COFFEE REGIONAL
MEDICAL CENTER

2019
Benefits Summary

Benefits Information

Coffee Regional Medical Center is pleased to offer several benefit options that provide you with flexibility and choice. You have the opportunity to design a personalized benefit package to fit your individual needs and lifestyle.

This booklet is designed to provide you with an overview of your benefits, guide you through your choices, and assist you with the enrollment process. Should there be a conflict between the information in this booklet and the terms of the plan documents and contracts, the terms of the plan documents and contracts will govern in all cases.

Plan descriptions can be found online through your Employee Navigator Account, by contacting Human Resources, or accessing the W Drive.

Available Benefits

• Stride to Wellness Program	Interactive Health
• Two Medical Plans (HDHP and PPO)	Meritain Health
• Dental Plan	Meritain Health
• Vision Plan	EyeMed
• Health Savings Account	Douglas National Bank
• Medical and Dependent Care Flexible Spending Accounts	Meritain Health
• Basic Life Insurance (employer paid)	Mutual of Omaha
• Term Life Insurance	Mutual of Omaha
• Short Term Disability Insurance	Mutual of Omaha
• Long Term Disability Insurance	Mutual of Omaha
• Critical Illness Insurance	Mutual of Omaha
• Accident Insurance	Voya
• Hospital Indemnity Insurance	Voya

Benefits Information

Who is eligible?

Regular, full-time employees working 30 or more hours per week are eligible for the benefits described in this guide. You may also enroll eligible dependents, including:

- Your legal spouse
- Your children, natural or adopted
- Step-children who meet the dependent status requirements of the plan
- Children who have been placed with you for adoption
- Children for whom you are the legal guardian

Coverage is available for children until they reach age 26

Medical and Dental Coordination Benefits

If you or your dependents have benefits under this plan and another plan, the two plans will coordinate your benefits. One plan will be primary (the first payer) and the other will be secondary (pays after the first plan has paid.) In addition, if both parents provide benefits to the child, the primary plan is the one from the parent whose birthday comes first in the year.

Is there a waiting period?

The waiting period for all insurance coverages is 60 days of full-time active employment. Your coverage effective date is the first of the month following the waiting period.

Enrollment

Coffee Regional Medical Center utilizes an online enrollment system called Employee Navigator. Please refer to pages 20 and 21 for details regarding how to enroll, or contact Human Resources.

If you are a new employee, you may enroll within 60 days of your hire date, or during the annual enrollment period. In addition, if you experience a qualifying event during the year you may make changes within 31 days of the event. A qualifying event could be:

- Involuntary loss of other benefits
- Marriage or divorce
- Birth of a child
- Adoption, or placement of a child in your home for adoption

You may be required to provide supporting documentation when you enroll following a qualifying event, such as marriage or birth certificate.

It is not mandatory that you participate in the benefit plans. Please note that even if you choose not to participate, you must go to the online enrollment system to decline enrollment.

Terms To Know

With any benefit topic, it helps to understand the terminology. Here are the terms you should understand as you read this guide.

Coinsurance: The way you and your employer share the cost of covered health care expenses after you meet your deductible. Coinsurance counts toward your annual out- of-pocket maximum.

Copay: A flat dollar amount you pay at the time you receive certain covered services or prescription drugs. Copays apply toward your annual out-of-pocket maximum.

Deductible: The amount of money you pay for certain covered services before the plan pays. Your deductible counts toward satisfying your annual out-of-pocket maximum.

> **EPO (PPO) Plan:** *The family deductible maximum is the most a family will pay during a calendar year. Each individual in a family is not required to contribute more than one individual deductible amount to a family deductible.*
>
> **HDHP Plan:** *The family deductible maximum is the most a family will pay during a calendar year. The entire family deductible must be satisfied by one individual or collectively before benefits will be paid at the coinsurance rate.*

If the deductible is satisfied in whole or in part during October, November or December, those expenses will also apply to the deductible in the next calendar year.

FSA (Flexible Spending Account): Accounts allowing you to set aside pre-tax money to pay for eligible healthcare and/or dependent care expenses.

In-Network: In-network providers have agreed to negotiated discounted rates. You will pay less when you use in-network providers.

Out-of-Network: Providers that are not on the network list. You may not have coverage, or will pay more, when you use an out-of- network provider.

Out-of-Pocket Maximum: The maximum amount of money you have to pay in copays, deductibles and coinsurance in any calendar year.

> *The single out-of-pocket maximum applies to someone with single coverage. When a person reaches the out-of-pocket maximum, the plan will pay 100% of eligible expenses for the remainder of the calendar year. The family out-of-pocket maximum applies collectively to all covered members of the family. The entire family out-of-pocket maximum must be satisfied, however each individual in a family is not required to contribute more than the single out-of-pocket maximum before the plan will pay 100% of eligible expenses for an individual during the remainder of the calendar year.*

Not all expenses apply to the out-of-pocket maximum. Those expenses that do not apply are charges over usual and customary, charges the plan does not cover and the Teledoc consulatation fee. Once you have paid the out-of-pocket maximum for the calendar year, the plan will pay eligible expenses at 100%.

PCP: Primary Care Physician. This is a physician who provides diagnosis of, and continuing care for, varied medical conditions.

Preventive Care: Services including screenings, immunizations and other procedures that are designed to detect and treat medical conditions to prevent avoidable illnesses.

Provider: Professionals who perform healthcare services including medical and eye doctors, hospitals, medical treatment centers, pharmacies and dentists.

Rates or Employee Rates: Your portion of healthcare costs that are deducted from your paycheck.

Stride to Wellness Program

Coffee Regional Medical Center partners with Stride to Wellness to offer a comprehensive health and wellness program to all employees and spouses enrolled in the medical plan. You enjoy a discount on your medical plan rate for meeting your wellness goals.

The components of the program are:

Preventive Health Evaluations

On-site evaluation that includes:

- Biometric screening with up to 38 tests that detect potential health issues including anemia, kidney and liver disease, high cholesterol, and diabetes).
- Blood pressure screening.
- Health history questionnaire.

Lab results are available online within 3 days of your evaluation (and can be shared with your physician). A personalized comprehensive report is mailed to your home within two weeks.

Personal Health Score and Goal

Your results will include a personal health score, and an achievable personal health goal to attain in subsequent annual evaluations.

6 month recheck

Six months after the preventive health evaluation, you can complete an additional biometric screening to review your progress.

Health Coaching

Through Stride to Wellness, you are provided the opportunity to connect with a personal health coach and take specific health courses. This can occur in the following ways:

- Based on your lab results, a health coach may reach out to you within 24-48 hours of your evaluation.
- Ongoing support is provided for the following conditions: metabolic syndrome, pre-diabetes, diabetes, elevated cholesterol, and hypertension.
- You can enroll in various telephonic courses, such as Better Nutrition.
- Or, you can participate in online coaching courses.

Member Website

- See your evaluations results, including any prior year results.
- Take a Health Risk Assessment.
- See your personal action plan.
- Participate in online education and wellness workshops.
- Use available interactive tools or access the mobile app

Your personal information is confidential. No individual health information is shared with your employer. There is no cost for you to participate in the Stride to Wellness Program. In order to have the opportunity for incentives, you (and your covered spouse, if applicable) must participate in the Stride to Wellness Program.

Your Medical Plans

Coffee Regional Medical Center offers you two comprehensive medical plans from which you may choose to add to your benefit package. Keep in mind that if you choose to waive or opt out of coverage, you must be covered under another medical plan to avoid Healthcare Reform mandated penalties.

The High Deductible Health Plan (HDHP)

This plan is a qualified high deductible health plan, offering you the greatest bi-weekly cost savings. The reason it is cost-effective is that you pay more healthcare costs in the form of the high deductible – the amount you pay out of your own funds before the plan begins to pay. The plan also offers a Health Savings Account (HSA) to help you pay for eligible expenses before (and sometimes after) you reach the deductible.

In this plan, your in-network hospitals are Coffee Regional Medical Center and St. Joseph's/Candler. Your in-network physicians are any physician in the Aetna Select Open Access Network . The plan does not have out-of-network benefits, however if a service is not available at Coffee Regional Medical Center or St. Joseph's/Candler, you will have access to Aetna Select Open Access facilities (upon medical review and authorization).

About the HSA

HSAs are great for employees who have little or no medical expenses and may wish to save funds for later on in life. An HSA is yours – you own it and the funds rollover from year to year.

- The money can be used to help pay your deductible or other qualified expenses (as determined by the IRS).
- The money in the account earns interest, and the interest is not taxed as long as you use it to pay qualified expenses.
- If you choose, you can leave the account untouched, earning interest, until you turn 65.
- The account is yours so it moves with you, even if you change jobs. As long as you are enrolled in a high-deductible health plan you may continue to contribute to the account.
- The HSA operates like a normal bank account – only the funds that are in the account are available for you to use

Aetna Select Open Access Network
To find a network physician, go to
www.aetna.com/docfind/custom/mymeritain

Douglas National Bank HSA

- If you want to open an HSA, you may do so with Douglas National Bank.
- You may contribute to the account by payroll deduction, lump sum, or fully fund on day one, up to the federal maximum.
- Account information must be provided to CRMC Accounting department prior to the first pay period of 2019.

HDHP Plan Summary

HDHP Plan Summary of Benefits

PLAN FEATURES	CRMC/SJC Aetna Select MDs	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible Per Person/Family	$1,350/$2,700	NA
Calendar Year Out-of-Pocket Maximum Per Person/Family (combined with Prescription Drug plan)	$5,000/$12,900	NA
Preventive Care - refer to Healthcare Reform website for comprehensive listing of included services	100%	NA
Routine Care (PCP or Specialist Office Visit)	85% after deductible	NA
Allergy Testing, Serum and Injections	85% after deductible	NA
Hosptial Benefits - Inpatient and Outpatient	85% after deductible	NA
Emergency Services - Medical Emergency	85% after deductible	85% after deductible
Emergency Services - Non- Emergency Condition	50% after deductible	NA
Urgent Care Visit	85% after deductible	NA
Surgical Benefits - Inpatient, Outpatient and MD Office	85% after deductible	NA
Diagnostic X-Ray and Laboratory Services	85% after deductible	NA
Mental/Nervous and Substance Abuse Services	85% after deductible	NA
Home Health Care	85% after deductible	NA
Hospice Services	85% after deductible	NA
Occupational, Physical and Speech Therapy	85% after deductible	NA
Durable Medical Equipment	85% after deductible	NA

PRESCRIPTION DRUGS	CRMC PHARMACY	RETAIL PHARMACY
NOTE: Pharmacy expenses apply to the medical deductible and out-of-pocket maximums; coinsurance applies AFTER the deductible is met. Specialty drugs must be purchased at the CRMC pharmacy.		
30-Day Supply Generic Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 90% after deductible 80% after deductible 80% after deductible	 90% after deductible 80% after deductible 80% after deductible
90-Day Supply Generic Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 90% after deductible 80% after deductible 80% after deductible	 NA

The PPO Plan

This plan is a standard PPO health plan, with both copays and coinsurance. If you prefer a more traditional approach to your healthcare, this plan may be the one for you. With this plan, for some services you will be responsible for a copay, so you will know what to expect when you see a provider. For other services, you will be responsible for meeting the deductible before the plan pays.

The PPO Plan utilizes the Coffee Select Network, meaning all services you seek must be through the Coffee Select Network. The plan does not have out-of-network benefits, however if a service is not available within this network, you will have access to Aetna Select Open Access network providers (upon medical review and authorization).

About your Copay, Deductible and Out-of-Pocket Maximum

- Copays apply to services such as office visits and urgent care or walk-in clinic visits. Once you pay the copay, the plan pays for the remaining eligible charges.
- The deductible applies to services like surgeries or inpatient hospital stays. After you pay your annual deductible, the plan will pay a percentage of the eligible charges. The remaining percentage is your responsibility, up to an annual out-of-pocket maximum.

Preventive Care

Most preventive care, such as immunizations, certain contraceptives, and lactation counseling and breast pumps, will be paid at 100% with no copay or coinsurance under both plans. You will not pay anything for these services when:

- The provider is in your network and the main purpose of your visit is for preventive care.
- You choose generic contraceptives.
- You purchase a breast pump (per the guidelines of your plan).

In addition, the plan pays at 100% for services that may have been billed separately, such as lab work.

Remember to consult your plan document for detailed information about covered preventive services.

PPO Plan Summary

PPO Plan Summary of Benefits

PLAN FEATURES	Coffee Select Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible Per Person/Family	$2,000/$6,000	NA
Calendar Year Out-of-Pocket Maximum Per Person/Family (combined with Prescription Drug plan)	$4,400/$12,000	NA
Preventive Care - refer to Healthcare Reform website for comprehensive listing of included services	100%	NA
Routine Care Office Visit Specialist Visit	 $15 copay $25 copay	NA
Allergy Testing	85% after deductible	NA
Allergy Serum and Injections	100%	NA
Hospital Benefits - Inpatient and Outpatient	85% after deductible	NA
Emergency Services - Medical Emergency	85% after deductible	85% after deductible
Emergency Services - Non-Emergency Condition	50% after deductible	NA
Urgent Care Visit	85% after deductible	NA
Surgical Benefits - Inpatient and Outpatient	85% after deductible	NA
Surgery performed in Physician's Office	100% to maximum of $400, then 85% after deductible	NA
Diagnostic X-Ray and Laboratory Services		NA
Occupational, Physical and Speech Therapy		NA
Mental/Nervous and Substance Abuse Inpatient or Partial Hospitalization Office Visit	 85% after deductible $15 copay	NA
Home Healthcare	85% after deductible	NA
Hospice Services	85% after deductible	NA
Durable Medical Equipment	85% after deductible	NA

PRESCRIPTION DRUGS	CRMC PHARMACY	RETAIL PHARMACY
NOTE: Specialty drugs must be purchased at the CRMC pharmacy.		
Calendar Year Our-of-Pocket Maximum Per Person/Family		***$1,000/$2,000***
30-Day Supply Generic Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 $10 copay $35 copay $50 copay	 $25 copay $60 copay $90 copay
90-Day Supply Generic Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 $10 copay $75 copay $100 copay	NA

Coffee Select Network

If you choose the PPO Plan, you must seek services through the Coffee Select Network.

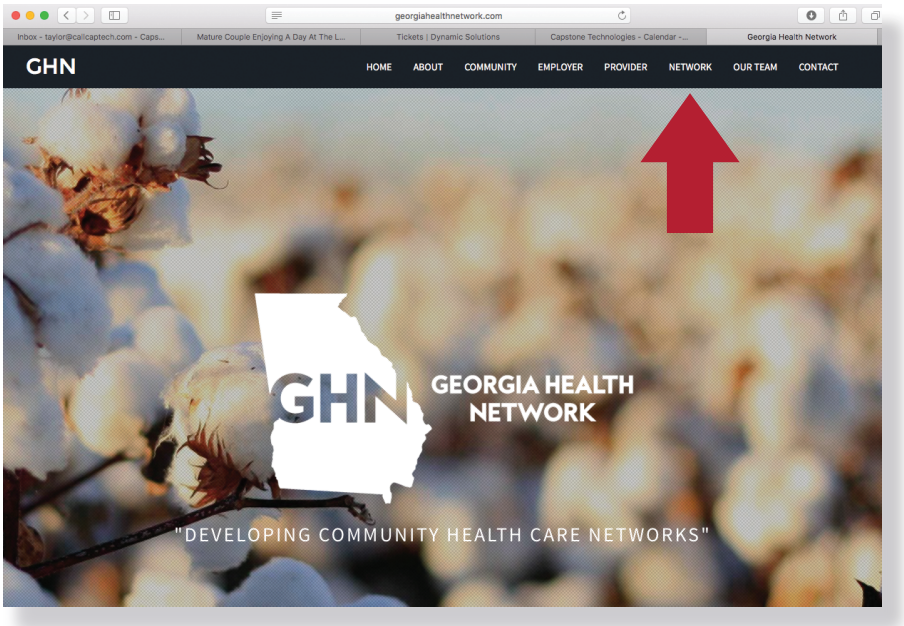
The Coffee Select Network is a member of the Georgia Health Network, and has been developed specifically for the community served by Coffee Regional Medical Center. The primary hospital facilities are Coffee Regional Medical Center and St. Joseph's/Candler. There is also a defined group of physicians participating in this network.

Any provider or facility not in the Coffee Select Network is considered out-of-network unless the service you require cannot be performed within the network, as determined by medical review. In such cases, an Aetna Select Open Access Network provider must be utilized.

Provider Search

To find providers in the Coffee Select Network, follow these steps:

- Go to www.georgiahealthnetwork.com
- Click on the Network tab at the top to begin your provider search



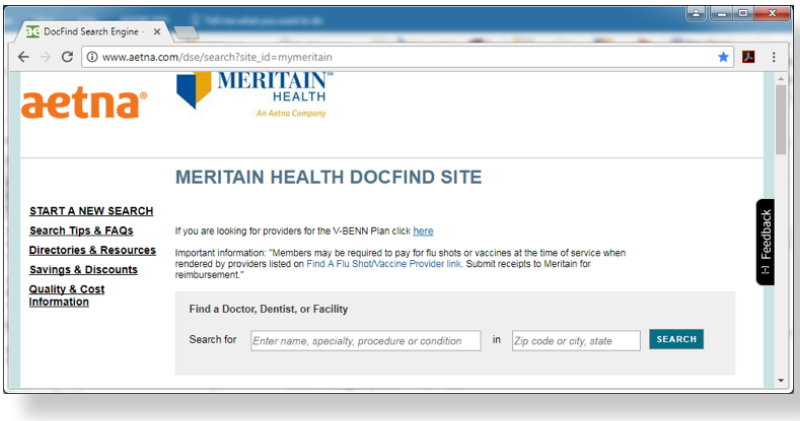
GHN COFFEE SELECT

Aetna Select Open Access Network

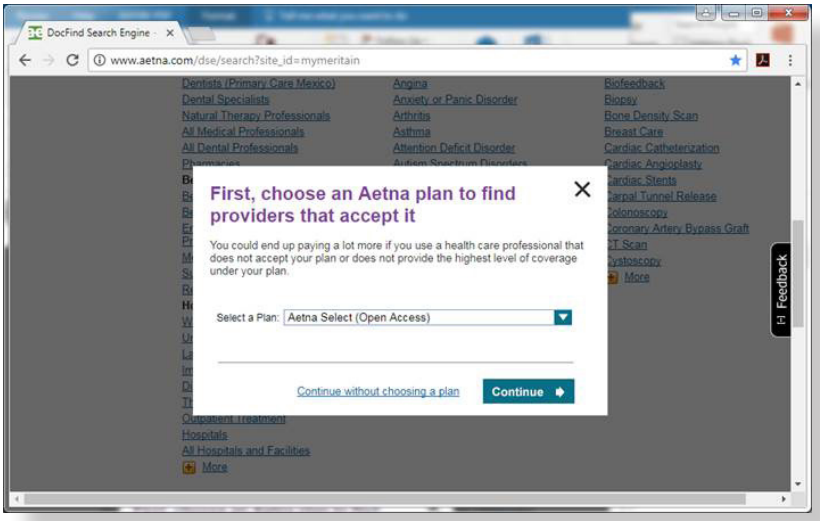
Provider Search

To find providers in this network, follow these steps:

- Go to www.aetna.com/docfind/custom/mymeritain/
- Enter the provider name, specialty, procedure or condition, as well as the desired zip code
- Click Search



- Then select the Aetna Select Open Access network from the drop down, as shown below. Click Continue.



If you need assistance, or need to find a provider when you are not near a computer, simply call the Aetna Provider Line at (800) 343-3140 from 8:00 a.m. to 9:00 p.m. (Eastern Standard Time),

Healthcare Access: Your Primary Care Options

Primary Care Physicians

According to the National Center for Health Statistics, 22% of adults aged 18 and over do not have a Primary Case Physician (PCP). In Georgia, 27% do not have a PCP.

Why is this important? Healthcare professionals agree that having a PCP is essential to ensuring that you recieve the best possible care. Regular visits to the same physician allow the physician to become familiar with your medical history, which makes diagnosis and treatment easier when you do get sick.

In addition, having a PCP that knows you may help lower your healthcare costs. Many people who do not have a PCP seek treatment in the Emergency Room, resulting in higher immediate costs (for the ER visit itself) and potentially higher health plan rates in the future.

Walk-In Clinic for Urgent Care

The CRMC walk-in clinic is another convenient option when your primary care physician is not available, or when you become ill after normal office hours, for urgent care. You should seek urgent care for non-emergent health conditions like ear aches, sprains, colds or stomach pain. The walk-in clinic is open 7 days a week from 7:30 am to 7:30 pm (closed for lunch from 12:30 pm to 1:30 pm)

Emergency Room - What is an Emergency?

An emergency is an unforseen medical event or condition that without immediate medical attention the person's health would be in serious jeopardy, serious impairment to bodily functions woud result, or the condition would cause serious dysfunction of any bodily part or organ.

Wow! That's a long definition! Let's try this: **It is a sudden onset of acute symptoms that pose an immediate health risk.** Some examples are:

- Loss of consciousness
- Sudden severe pain with no known cause
- Severe chest pain
- Head injury or possible broken bones
- Bleeding that won't stop
- Sudden weakness on one side of the body
- Serious burns

While the hospital emergency room is open 24 hours a day, you may not receive prompt care if your illness or injury is not a true emergency. You may wait a long time while others with more serious conditions are evaluated and treated.

Consider: Some studies estimate that one-third to one-half of all ER visits are for non-acute that could have been addressed at a PCP office.

We want you to obtain the care you need - while making knowledgeable decisions about where to go for care. **We encourage you to establish a relationship with a PCP if you don't already have one.**

Your Prescription Drug Plan

When you elect medical coverage, you are automatically covered under the prescription drug plan based on your medical plan election. The coverage allows you to fill your prescriptions at the Coffee Regional Medical Center pharmacy or participating retail pharmacies. You enjoy a lower cost at the Coffee Regional pharmacy.

Controlling your prescription drug costs

When you have a prescription filled, the amount you pay is based on what type of drug you choose. You have the opportunity to lower your cost by choosing a generic drug over a brand name, or formulary, drug.

- A **generic** drug is one that meets the same standard as brand name drugs for safety, purity, strength and effectiveness. You pay a lower amount when you choose generic drugs.
- A **preferred brand** name drug is a brand name drug that is listed on the Preferred Drug List (often referred to as a formulary). These drugs are determined to be the drug of first choice for certain conditions, and may not have generic equivalents.
- A **non-preferred brand** name drug is a brand name drug that is not listed on the preferred list, and usually has a less costly generic or preferred brand alternative. These prescriptions are usually covered at the highest copay or coinsurance level.

The Preferred Drug List is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs. If you are using a drug that is not on the Preferred Drug List, talk with your doctor to determine if a generic or preferred brand name drug might be appropriate for you.

Why generics make sense

- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original, brand-name drug in color or shape, but only because they may have different inactive ingredients that won't change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents, but you may have to ask for them.

How the Preferred Drug List Works

- Drugs are added to the list on a quarterly basis.
- Brand-name drugs can be removed at the end of a calendar year.
- The list is updated every January.
- If a generic becomes available, the brand-name drug will become a "non-preferred' drug, and then only available at a higher cost.

Dental and Vision Plans

Did you know that good dental care not only helps to prevent periodontal disease, but it can also add as many as six years onto your life? Brushing and flossing your teeth, combined with regular dental check-ups, may also help to prevent the onset of cardiovascular disease. For these reasons, Coffee Regional Medical Center offers a dental plan for you and your dependents. There is no dental network, so you can visit any dentist you choose.

Dental Plan Summary

PLAN DETAILS	
Calendar Year	$50 per person/ $150 per family Applies to Class B, C & D Services
Class A | Preventive Services	Covered at 100%
Class B | Basic Services	Covered at 80% (you pay 20%)
Class C | Major Services	Covered at 50% (you pay 50%)
Calendar Year Maximum	$2,000
Orthodontia (children under 19)	Covered at 50% (you pay 50%) Lifetime maximum of $1,500

Along with dental care, it is important to protect your vision. Coffee Regional Medical Center offers you a vision plan through EyeMed, which has a broad network of providers including top retail chains like LensCrafters® and Wal-Mart Vision Center. To find an EyeMed network provider, go to www.eyemed.com.

Vision Plan Summary

PLAN DETAILS	IN-NETWORK
Eye Exam (once every 12 months)	$10 copay
Frames (once every 24 months)	$0 copay; $130 allowance; 20% off the balance over $130
Standard Plastic Lenses (once every 12 months)	$25 copay
Conventional Contact Lenses (once every 12 months)	$0 copay; $130 allowance; 15% off the balance over $130
Disposable Contact Lenses	$0 copay; $130 allowance, plus the balance over $130

ID Cards

Medical and Dental Plans

If you elect a medical plan and/or the dental plan, you will receive an ID card from Meritain Health (one card will be for both medical and dental)

Card front

- The customer service number and TPA website appear at the top.
- In the upper left are your name, ID number, group number and name, and plan name.
- The lower left contains your dental plan information.
- On the top right, your medical plan network and copays, if applicable.
- On the lower right, your pharmacy coverage information.

Card back

- Claims submission information is on the left.
- The upper right has the precertification information.
- The lower right, information regarding verification of benefits and the network website

Vision Plan

Your EyeMed ID card will come to you with detailed information about your plan, as well as a listing of nearby providers.

Your Flexible Spending Account (FSA)

Coffee Regional Medical Center offers you the opportunity to take advantage of tax savings available by participating in a Healthcare FSA and/or a Dependent Care FSA. An FSA is a tax- effective, money-saving option that helps you pay for qualified healthcare expenses that aren't covered by your health plan, and for dependent care services necessary to enable you to work.

How an FSA works

You determine how much to contribute to the account in pre-tax money each pay period.

Healthcare FSA

- The maximum you can contribute per year is $2,600.
- Use the money in the account to pay for eligible expenses not reimbursed by your medical, dental or vision plan.
- All IRS code 213(d) expenses are eligible, including deductible, coinsurance, and copays.
- Certain over-the-counter items qualify too, as long as you have a written prescription.
- Your entire annual election is available to you on day one

Dependent Care

- The maximum you can contribute is $5,000 per year or $2,500 if you are married and filing seperate tax returns.
- Use the money in the account to pay for eligible day care type expenses for the care of children or adults.
- Expenses are eligible if they are for the care of a person under age 13, or an adult dependent who is unable to care for themselves.

Calculating your contribution

You will gain the most savings if you plan carefully. You can use the worksheet on the next page to help you determine how much to contribute to either FSA.

Is FSA right for you?

• The Healthcare FSA may be right for you if you and your eligible dependents typically have predictable out-of-pocket expenses during the year, like maintenance medications.

• The Dependent Care FSA may be right for you if you have day care expenses for an eligible dependent while you are at work.

Important Notes

• If you participate in the HDHP Plan with an HSA, you cannot participate in the Healthcare FSA (but you can participate in the Dependent Care FSA).

• If you decide to use the Dependent Care FSA you cannot use the Federal Tax Credit for the same purpose. Consult your tax advisor to determine the most tax-efficient method for you.

• If there is money left in your FSA at the end of the year, you will unfortunately forfeit this money (the IRS's rule of thumb is "use-it- or-lost-it").

• You can enroll in the FSA even if you are not covered on CRMC's medical plan.

Your Flexible Spending Account (FSA)

FSA Worksheet

This worksheet is intended to assist you with the enrollment process by helping you calculate your eligible expenses and how much money to contribute to an FSA.

Healthcare FSA

Annual Medical Expenses, such as:

Deductibles and copays	$ _____
Routine physical exams	$ _____
Prescriptions	$ _____
Chiropractic care	$ _____
Other	$ _____

Annual Dental Expenses, such as:

Deductibles and copays	$ _____
Routine check-ups	$ _____
Orthodontia	$ _____
Other	$ _____

Annual Vision Care Expenses, such as:

Eye Exams	$ _____
Eyeglasses	$ _____
Contact lenses, solutions, cleaners	$ _____
Other	$ _____

Total Estimated Medical, Dental & Vision Expenses

$ _____ ÷26 pay periods = $ _____

Annual Amount (cannot exceed $2,650) — Per Pay Period Contribution

Dependent Care FSA

Annual Dependent Care Expenses:

Payment to a dependent care facility or indivdual	$ _____
Payment to other care providers	$ _____

Total Estimated Dependent Care Expenses

IRS Limit: $5,000 if married filing joint tax returns; $2,500 if married filing separate tax returns

$ _____ ÷26 pay periods = $ _____

Annual Amount (cannot exceed IRS limit) — Per Pay Period Contribution

Other Insurance Coverage

Basic Life Insurance and Accidental Death Insurance

Coffee Regional Medical Center's Basic Life and Accidental Death insurance provides important financial protection for you and your survivors. Basic Life coverage is provided for all full-time employees in the amount of $30,000. This coverage includes Accidental Death and Dismemberment equal to one times the amount of Basic Life coverage.

Your spouse is also eligible for coverage in the amount of $5,000, and your dependent children from live birth to age 26 are eligible for coverage in the amount of $2,000.

With the Basic Life, you and your family also have access to Mutual of Omaha's Employee Assistance Program (EAP). There is no cost to you for utilizing EAP services.

Voluntary Term Life

You can also purchase additional optional Voluntary Term Life insurance coverage for yourself, your spouse and your children. You can purchase coverage for yourself in increments of $10,000 to a maximum of $500,000 (or 5 times your salary, whichever is less). You must purchase coverage for yourself in order to cover your dependents. Any amount over $180,000 will have to be approved by Mutual of Omaha through the Evidence of Insurability (EOI) process.

For your spouse, you can purchase in increments of $5,000 to a maximum of $250,000 but not more than the amount purchased for yourself. Any amount over $75,000 will have to be approved by Mutual of Omaha through the EOI process.

If purchasing coverage for your children, you can purchase in increments of $2,000 to a maximum of $10,000. Any amounts that exceed the guarantee issue amount will require EOI. If you do not enroll within 31 days of your first eligibility date, you can apply during annual enrollment and may be required to furnish EOI for the entire amount of coverage.

About Taxes

The IRS considers the cost of life insurance premiums on coverage above $50,000 as taxable income. This taxable amount is called imputed income, and will appear on your annual W2 document. In most cases, the amount of the tax is small.

Other Insurance Coverage

Short Term Disability Insurance

Every day illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs. Short term disability coverage can pay up to 70% of your income, so you can focus on getting better, and worry less about keeping up with your bills. If you elect coverage, you can choose monthly benefits of 20%, 30%, 40%, 50%, 60% or 70% of income up to a maximum of $1,200 per week. You also have the option to elect either a 7 or 14 day benefit waiting period.

Long Term Disability Insurance

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years. Long term disability can pay up to 60% of your income, so you have financial support to manage your disability and your household. The monthly Long Term Disability benefits will be 60% of your monthly pre-disability earnings, up to a maximum of $5,000. Long-term disability payments begin following a 180 day disability waiting period.

Critical Illness Insurance

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. It can pay you a lump-sum cash benefit, which you can use any way to meet your needs. To help prevent illness, this plan can also pay you an annual cash benefit when you take a covered health screening test.

Accident Insurance

You can't always avoid accidents – but you can protect yourself from accident-related costs that can strain your budget. Accident insurance pays a benefit directly to you if you have a covered injury and need treatment. You can get coverage for your spouse and dependents, too. As medical costs continue to rise, accident insurance provides a necessary layer of financial protection. To help prevent illness, this plan can also pay you an annual cash benefit when you take a covered health screening test.

Hospital Indemnity Insurance

A trip to the hospital can be stressful, and so can the bills. Even with major medical insurance, you may still be responsible for co-payments, deductibles and other out-of-pocket costs. Our hospital indemnity plan pays a cash benefit directly to you whenever you or your covered family members are admitted to the hospital. Whether you're being treated on an inpatient or outpatient basis, this coverage can help you manage your expenses.

Refer to page 34 for phone and website contact information. Claim forms are available on the carrier websites.

Bi-Weekly Employee Rates

Medical Plans

HDHP PLAN	STANDARD RATES	GOAL ACHIEVER RATES
Single	$63.43	$40.36
Employee + Child(ren)	$69.19	$46.12
Employee + Spouse	$172.53	$149.53 (1 Goal Achiever) $126.43 (2 Goal Achievers)
Family	$178.29	$155.29 (1 Goal Achiever) $131.91 (2 Goal Achievers)
PPO PLAN	**STANDARD RATES**	**GOAL ACHIEVER RATES**
Single	$90.00	$55.38
Employee + Child(ren)	$96.92	$62.31
Employee + Spouse	$253.80	$219.19 (1 Goal Achiever) $179.96 (2 Goal Achievers)
Family	$260.72	$226.10 (1 Goal Achiever) $186.87 (2 Goal Achievers)

Vision Plan

Single	$2.59
Employee +1	$4.92
Family	$7.23

Dental Plan

Employee Only	$8.15
Employee + Spouse	$21.00
Employee + Child(ren)	$18.00
Family	$25.00

Voluntary Insurance Plans

Rates will be calculated within the enrollment system, and are determined based on factors such as coverage level, age and policy type.

How To Enroll

Are you ready to enroll? It's simple to do so – just follow these steps. If you have any questions during the process, check with Human Resources.

Gather your information

For a complete, efficient enrollment, you may need some of the information below.

- Spouse and children's birth dates and Social Security Numbers.
- If your spouse or children are covered under another health plan, the name of the plan or insurance carrier and the effective date of benefits.
- If your benefits will include life insurance, your beneficiaries' names and Social Security Numbers.
- If you cover a disabled child age 26 or older, you may need to provide medical documentation of their disability.

Under Healthcare Reform, Coffee Regional Medical Center must now report covered member's Social Security Numbers to the IRS. It is important that you have this information available for enrollment.

Review plan and enrollment materials

The decisions you make as you enroll will affect your benefit coverage for the coming year, as well as your finances. Be sure to read all information available to determine the best benefits for you and your family. Don't enroll without understanding your options. Consider the following:

- Your personal health and the health of your family members.
- Medical, dental and vision expenses that you can predict for you and your family.
- Other benefits your or your family members may have.
- Your overall budget for benefits.

Complete your enrollment

If you do not already have a login, go to https://www.employeenavigator.com/benefits/Account/Login and select "Register as a new user" then follow the instructions to complete your registration. Once you have created a login, you can move right into enrollment or come back later to finish.

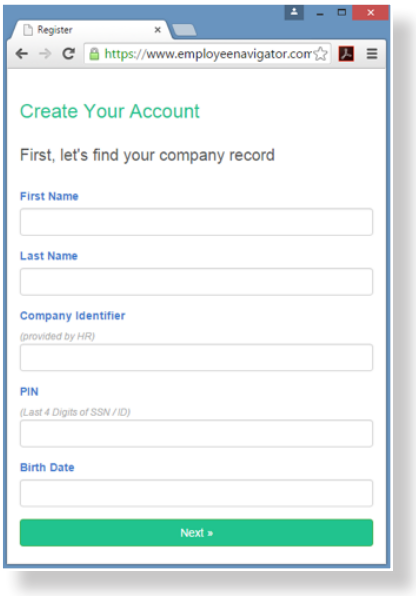
If it is annual enrollment (usually during the month of October), you will also have the opportunity to visit with an Enrollment Counselor on site. Human Resources will communicate specific dates and times that counselors will be on site.

How To Enroll

1 Complete all information on this screen and click "Next."

Your company identifier is CRMCGA

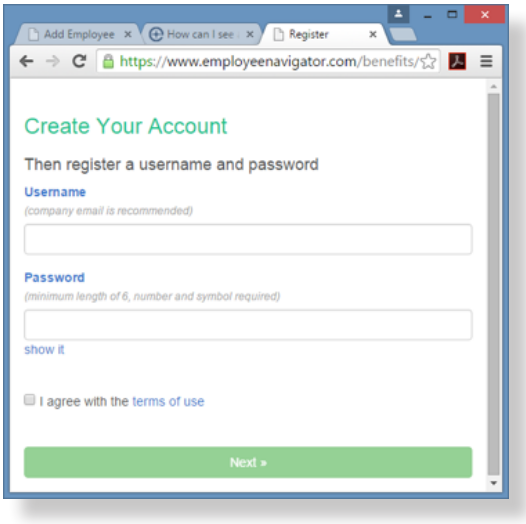
Your PIN is the last 4 digits of your social security number.



2 Create a user name and password

Review the terms of use, then check the box

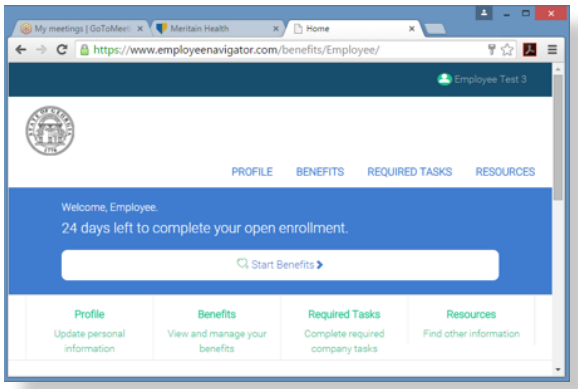
Click "Next."



3 Once you have registered, you can move right to enrollment or come back later to finish. If you come back later, go to:

https://www.employeenavigator.com/benefits/Account/Login

Remember, if you have questions or need assistance, visit with an enrollment counselor or Human Resources.



Other Benefits

Educational Assistance Program

Coffee Regional Medical Center is committed to the educational development of its employees in all aspects of job performance. Through the company's Educational Assistance Program, Coffee Regional Medical Center will reimburse costs for participation in and satisfactory completion of job-related college, university, or vocational/technical courses for a job currently held by an employee or for a job that is part of an advancement plan for the employee.

The maximum reimbursement amount per calendar year is typically consistent with the IRS limit of the amount of tuition reimbursement that can be provided on a tax-free basis. The limit is currently $5,250. Please contact Human Resources in advance of pursuing courses for additional information and an application.

The full Educational Assistance Program Policy can be obtained through Human Resources or on the policy drive.

401(k) Retirement Savings Plan

Full-time, part-time and temporary employees are eligible to participate in the 401(k) plan administered by Fidelity Investments. Plan highlights include:

- 100% vesting from day one
- access to financial advisors at no cost to you
- automatic enrollment at 3% contribution
- contributions are tax-deferred
- multiple fund options

Visit Fidelity at www.fidelity.com/atwork for more information about your 401(k).

Notices

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, 2018. Contact your State for more information on eligibility –

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

Notices

Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
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
LOUSIANA | 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
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: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA | Medicaid	PENNSYLVANIA| Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA | Medicaid	RHODE ISLAND | Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA | Medicaid	SOUTH CAROLINA | Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

Notices

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

To see if any other states have added a premium assistance program since January 31, 2018, 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)

Notices

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at (800) 749-9963, ext. 3417.

General Notice Of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

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 obligation sunder 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 must 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 continuation 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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: Group Resources, Inc, Street, City, State, Zip, Attn: Someone.

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.

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 you 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 moths, 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 even not occurred.

Notices

Notice Regarding Wellness Program

Coffee Regional's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary Health Risk Assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Glucose and Uric Acid, Kidney (Renal}, Electrolytes, Liver (Hepatic), Lipids, Complete Blood Count, PSA (men over 50 yrs old), and TSH (women over 40 yrs old). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a premium discount for completing wellness activities. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the premium discount.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Interactive Health at 800-840-6100.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as personal coaching from a health coach. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Coffee Regional Medical Center may use aggregate information it collects to design a program based on identified health risks in the workplace, Coffee Regional Medical Center's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by

the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Interactive Health and their wellness coaches in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Theresa Hepburn at 912.383.5607.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 Theresa Hepburn, Benefits Coordinatior

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Coffee Regional Medical Center	4. Employer Identification Number (EIN) 65-0543088	
5. Employer address 1101 Ocilla Road	6. Employer phone number	
7. City Douglas	8. State GA	9. ZIP code 31534
10. Who can we contact about employee health coverage at this job? Theresa Hepburn		
11. Phone number (if different from above) 912-383-5607	12. Email address theresa.hepburn@coffeeregional.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: Employees that work more than 30 hours per week and have satisfied the waiting period of 90 days.
  - ☒ Some employees. Eligible employees are: All fulltime employees that work more than 30 hours per week and have satisfied the waiting period of 60 days.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: Subscriber's spouse, children (including natural born, stepchildren, legally adopted children, children under legal guardianship) up to age 26. Disabled children may be covered beyond age 26 with proper certification of disability.
  - ☐ 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 or 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 is 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, and will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C) of the Internal Revenue Code of 1986)

When You Have Questions

TOPIC	CONTACT	TELEPHONE	WEBSITE/EMAIL
Medical Claims	Meritain Health	800.925.2272	www.meritain.com
Medical Precertification	Meritain Health	888.925.1799	www.meritain.com
Refer to Summary Plan Description for items requiring pre-certification			
Prescription Plan	Scrip World (powered by Caremark)	866.475.7589	www.caremark.com
Flexible Spending Accounts	Meritain Health	See Debit Card	www.meritain.com
HSA Account	Douglas National Bank	912.384.2233	www.dnbdouglas.com
Dental	Meritain Health	800.925.2272	www.meritain.com
Vision	EyeMed	866.800.5457	www.eyemed.com
Basic & Term Life Insurance	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
STD, LTD & Cancer Insurance	Mutual of Omaha	800.877.5176	www.mutualofomaha.com
Accident & Hospital Indemnity Insurance	Voya	800.325.4368	www.voya.com
Employee Assistance Plan	Mutual of Omaha	877.236.7564	www.mutualofomaha.com
Enrollment	CRMC Human Resources	912.383.5607	theresa.hepburn@coffeeregional.com

This booklet is intended to provide an easy-to-read overview of the benefits available at Coffee Regional Medical Center. Should there be any conflict between the explanations in this booklet and the actual terms of the plan documents and contract, the terms of the plan documents and contracts will govern in all cases. You will not gain any new rights or benefits due to a misstatement or omission in this booklet. None of this information should be interpreted as a guarantee of employment. Coffee Regional Medical Center reserves the right to amend, modify, suspend or terminate any benefit at any time.