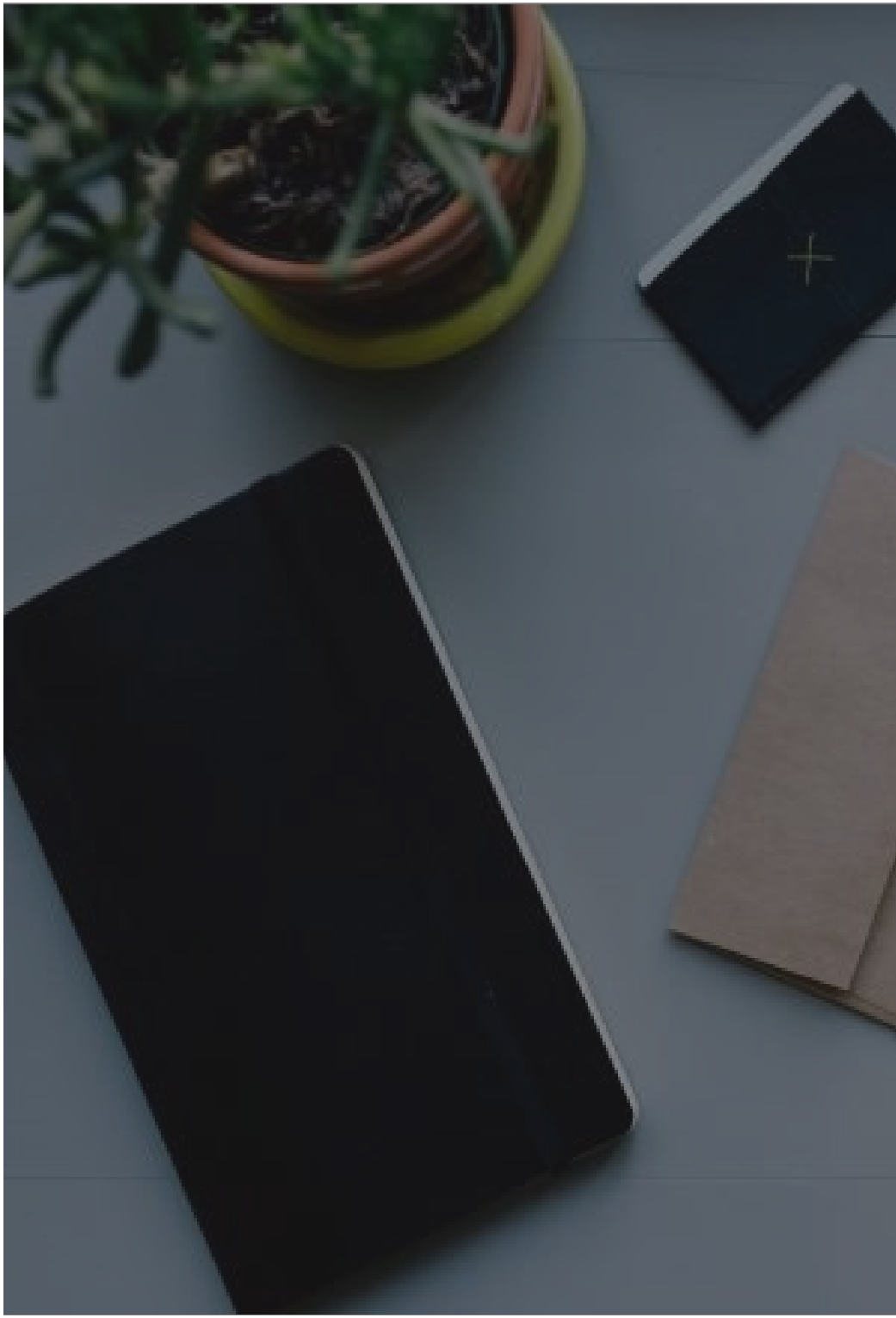
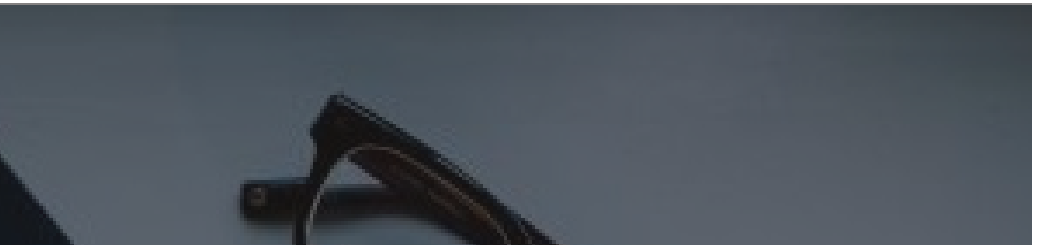
2024
EMPLOYEE BENEFIT GUIDE

Please email JTS to schedule an enrollment call.
hstover@jtsfs.com
niema@jtsfs.com

EACC East Arkansas COMMUNITY COLLEGE

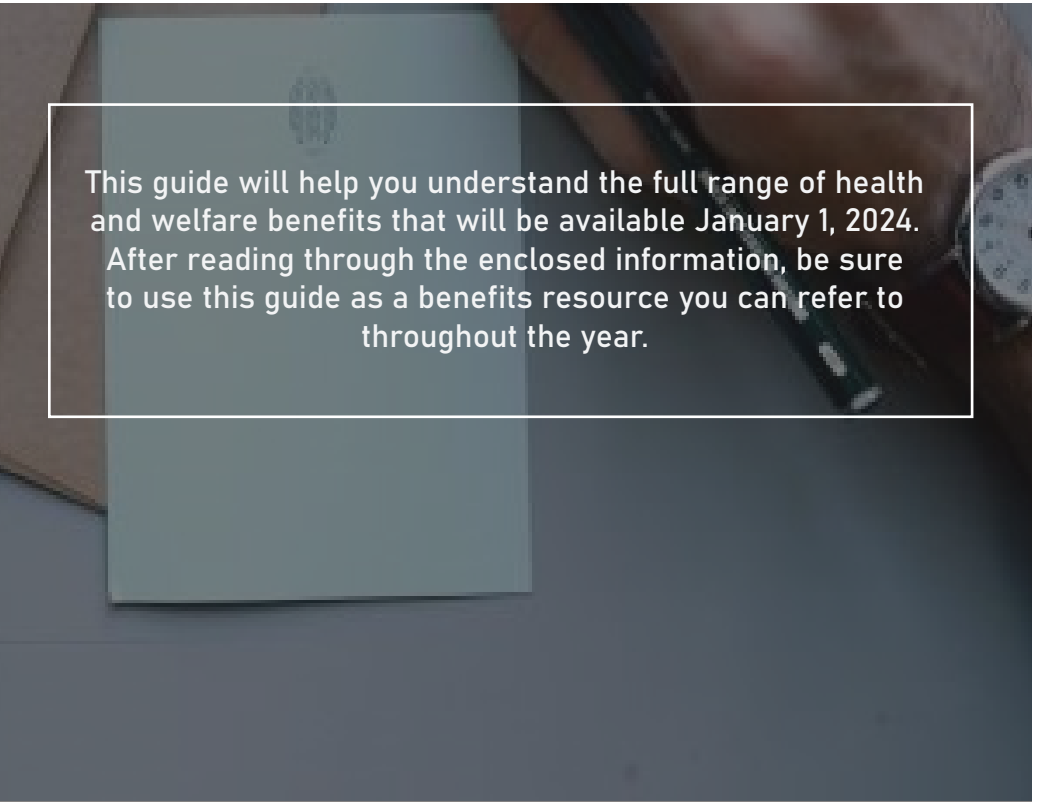




2024 Benefit Guide

East Arkansas Community College is committed to providing their employees with comprehensive and affordable benefit options.

The 2024 Health and Welfare benefit offerings provide employees with unlimited flexibility that reflects East Arkansas' optimal culture and class.



This guide will help you understand the full range of health and welfare benefits that will be available January 1, 2024. After reading through the enclosed information, be sure to use this guide as a benefits resource you can refer to throughout the year.

ENROLLMENT 2024

What You Need to Do During Annual Open Enrollment

Review the benefits available and determine which plans best meet your needs.

Review the family members you want covered under the plan. During the annual open enrollment period, please verify that your dependents meet East Arkansas' benefit eligibility requirement. You may be required to provide supporting documentation.

Ensure all your personal information, such as address, phone, email, etc., are updated and correct.

Important Enrollment Information

The first premium for 2024 will be deducted from your earnings in January, 2024. Remember to review your paycheck to ensure that the proper premiums are being deducted based on the 2024 enrollment elections.

PLEASE NOTE: ***If you are participating in the Flexible Spending Accounts, your 2023 election will NOT rollover into the 2024 plan year. You MUST enroll with a new election for the 2024 plan year to continue the benefit.***

Remember...

We recommend that you review your current information, including...

- Updating your beneficiaries
- Removing ineligible dependents
- If you have Spousal Life Insurance coverage, and you are divorced, your ex-spouse may no longer be eligible for this coverage
- If a child no longer qualifies for coverage as a dependent (i.e. stepchildren who are no longer eligible due to divorce, loss of guardianship, etc.)

WHAT YOU NEED TO KNOW

Employees under contract who work a minimum of 30 hours per week are eligible to enroll themselves and their qualified dependents in applicable East Arkansas Community College employee benefits. Employees must be actively at work to enroll in benefits.

If you are a current employee (not a new hire), please keep the following information in mind:

- You cannot make any changes until the annual "open enrollment period", which allows employees, who may have previously declined to enroll, the opportunity to enroll in new coverage. (Certain restrictions and limitations may apply to employees who initially declined coverage when they first became eligible to enroll.)

  - However, there are certain qualifying events that allow current employees to make benefit changes. These include, but are not limited to:

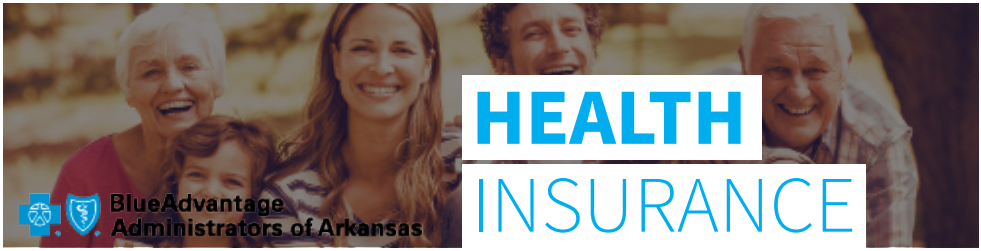
    - *marriage, divorce, adoption or birth of child, death of a spouse or other eligible dependent.*

DISCLAIMER: This benefit summary is provided for illustrative purposes only and is simply an overview of your benefits. For a detailed explanation for each policy you should review a copy of the actual policy on file with the Human Resources Department or you may specifically request a copy of each policy from JTS Financial Services, LLC

EMPLOYEE BENEFITS

Below is a list of available benefits and respective carriers for the 2024 plan year. Please reach out to a JTS representative if you have any questions at open enrollment or throughout the year.

BENEFIT	CARRIER	website
Medical	BlueAdvantage Administrators of Arkansas	https://www.blueadvantagearkansas.com/
Flexible Spending Account	Acuity Group	https://acuityppt.lh1ondemand.com/Login.aspx?ReturnUrl=%2f
Medical Transport Solutions	MASA	https://www.masamts.com/
Employee Assistance Program	Lincoln Financial Group	https://www.guidanceresources.com/groWeb/login/login.xhtml
Dental	Delta Dental	https://www.deltadentalar.com/
Vision	VSP	https://www.vsp.com/
Basic Life & AD&D	Lincoln Financial Group	https://www.lfg.com/public/employersorganizations
Voluntary Life	Lincoln Financial Group	https://www.lfg.com/public/employersorganizations
Universal Life & Life Events	Trustmark	https://www.trustmarkbenefits.com/
Disablity (Long & Short Term)	Lincoln Financial Group	https://www.lfg.com/public/employersorganizations
Critical Illness	Lincoln Financial Group	https://www.lfg.com/public/employersorganizations
Cancer	Guardian	https://www.guardianlife.com/
Hospital Indemnity	USAble	https://www.usablelife.com/
Accident	USAble	https://www.usablelife.com/



East Arkansas offers a choice of three medical plans designed to help you and your family maintain good health and offer protection from the financial burden of a serious illness or injury. You can select from the following medical plans:

HEALTH BENEFITS	Base Plan	Core Plan	Enhanced Plan
CALENDAR YEAR DEDUCTIBLE			
Per Covered Person	$3,000	$2,000	$1,000
Per Family Unit	$6,000	$4,000	$2,000
Coinsurance	20%	20%	20%
OUT-OF-POCKET CALENDAR YEAR MAXIMUM			
Per Covered Person	$6,000	$6,000	$4,500
Per Family Unit	$12,000	$12,000	$9,000

The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise:

- Deductible(s)
- Coinsurance
- Medical and Pharmacy Copayments

- For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by BlueAdvantage. For details and to access the most current listing of services requiring pre-authorization, visit www.blueadvantagearkansas.com
- All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.
- Calendar Year maximums are combined between In-Network and Out-of-Network. If, for example, "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

MONTHLY RATES	BASE	CORE	ENHANCED
Employee Only	$0.00	$19.00	$44.00
Employee + Spouse	$290.00	$339.00	$438.00
Employee + Child(ren)	$217.00	$257.00	$339.00
Family	$571.00	$639.00	$785.00

HEALTH BENEFITS	All Plans
IN-NETWORK SERVICES	
Inpatient/Outpatient Services	20% after deductible
Emergency Room Services	$200 Copayment + 20% after deductible
Urgent Care Services	$50 Copayment
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance	20%; deductible waived
PHYSICIAN SERVICES	
Virtual Health Visits	$20 Copayment
Primary Care Physician Office Visits Evaluation & Management	$20 Copayment
Specialists Office Visits Evaluation & Management	$50 Copayment
Routine Procedures such as Routine X-rays & Labs in a physician's office	0% after Copayment
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as, advanced surgical services performed in a physician's office.	20% after Deductible
PREVENTIVE CARE SERVICES	
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor find-ings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.	
Routine Well Baby Care & Child/ Adult Immunizations	No Cost to You
Routine Vision Exam (limit 1 every 24 months)	No Cost to You

Preventive services are always 100% covered *in-network*. You can look up eligbile services and immunizations by clicking below.

https://www.blueadvantagearkansas.com/members/health-and-well-ness/preventive-health-information

HEALTH BENEFITS	All Plans
OTHER SERVICES	
Home Health Care 100 days per Calendar Year Maximum	20% after Deductible
Hospice Care 6 months per Calendar Year Maximum	20% after Deductible
Therapy Services	Limited to 30 visits per Calendar Year for all therapies combined
Occupational Therapy **Physical Therapy** **Speech & Audiology** **Spinal Manipulation/ Chiropractic**	$50 Copayment
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You
Hearing Exam Covered once every 3 years	No Cost to You
INFERTILITY COVERAGE / BARIATRIC SERVICES	
Infertility Diagnostic Services Only	20% after Deductible
Infertility Treatment	Not Covered
Bariatric Services Lifetime Maximum of $10,000	20% after Deductible
SUPPLEMENTAL ACCIDENT BENEFIT	
Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a result of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to deductible and coinsurance.	

All Plans		
PRESCRIPTION DRUG BENEFITS	30 Day Supply Retail (You Pay)	90 Day Supply Retail or Mail Order (You Pay)
Tier 1 - Generic	$5 Copayment	$10 Copayment
Tier 2 - Preferred	$55 Copayment	$110 Copayment
Tier 3 - Nonpreferred	$75 Copayment	$150 Copayment
Speciality Pharmacy	50% Coinsurance	Not Covered

Note: If your prescription drugs are dispensed at your physician's office/ facility, see your medical plan for your cost share.

Limitations
- All new prescriptions are limited to a 30-day supply.
- Refills are limited to a 90-day supply at certain contracted pharmacies, retail, and mail-order.

Step Therapy
- Certain medications may require to be taken before another medication is covered. Step Therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug prescribed before progressing to other, more costly therapy.

Benefit Details
- Benefits are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail-order pharmacy or an out-of-network pharmacy; provided that the drug is a Covered Prescription Drug.

RxBenefits®

CVS caremark™

PRESCRIPTIONS

Manage your Rx on your own time.

We make it easy to keep track of your Rx, check for savings and more from your computer or mobile device.

Our website and mobile app give you a secure, simple way to manage your prescription benefits and member information. You'll find easy-to-use tools that help you save time, get organized and stay on your path to better health.

Save Time

Stay in the know on the go with easy refill ordering and order tracking.

Get Organized

Easily show providers your ID card or medication list and manage your pharmacy needs in one place.

Stay on Budget

Check drug costs and coverage and get drug advice about money-saving generic alternatives.

Commit to Health

A single place to find a pharmacy anywhere, check drug interactions, identify unknown pills, and more.

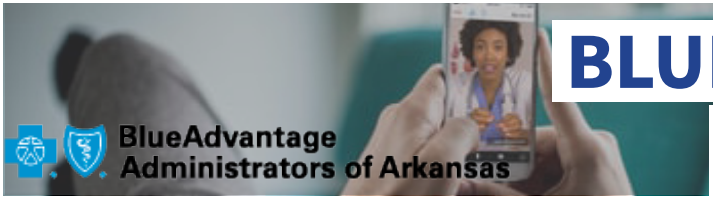
Your plan requires prior authorization (PA) before covering certain prescriptions. This process is to help ensure that the medication is appropriate for your treatment. It also helps to make sure it's the most cost-effective option. The process usually takes 2 days. To initiate a PA Review, the provider can submit a Prior Authorization Request one of three ways:

1. Online at www.rxb.promptpa.com
2. Fax form to 888-610-1180
3. Email form to PASupport@rxbenefits.com

scan the QR code to access Caremark's website

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

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



BLUEPRINT PORTAL

24/7 ACCESS TO YOUR HEALTH PLAN-
THE APP HAS YOU COVERED!

One of the most important tools to use on the Blueprint portal is the access to your EOB (Explanation of Benefits). This is **NOT** a bill, but shows you a specific breakdown of how much insurance pays your provider after service and what your responsibility will be for that service. ***Always compare your EOB to your provider bills after services and prior to paying your provider.***

How to register for Blueprint Portal

- Go to blueprintportal.com
- Select Register
- Follow the instructions. All you need is your:
  - » Member ID or the last four digits of your Social
  - » Security number
  - » Name
  - » Date of birth

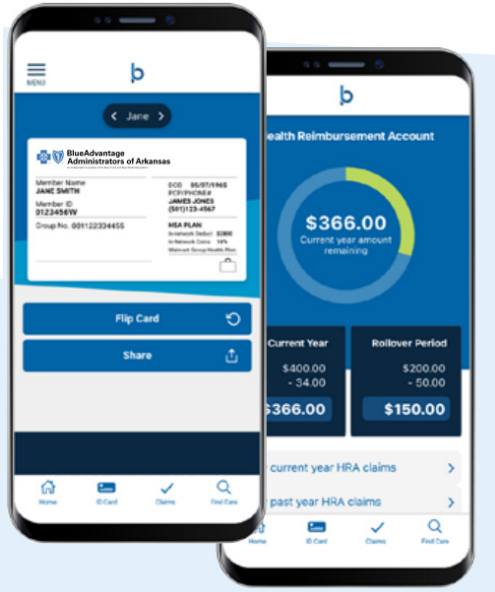
And anyone covered on your health plan can set up a Blueprint Portal account.

Already registered?

If you're already a Blueprint Portal user, simply go to blueprintportal.com and enter your username and password to sign in and access your account.

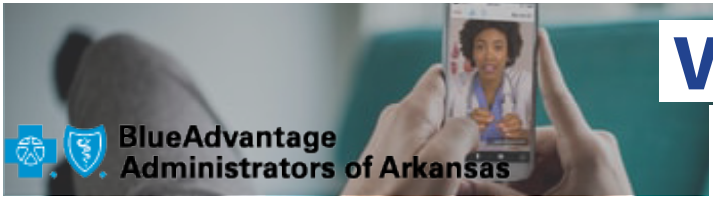
No ID Card? No Problem!

With the Blueprint Portal app, you can access, share or fax your ID card while in your doctor's office. You can also access many more Blueprint portal features.



Download on the App Store

GET IT ON Google Play



VIRTUAL HEALTH

Register today, so when you need care, help is available.

$20 Copay for Virtual Health

You need healthcare 24/7 - not just when it's convenient. Virtual health (powered by MDLIVE) gives you access to medical help for nonemergency conditions and behavioral health needs on your smartphone or computer.

Get Started!

1. Go to MyVirtualHealth.com
2. Go to Member sign in
   - sign in or register for your Blueprint Portal account.
3. Activate your virtual health account
   - In Blueprint Portal, select Virtual Health from the Health & Wellness tab, select Visit MDLIVE and follow the prompts to activate your account.
   - (Note: You'll skip this step in the future and be sent directly to MDLIVE.)
   - Establish your accout profile and those of your dependents if applicable. You will need member ID numbers to complete this step.

What can be treated:

- Allergies
- Common cold/Cough
- Constipation
- Diarrhea
- Ear problems
- Fever/Flu
- Headache
- Insect bites
- Nausea
- Pink eye
- Rash
- Respiratory problems
- Sore throat
- Urinary problems
- Vomiting
- More
- Addictions
- Anxiety
- Depression
- Bipolar disorders
- Eating disorders
- LGBTQ support
- Grief & loss
- Relationship issues
- Men's issues
- Panic disorders
- Stress management
- Trauma and PTSD
- Women's issues
- More

BlueAdvantage Administrators of Arkansas

Scan the QR code to get started.

FLEXIBLE & MEDICAL SPENDING ACCOUNTS

This plan runs calendar year (January 1-December 31, 2024).

TWO WAYS TO SAVE

SAVE MONEY ON HEALTH CARE & DEPENDENT DAYCARE EXPENSES WITH FLEXIBLE SPENDING ACCOUNTS (FSAs)

PUT MORE MONEY IN YOUR POCKET

Each dollar you contribute to your FSA is tax-deductible. That means you could potentially save as much as 30 percent or more on qualified expenses.

ELIGIBLE EXPENSES

Use Health Care FSA for medical, dental, vision, and prescription expenses. Dependent Care FSA can be used for child and elder day care while you are at work. For a full list of eligible expenses please see the below link.

COVERS YOU & FAMILY MEMBERS

FSA dollars can be used on you, your spouse, and eligible dependents that live in your household. You or your dependents do not have to be covered on your employer's health insurance to access this benefit.

know your options

FSA decisions can only be made during open enrollment (unless you have a qualifying event)

Choose the amount you want to contribute then your employer will deduct that amount pretaxed from each paycheck over 12 months

Unused Health Care FSA dollars are forfeited. But $610 or less rolls over into the next plan year

USING YOUR FLEXIBLE SPENDING ACCOUNT

- You will receive a payment card to access your Health Care FSA funds. You can also pay for eligible expenses with any other form of payment and request reimbursement from your account.
- You can check your account balance and submit claims for reimbursement on our website, please see the below link.

Account login:
https://consolidatedadmin.lh1ondemand.com/Main.aspx

FSA Eligible Items list:
https://www.irs.gov/publications/p502#en_US_2013_publink1000178885

Health Care FSA
Maximum contribution limits:
Individual maximum- $3,050
Family- $5,000

Dependent Care FSA
Maximum contribution limits:
$5,000

MEDICAL TRANSPORT SOLUTIONS (MASA)

The high cost of emergent and non-emergent transportation results in unexpected out of pocket expenses. MASA protects members from these expenses related to emergency air transportation and ground ambulance charges.

ANY GROUND. ANY AIR. ANYWHERE.™

MASA Medical Transport Solutions

- Leading company in the Industry
- MASA steps in where insurance falls short by helping protect families against uncovered costs
- MASA also provides many benefits not covered by insurance
- Any Ground. Any Air. Anywhere TM Simply contact 911 for Emergency Transport
- Covers any of the 1,500+ Air Ambulances in US with 300 different Provider Companies
- Covers any of the 21,000 Ground Ambulance Providers in the US
- US Based Support, Local Reps, Simple Enrollment, Easy Claims, and Online access

BENEFITS	EMERGENT PLUS
Cost	$14 per month
Family Included	Yes
Emergent Ground Transportation (U.S. & Canada)	Yes
Emergent Air Transportation (U.S. & Canada)	Yes
Repatriation (Worldwide)	Yes
Non-Emergent Interfacility Transportation (Worldwide)	Yes

Make sure to submit claims to MASA within 6 months of the date of service to ensure payment of claim.

https://www.masamts.com/

EMPLOYEE ASSISTANCE PROGRAM

You have hopes, dreams and goals for your future. So, when you encounter bumps along the road, you'll be glad to know the *EmployeeConnect* program is on your side. Whether it's a helping hand during tough times or a bit of professional guidance, we're here for you with the support you need to keep moving forward. *EmployeeConnect* offers professional, confidential services to help you and your loved ones improve your quality of life.

With *EmployeeConnect*, help is availabe 24/7 for your and your dependents- at no additional cost to you- for:

- Depression
- Marital or family difficulties
- Managing stress and anxiety
- Substance abuse
- Legal and financial matters
- Locating child or elder care
- Moving and relocation
- Planning for college, events or vacation
- Family planning and pregnancy health

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance onhousehold budgeting and short- and long-term planning

Online resources

EmployeeConnectSM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit *GuidanceResources.com* or download the *GuidanceNow* mobile app.

You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

Take advantage of *EmployeeConnect*

For more information about the program, visit GuidanceResources.com, download the GuidanceNow mobile app or call 888-628-4824.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

DENTAL INSURANCE

With Delta Dental you can receive care from any dentist. However, Delta Dental has contracts with a large network of dentists who have agreed to not charge more than a specified amount for particular services. If you use one of these network dentists, you won't have to worry about being charged for additional amounts above the allowable amount covered by the plan.

DENTAL SERVICES	IN-NETWORK BENEFITS
DIAGNOSTIC & PREVENTIVE SERVICES **(No Deductible)** • Exams (2 times per year) • Cleanings (2 times per year) • Fluoride (2 times per year) • X-rays (1 time within any 36 consecutive months) • Sealants (prior to age 19-1 time per tooth per 60 consecutive months)	In Network-100% Out of Network-90%
BASIC SERVICES • Emergency Palliative Treatment (1 time per visit, not combined with any other treatment) • Brush Biopsy (upon review) • Minor Restorative Services - Fillings (1 time per surface, per tooth per 12 months) • Non-Surgical Peridontics • Space Maintainer (1 time per 60 consecutive months)	In Network-80% Out of Network-72%
MAJOR SERVICES • Surgical Periodontic Services • Major Restorative Services - Crowns, Inlays, Onlays, Veneers (for treatment of visible decay and tooth fractures) • Endodontic Services- Root canals • Prosthodontic Services - Bridges, Implants, and Dentures • Child Orthodontia- children to age 19, $1,000 lifetime maximum	In Network-50% Out of Network-45%
CARRYOVER BENEFIT If at least one covered service is applied toward your plan in a calendar year and the plan has not paid more than $749 in benefit, up to $375 will carry over to the next plan year. The carryover amount will accumulate from one year to the next, but will not exceed $1,500.	
ANNUAL MAXIMUM	$1,500 per person per calendar year
DEDUCTIBLE	$50 per person / $150 per family

COVERAGE TIER	MONTHLY RATES
Employee	$0.00
Employee + Spouse	$24.16
Employee + Child(ren)	$38.92
Family	$47.89

Need to look up providers near you? Go to www.deltadentalar.com

VISION INSURANCE

Regular vision checkups can help identify vision issues, and corrective lenses can make the difference between performing well on the job and at school, as well as affecting safe driving. That's why we offer you the opportunity to purchase voluntary vision coverage for you and your family.

VISION SERVICES	In-Network	Out-of-Network
EXAM (OPHTHALMOLOGIST)	$5 Copay	Up to $45
EXAM (OPTOMETRIST)	$5 Copay	Up to $45
FRAMES	Covered up to $175 retail allowance	Up to $50
CONTACT LENS FITTING (standard)	Covered in full	Not covered
CONTACT LENS FITTING (specialty)	$50 Retail Allowance	Not Covered
CONTACT LENSES	$175 Retail Allowance	Up to $100
LENSES		
SINGLE VISION	Covered in full	Up to $30
BIFOCAL	Covered in full	Up to $50
TRIFOCAL	Covered in full	Up to $60
LENTICULAR	Covered in full	Up to $75

SERVICES	FREQUENCY
EXAM	12 months
FRAMES	12 months
LENSES	12 months
CONTACTS	12 months

COVERAGE TIER	MONTHLY RATES
Employee	$10.85
Employee + Spouse	$21.71
Employee + Child(ren)	$23.23
Family	$34.13

CO-PAYS	
EXAMS	$5
MATERIALS	$5
CONTACT LENS FITTING	$5

Discounts on Covered Materials	
Frames	20% off amount over allowance
Lens options	20% off retail
Progressives	20% off amount over standard progressive retail

Need to look up providers near you? Go to www.vsp.com

BASIC LIFE AND AD&D

East Arkansas Community College provides life insurance to help protect the employee's family in the event of a death. Basic Life and AD&D Insurance coverage is available while you are a full-time employee. AD&D insurance covers you and your beneficiaries in the event of an accidental loss of life.

	EMPLOYEE	SPOUSE	DEPENDENT
COVERAGE AMOUNT	$20,000 and $10,000	$2,000 increments up to $20,000 *EOI required for late entrants	$2,000 increments up to $20,000
MINIMUM AMOUNT	NA	$2,000	$2,000
AD&D BENEFIT	Matches Life Amount		
BENEFIT REDUCTION	Benefits will reduce 35% Employee Age 65; an additional 15% at age 70; and benefits terminate at the employee's retirement.		

CONVERSION

If you terminate your employment you have the option to convert all or part of the amount of coverage in force to an individual life policy. Conversion elections must be made within 31 days of your date of termination.

	COVERAGE	MONTHLY RATE
Employee	$20,000 & $10,000	$0.00
Spouse/child	$20,000	$2.40

VOLUNTARY TERM LIFE

Your needs vary greatly upon age, number of dependents, dependents ages and your financial situation. Term Life is designed to provide benefits to your designated beneficiary for loss of life.

	EMPLOYEE	SPOUSE	DEPENDENT
COVERAGE AMOUNT	Choice of $5,000 increments up to $300,000, limited to 5x your annual compensation	Choice of $2,500 increments up to $100,000, limited to 50% of employee's annual compensation. *Employee must have coverage under voluntary life plan to have coverage on spouse.*	• Newborn - 14 days: not eligible • 14 days - 6 mo.: $250 • 6 mo. - Age 26: $10,000 *Employee must have coverage under voluntary life plan to have coverage on dependent.*
MINIMUM AMOUNT	$5,000	$2,500	$250
MAXIMUM AMOUNT	$300,000, up to 5x annual salary	$100,000, limited to 50% of the Employee's Life Amount	$10,000
GUARANTEE ISSUE	Newly Eligible: $200,000 age 75+: $0 Currently Enrolled- $40,000 increase	$20,000 age 60+: $0	--
BENEFIT REDUCTION	Benefits will reduce at age 65; additional 15% decrease of original amount at age 70; Benefits terminate at retirement.	Benefits will reduce 35% when the employee turns 65. Additional 15% of original amount at the employee's age of 70; Benefits terminate when employee retires.	Terms at age 26

RATES WILL BE CALCULATED BY BENEFIT AMOUNT AND AGE DURING ENROLLMENT PROCESS. CONTACT JTS WITH QUESTIONS.

ANNUAL INCREASES

Employees who are current voluntary life participants have the opportunity at Open Enrollment to increase his or her employee life amount without any medical questions. They may increase the amount in increments of $10,000 up to a maximum of $40,000.

UNIVERSAL LIFE

This coverage provides permanent life insurance protection with a premium that never increases due to age or a specified term. Life Insurance is a promise to your family to help protect their future. The death benefit can be used any way you or your family sees fit.

PLAN FEATURES

- Policy builds cash value & accrues interest
- Rate stability and benefit stability
- ***Fully Portable*** - You can keep this policy should you change jobs or retire
- ***Guarantee Renewable*** - Guarantee coverage to age 100 as long as your premiums are paid.
- ***Accelerated Death Benefit for Terminal Illness*** - Pays 75% of death benefit up to $225k.
- Spouse and dependent coverage available without purchase of employee policy
- Employees up to 75 years of age can apply for voluntary Universal Life Insurance for permanent protection.

BENEFIT AMOUNTS

Employee (Age 18-64)	
All Employees Guarantee Issue	$60,000
Guarantee Issue (New Hire)	Up to $120,000
**Simplified Issue *(Age 18-75)*	Up to $300,000
Spouse (Age 18-64)	
Guarantee Issue (if employee applies for coverage) (New Hire)	The greater of $25,000 or $3 per week
*Modified Issue (if employee does not apply for coverage)	The greater of $25,000 or $3 per week
**Simplified Issue *(Age 18-70)*	Up to $300,000
Children (Up to Age 22)	
Guarantee Issue (New Hire)	Up to $25,000
*Modified and **Simplified Issue	Amount of coverage purchased by $4.23
Grandchildren (Up to Age 18)	
**Simplified Issue	Amount of coverage purchased by $4.23

*MODIFIED ISSUE QUESTIONS

1) Is any person to be insured now disabled, been seen by a physician or been treated in a medical facility, including doctor's office, within the last six months for illness or disease (other than flu, colds)?

2) Has any person to be insured been treated for, or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or tested positive on an AIDS or HIV test?

**SIMPLIFIED ISSUE QUESTIONS

1) Major Medical Impairments (5 years)
2) History of drug/alcohol treatment (10 years)
3) Reason for seeing a medical practitioner in the past 12 months (other than for routine physical exams, including school, employment, aviation, sports, etc).

UNIVERSAL LIFE EVENTS

Universal Life Events insurance addresses differing employee needs for permanent life insurance and peace of mind for a lifetime, and is available for employees and their spouses in face amounts from $5,000 up to $300,000. This policy pays a higher death benefit during working years when expenses are high.

PLAN FEATURES

- ***Fully Portable*** - You can keep this policy should you change jobs or retire.
- Maximum benefit protection during working years, when expenses are typically higher
- ***Guarantee Renewable*** - Guarantee coverage, as long as your premiums are paid
- ***Accelerated Death Benefit for Terminal Illness*** - Pays 75% of death benefit up to $225k
- Spouse coverage available without purchase of employee policy
- ***Long Term Care Benefit*** - Pays a monthly benefit equal to 4% of your death benefit for up to 50 months. The LTC benefit accelerates the death benefit and proportionately reduces it
- ***Benefit Restoration*** - Restores the death benefit that is reduced to pay for Long Term Care, so your family receives the full death benefit amount when they need it most
- Employees up to 65 years of age can apply for voluntary Universal LifeEvents insurance for permanent protection.

BENEFIT AMOUNTS

Employee (Age 18-64)	
All Employees Guarantee Issue	$60,000
Guarantee Issue (New Hire)	Up to $120,000
**Simplified Issue	Up to $300,000

Spouse (Age 18-64)	
Guarantee Issue (if employee applies for coverage) (New Hire)	The greater of $25,000 or $3 per week
*Modified Issue (if employee does not apply for coverage)	The greater of $25,000 or $3 per week
**Simplified Issue	Up to $300,000
Children (Up to Age 22)	
Guarantee Issue (New Hire)	Up to $25,000
*Modified Issue (if employee does not apply for coverage)	Amount of coverage purchased by $4.73

*MODIFIED ISSUE QUESTIONS

1) Is any person to be insured now disabled, been seen by a physician or been treated in a medical facility, including doctor's office, within the last six months for illness or disease (other than flu, colds)?

2) Has any person to be insured been treated for, or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or tested positive on an AIDS or HIV test?

*SIMPLIFIED ISSUE QUESTIONS

1) Major Medical Impairments (5 years)
2) History of drug/alcohol treatment (10 years)
3) Reason for seeing a medical practitioner in the past 12 months (other than for routine physical exams, including school, employment, aviation, sports, etc).

SHORT TERM DISABILITY

Voluntary Short-Term Disability Insurance replaces a portion of your income when you are recovering from a covered illness or injury– a big help while you are unable to work. You can feel better sooner knowing that your income is protected while you're on the mend.

BENEFITS	BENEFIT AMOUNTS
MAXIMUM WEEKLY BENEFIT	66.67% of your weekly salary; up to $1,500 per week
MAXIMUM BENEFIT DURATION	17 weeks
ELIMINATION PERIOD	Accident - 1 days Sickness - 8 days
PRE-EXISTING CONDITION	You may not be eligible for benefits if you have received treatment for a condition with the past 3 months until you have been covered under this plan for 12 months
PRE-EXISTING CONDITION	As a new hire, you are able to take advantage of this coverage without a health exam. However, if you have declined coverage in the past, you may apply for coverage, but will have to submit Evidence of Insurability form before acceptance can be determined.
MATERNITY INFORMATION	Pregnancy is one of the most common examples of short term disability leave. This policy pays your benefit up to six weeks after a normal delivery and eight weeks after a c-section delivery minus the elimination period. The pre-existing conditions clause also applies to pregnancy. For more information about pregnancy and your short term disability policy, click the link below or reach out to a JTS representative.

ADDITIONAL BENEFITS	
Portability	Can be kept after employment
Rehab Assistance	5%
Survivor Income	3 weeks

RATES WILL BE CALCULATED DURING ENROLLMENT PROCESS.

CONTACT JTS WITH QUESTIONS.

To submit a claim online, visit
https://www.lincolnfinancial.com/public/employers/support/employeebenefits#startaclaim

If you stopped receiving a paycheck today, how would you pay for your mortgage, bills, food, and other monthly expenses? Could you maintain your current lifestyle?

BENEFITS	BENEFIT AMOUNTS
MAXIMUM MONTHLY BENEFIT	60% of your paycheck; up to $6,000 per month
MAXIMUM BENEFIT DURATION	SSNRA
ELIMINATION PERIOD	120 Days
PRE-EXISTING CONDITION	You may not be eligible for benefits if you have received treatment for a condition with the past 3 months until you have been covered under this plan for 12 months.

EMPLOYER PROVIDED BENEFIT

East Arkansas Community College provides eligible employees with Long-Term Disability Insurance. It is designed to provide protection if you become disabled and can no longer work due to a covered Accidental Injury or Sickness.

HOW THE PLAN WORKS

If you become disabled due to a covered accident or sickness, long-term disability income insurance will pay up to 60% of your monthly income (once you have satisfied the elimination period.) Disability benefits will be payable up to the benefit period stated in your policy.

BENEFITS BEGIN

Accidental injury and sickness benefits will become payable beginning on the 121st day of disability.

To submit a claim online, visit
https://www.lincolnfinancial.com/public/employers/support/employeebenefits#startaclaim

Critical Illness benefits can help meet the needs your family by offering financial support when it is needed the most. Critical Illness Insurance supplements any existing medical benefits you may already have.

BENEFIT DESCRIPTION	BENEFIT AMOUNTS
MAXIMUM PRINCIPAL SUM Employee Spouse Child	 $100,000 $50,000 $10,000
GUARANTEE ISSUE Employee Spouse Child	 $20,000 $10,000 $10,000
EMPLOYEE COVERAGE	*Flat Benefit Options of*: $10,000 - $100,000
SPOUSE COVERAGE	*Flat Benefit Options of*: 100% of Employee Benefit; Maximum of $50,000
DEPENDENT COVERAGE	$10,000
WELLNESS	$75
COVERED CRITICAL ILLNESSES	Stroke, heart attack, heart transplant, major organ transplant, renal failure, Lou Gehrig's, Alzheimers, Burns caused by accidents, paralysis caused by accident; coronary artery bypass surgery
PORTABLE	Yes
BENEFIT WAITING PERIOD	None
PRE-EXISTING PERIOD	None
BENEFIT REDUCTION	None

RATES WILL BE CALCULATED BY BENEFIT AMOUNT AND AGE DURING ENROLLMENT PROCESS.

To submit a claim online, visit
https://www.lincolnfinancial.com/public/employers/support/employeebenefits#startaclaim

With Cancer insurance, you can rest a little easier. The coverage pays you a cash benefit to help with costs associated with treatments, to pay for daily living expenses and more importantly, to empower you to seek the care you need.

RADIATION & CHEMOTHERAPY	BENEFIT PAYS	BENEFIT DETAILS
RADIATION & CHEMOTHERAPY	$20,000	maximum benefit per 12-month period
BLOOD, PLASMA, AND PLATELETS	$20,000	maximum benefit per 12-month period
WELLNESS & NON-MEDICAL BENEFITS	**BENEFIT PAYS**	**BENEFIT DETAILS**
WELLNESS	$100	per calendar year for cancer screening tests
FIRST OCCURRENCE	$5,000	pays a one-time,lump sum benefit when a covered person is initially diagnosed with cancer
LODGING BENEFIT	$50	per day
GUARANTEE ISSUE	Yes	
PRE-EXISTING PERIOD	Yes	12/12
PORTABLE	Yes	
HOSPITAL BENEFITS	**BENEFIT PAYS**	**BENEFIT DETAILS**
ANESTHESIA	25%	
SURGERY	up to $3,000	actual charges
HOSPITAL CONFINEMENT	$200	per day

COVERAGE TIER	MONTHLY RATES
Employee	$32.59
Employee + Spouse	$52.61
Employee + Child(ren)	$39.63
Family	$59.65

Click the link below to create an account and sign in to submit/view cliams.
https://signin.guardianlife.com/signin

Guardian does not pay benefit for an employee who is undergoing current treatment for Cancer, enrolls in the Cancer plan, and remains on the plan for 12 months. That treatment is excluded. Scheduled benefits are only paid for Cancer that is diagnosed while insured under the Guardian plan and is not pre-existing. Scheduled benefits are paid for a recurrence of Cancer, if the employee has been deemed Cancer-free prior to coming onto our plan, is not undergoing treatment for that previous cancer during the pre-x window, and is diagnosed with the recurrence while currently under our plan. Employee will not be eligible for the Initial Diagnosis Benefit for a recurrence of a similar Cancer.

HOSPITAL CONFINEMENT

Having to undergo hospital treatments can be financially difficult, especially if it is unexpected. A hospital indemnity policy can help by eliminating your financial concerns and provide support when a sudden sickness or injury does occur.

BENEFITS	LOW	HIGH
INITIAL HOSPITALIZATION	$750	$1,500
HOSPITAL CONFINEMENT	$150 per day, 10 per year	$300 per day, 10 per year
SURGERY & ANESTHESIA	Up to $1,000	Up to $1,000
WELLNESS	$30	$30
MATERNITY COVERAGE	Yes	Yes
PRE-EXISTING CONDITION	12/12	12/12
GUARANTEE ISSUE	Yes	Yes
PORTABLE	Yes	Yes

RATES WILL BE CALCULATED BY BENEFIT AMOUNT AND AGE DURING ENROLLMENT PROCESS.

To submit a claim online, visit
https://www.usablelife.com/claims/

ACCIDENT INSURANCE

Accident coverage pays cash benefits for expenses associated with an accidental injury and can help protect hard-earned savings should an on- or off-the-job accidental injury occur.

BENEFITS	LOW	HIGH
EMERGENCY ROOM TREATMENT	$125	$225
INITIAL HOSPITALIZATION	$1,200	$1,200
HOSPITAL CONFINEMENT	$250 per day	$250 per day
AIR AMBULANCE	$1,500	$1,500
WELLNESS	$105	$105
BURNS	Up to $2,500	Up to $4,500
FRACTURES *• fee schedule*	Up to $2,750	Up to $4,950
LACERATION	$450	$810
EYE INJURY	$200	$360
PORTABLE	Yes	Yes

MEETING YOUR NEEDS

- Coverage that is guaranteed issue; not required to take medical exams or tests
- Benefits that correspond with treatment for on- and off-the-job accidental injuries including hospitalization, emergency treatment, intesive care, fractures, and more.
- Benefits paid directly to you (unless you assign them to someone else)

COVERAGE TIER	LOW	HIGH
Employee	$12.13	$14.11
Employee + Spouse	$23.27	$27.05
Employee + Child(ren)	$23.98	$29.81
Family	$35.12	$42.75

To submit a claim online, visit
https://www.usablelife.com/claims/

EMPLOYEE NOTICES

HIPAA Special Enrollment Rights

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. You may be asked to submit a signed statement that this other coverage was the reason for waiving enrollment originally. 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.

Medicaid Coverage - The health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE** - If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP** - If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, 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 provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact Human Resources.

HIPAA Privacy Notice

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE EMPLOYER AND ITS AFFILIATES, IF ANY, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS MANDATED FOR HEALTH PLANS THAT ARE SUBJECT TO HIPAA. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plan (the Plan). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the Plan protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the Plan's legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI without your written authorization:

For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the Plan. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The Plan may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the Plan to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the Plan by third-party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The Plan will disclose your PHI when required to do so by Federal, State or Local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The Plan may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations
The Plan may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You
Your rights regarding the health information the Plan maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plan have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The Plan may deny your request if you ask to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the Plan use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the Plan's use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The Plan is not required to agree to your request.

Right to Request Confidential Communications.
You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Opt-Out of Fundraising Communications. While the plan has no intention of being involved in fundraising activities, if the plan intends to contact you to raise funds for the plan, you have the right to opt-out of receiving such communications.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Privacy Officer to request a written copy of this notice at any time.

A Note About Personal Representatives
You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Changes to this Notice
The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI
You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints
If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally, within 180 days of when the act or omission complained of occurred. Note: The Plan, the Employer, and any of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information
A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.
Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer.

Maternity Coverage
For maternity stays, in accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a cesarean delivery).

Women's Health and Cancer Rights
On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact your HR Department.

Important Notice 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 East Arkansas Community College 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. East Arkansas Community College has determined that the prescription drug coverage offered by the Benefit 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.

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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current 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 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 DrugCoverage…
Contact a JTS representative for more information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and of this coverage through East Arkansas Community College.

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).

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