARKANSAS, INC. Group Administration Holly Gray	**Phone: 479-783-4500** **Fax: 479-783-0029** **Email: hgray@agingwest.org**
GALLAGHER BENEFIT SERVICES, INC. Marla Crews Account Executive	**marla_crews@ajg.com** **(479) 221-9707- Direct Line** **(479) 452-9969 Fax** **www.gallagherbenefits.com**

There is nothing more important to us than customer service. The staff at Gallagher Benefit Services takes pride in providing the best possible customer service to each and every customer and we welcome your calls any time you need help with your insurance questions.

- Thank you

Area Agency on Aging of Western Arkansas and Visiting Nurses Agency

"Our heart is in your home."

Arthur J. Gallagher & Co.

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