COFFEE REGIONAL MEDICAL CENTER

2020 Benefits Summary

Introduction

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.

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Terms to Know

With any benefit topic, it helps to understand the terminology. Here are some of 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 but not your deductible.

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 but not your deductible.

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

- ***EPO 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.

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 pay in copays, deductibles and coinsurance in a calendar year. Not all expenses apply to the out-of-pocket maximum, such as charges the plan does not cover and the Teledoc consultation fee. Once you have paid the out-of-pocket maximum for the calendar year, the plan will pay eligible expenses at 100%

- 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.

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 Contributions: Your portion of healthcare costs that are deducted from your paycheck.

Eligibility

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 of Benefits

If you and/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 for a 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 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 for your hire date; keep in mind that coverage will be effective the first of the month following your 60-day waiting period. You may also enroll during the annual enrollment period for a January 1 effective date. In addition, if you experience a qualifying event during the year you may make changes within 31 days of the event. Refer to page 21 for additional information about qualifying events.

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.

Preventive Care

Most preventive care, such as immunizations and certain contraceptives, 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 visits is for preventive care.
- You choose generic contraceptives.

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.

Wellness Program

Coffee Regional Medical Center partners with Strive365 to offer a comprehensive health and wellness program. This program is available to all employees, as well as spouses who are enrolled in the medical plan. You will enjoy a discount on your medical plan rate for meeting your wellness goals.

The components of the program are:

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 evaluations (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 annual health evaluation, you can complete an additional biometric screening to review your progress.

Health Coaching

Through Strive365 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

- View your evaluation results, including prior year results.
- Take a Health Risk Assessment.
- Access 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 Strive365 program.

In order to have the opportunity for incentives, you (and your current spouse, if applicable) must participate in the Strive365 wellness program.

Medical Plans

Coffee Regional Medical Center offers two comprehensive medical plans from which you may choose to add to your benefit package. Both plans are administered by Meritain Health.

The PPO Plan

This plan is a standard PPO (Preferred Provider Organization) 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.

This plan utilizes the Coffee Select Network. When you choose in-network providers, you will have office visit copays, and then the deductible and coinsurance will apply to hospitalizations. This plan does not have out-of-network benefits; if a service is not available within the Coffee Select Network you will have access to the 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. Note that the copay applies to the office visit only; all other services performed in the office are subject to deductible and coinsurance.
- 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.
- Your copays, deductible and coinsurance all apply to the annual out-of-pocket maximum.
- There is a separate annual out-of-pocket maximum for prescription drugs.

Bi-Weekly Employee Contributions – PPO Plan

COVERAGE LEVEL	STANDARD RATES	GOAL ACHIEVER RATES
Employee	$90.00	$55.38
Employee + Spouse	$253.80	$219.19 (1 Goal Achiever) $179.96 (2 Goal Achievers)
Employee + Children	$96.92	$62.31
Family	$260.72	$226.10 (1 Goal Achiever) $186.87 (2 Goal Achievers)

PPO Plan Summary

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	$4,400/$12,000	NA
Preventive Care - refer to www.healthcare.gov 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
Emergency Services – Medical Emergency	85% after deductible	85% after deductible
Emergency Services – Non-Emergent Condition	50% after deductible	NA
Urgent Care Visit	85% after deductible	NA
Hospital Benefits – Inpatient and Outpatient	85% after deductible	NA
Surgical Benefits – Inpatient and Outpatient	85% after deductible	NA
Surgery performed in Physician's Office **Diagnostic X-Ray and Laboratory Services** **Occupational, Physician and Speech Therapy**	100% to maximum of $400, then 85% after deductible	NA
Home Healthcare	85% after deductible	NA
Hospice Services	85% after deductible	NA
Durable Medical Equipment (DME)	85% after deductible	NA
Mental/Nervous and Substance Use Services Inpatient or Partial Hospitalization Office Visit	 85% after deductible $15 copay	NA

PRESCRIPTION DRUGS	CRMC PHARMACY	RETAIL PHARMACY
Calendar Year Out-of-Pocket Maximum Per Person/Family	$1,000/$2,000	
<u>30-Day Supply</u> Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 $10 Copay $35 Copay $50 Copay	 $25 Copay $60 Copay $90 Copay
<u>90-Day Supply</u> Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 $10 copay $75 copay $100 copay	 NA
NOTE: Specialty drugs are only available in 30-day supply and must be purchased from the CRMC pharmacy. You will pay the same copayments as shown above depending on the tier.		

Medical Plans

The High Deductible Health Plan (HDHP)

This plan is a high deductible health plan (HDHP) offering you the greatest 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. Thus, you enjoy lower contributions out of your paycheck. The plan also offers a Health Savings Account (HSA) to help you pay for eligible expenses before (and sometimes after) your reach the deductible.

In this plan, the in-network hospitals are Coffee Regional Medical Center and St. Joseph's/Candler. The 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 individuals who have little or no medical expenses and may wish to save funds for later 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 HSA operates like a normal bank account – only the funds that are in the account are available for you to use.
- If you want to open an HSA, you may do so with Douglas National Bank. Account information must be provided to CRMC Accounting department prior to the first pay period of 2020.

Bi-Weekly Employee Contributions – High Deductible Health Plan

COVERAGE LEVEL	STANDARD RATES	GOAL ACHIEVER RATES
Employee	$63.43	$40.36
Employee + Spouse	$172.53	$149.53 (1 Goal Achiever) $126.43 (2 Goal Achievers)
Employee + Children	$69.19	$46.12
Family	$178.29	$155.29 (1 Goal Achiever) $131.91 (2 Goal Achievers)

HDHP Plan Summary

PLAN FEATURES	CRMC/SJC Aetna Select Network MDs	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible Per Person/Family	$1,400/$2,800	NA
Calendar Year Out-Of-Pocket Maximum Per Person/Family	$5,000/$12,900	NA
Preventive Care - refer to www.healthcare.gov for comprehensive listing of included services.	100%	NA
Routine Care Office Visit Specialist Visit	 85% after deductible 85% after deductible	NA
Allergy Testing	85% after deductible	NA
Emergency Services – Medical Emergency	85% after deductible	85% after deductible
Emergency Services – Non-Emergent Condition	50% after deductible	NA
Urgent Care Visit	85% after deductible	NA
Hospital Benefits – Inpatient and Outpatient	85% after deductible	NA
Surgical Benefits – Inpatient, Outpatient & MD Office	85% after deductible	NA
Diagnostic X-Ray and Laboratory Services	85% after deductible	NA
Occupational, Physical and Speech Therapy	85% after deductible	NA
Home Healthcare	85% after deductible	NA
Hospice Services	85% after deductible	NA
Durable Medical Equipment (DME)	85% after deductible	NA
Mental/Nervous and Substance Use Services Inpatient or Partial Hospitalization Office Visit	 85% after deductible 85% after deductible	NA

PRESCRIPTION DRUGS	CRMC PHARMACY	RETAIL PHARMACY
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.		
<u>30-Day Supply</u> Generic Drugs 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
<u>90-Day Supply</u> Generic Drugs Preferred Brand Name Drugs Non-Preferred Brand Name Drugs	 90% after deductible 80% after deductible 80% after deductible	 NA

Coffee Select Network

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

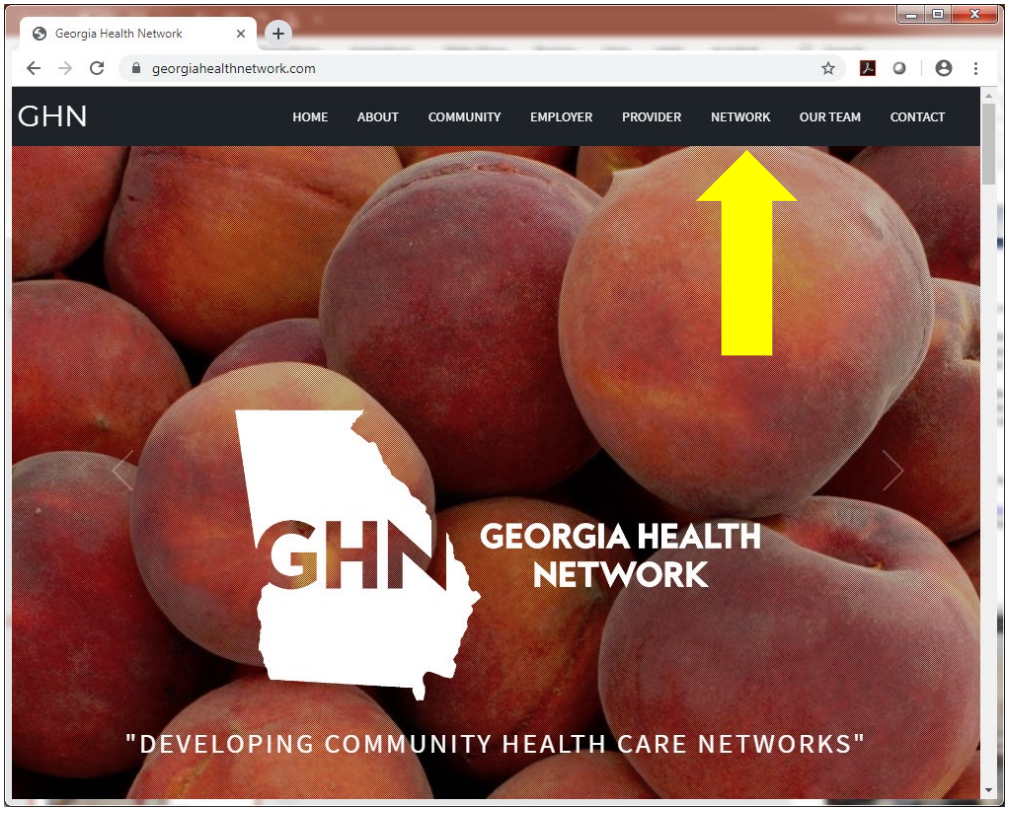
The Coffee Select Network is a member of the Georgia Health Network and was developed specifically for the community serviced by Coffee Regional Medical Center. The primary hospital facilities are Coffee Regional Medical Center and St. Joseph's /Candler. There is also a defined group of physicians participating 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 being your provider search.



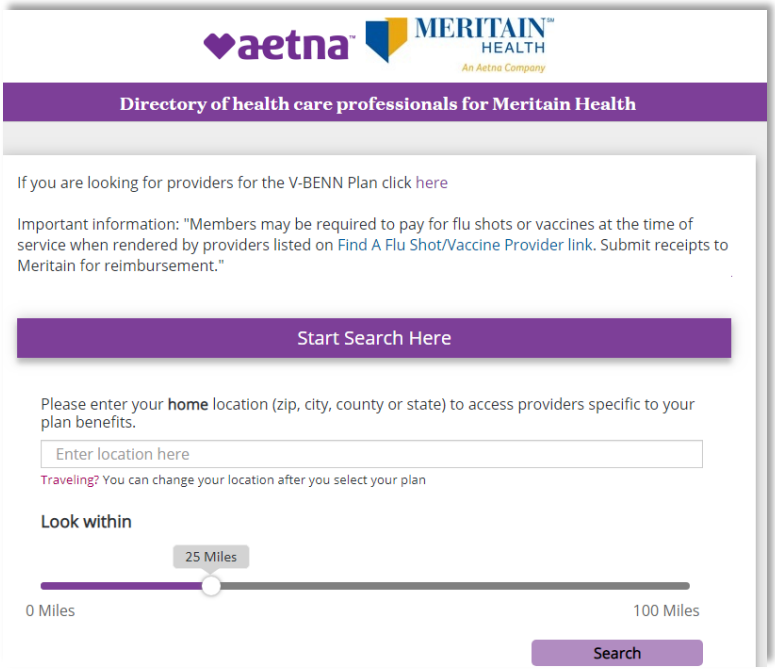
GHN COFFEE SELECT

Aetna Select Open Access Network

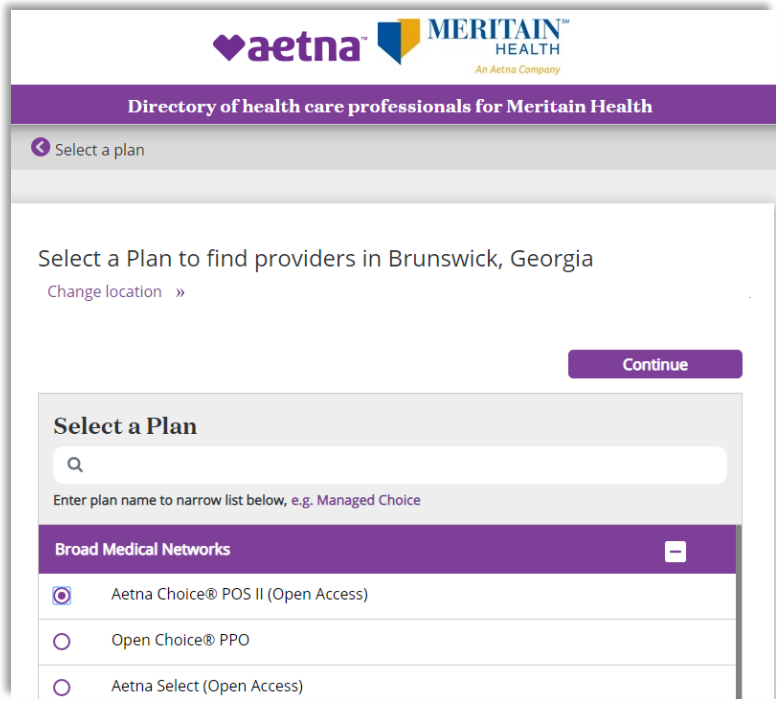
Provider Search

To find providers in this network, follow these steps:

- Go to www.aetna.com/docfind/custom/mymeritain/
- Enter your location and number of miles
- Click search



- Then select the Aetna Select Open Access network by clicking the circle. Click continue.



- On the next screen you can enter the provider name or type of provider you are looking for.

- If you need assistance or need to find a provider when you are not near a computer, simply call the Aetna Provider Line at 1.800.343.3140 from 8:00 a.m. to 9:00 p.m. (Eastern Standard Time).

Healthcare Access: 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 Care Physician (PCP). In Georgia, 27% do not have a PCP, and in Washington, 24%.

Why is this important? Healthcare professionals agree that having a PCP is essential to ensuring that you receive 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 you 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 earaches, sprains, colds or stomach pain. The walk-in clinic is open 7 days a week from 7:30 a.m. to 7:30 p.m. (closed for lunch from 12:30 p.m. to 1:30 p.m.).

Emergency Room – What is an Emergency?

An emergency is an unforeseen medical event or condition that without immediate medical attention the person's health would be in serious jeopardy, serious impairment to bodily functions would 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 sever 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 Emergency Room visits are for non-acute conditions that could have been addressed at a Primary Care Physician's 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.**

Prescription Drug Plan

When you elect medical coverage, you are automatically covered under the prescription drug plan based on your medical plan election.

Managing Your Prescription Drug Costs

When you have a prescription filled, the amount you pay is based on the 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 less 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 first drug of 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.
- A ***specialty*** drug is a brand name drug used to treat or manage complex, chronic or rare conditions such as multiple sclerosis and rheumatoid arthritis. These drugs typically require special handling, administration, or monitoring, and are usually self-injected or administered in a physician's office.

The Preferred Drug List, or **Formulary**, 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 at minimum every January.
- If a generic drug becomes available, the brand-name drug will become a "non-preferred" drug and then will only be available at a higher cost.
- If you are taking a brand-name drug and this occurs, you will be notified by the pharmacy benefit manager.

Dental Plan

Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many as six years to 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	BENEFITS PAYABLE
Calendar Year Deductible (Applies to Class B, C & D services)	Individual: $50 Family: $150
Calendar Year Benefit Maximum per person	$2,000
Class A: Preventive Services	100% deductible waived
Class B: Basic Services	80% after deductible (you pay 20%)
Class C: Major Services	50% after deductible (you pay 50%)
Orthodontic Services (children under age 19)	50% after deductible (you pay 50%)
Lifetime Orthodontia Maximum	$1,500

Employee Contributions

COVERAGE LEVEL	BI-WEEKLY CONTRIBUTION
Employee Only	$8.15
Employee + Spouse	$21.00
Employee + Children	$18.00
Family	$25.00

Vision Plan

Along with dental care, it is important to protect your vision. Coffee Regional Medical Center offers 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 to www.eyemed.com and select the INSIGHT network.

Vision Plan Summary

PLAN DETAILS	IN-NETWORK	FREQUENCY
Vision Exam	$10 copay	Every 12 months
Frames	$130 allowance 20% off balance over $130	Every 24 months
Lenses Single Vision Lined BiFocal Lined TriFocal	 $25 copay $25 copay $25 copay	Every 12 months
Contact Lenses (In lieu of glasses) Conventional Disposable Medically Necessary	 $130 allowance; 15% off balance over $130 $130 allowance, plus balance over $130 Paid in Full	Every 12 months

Employee Contributions

COVERAGE LEVEL	BI-WEEKLY CONTRIBUTION
Employee Only	$2.72
Employee + 1	$5.16
Family	$7.58

Flexible Spending Account (FSA)

Coffee Regional Medical Center offers you the opportunity to take advantage of available tax savings 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 the FSA Works

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

Healthcare FSA

- The maximum you can contribute per year is $2,700, per IRS regulations.
- 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 deductibles, coinsurance, and copays.
- Certain over-the-counter items qualify too, as long as you have a written prescription.
- While contributions are made over the course of the year, your entire annual election is available to you on day one.

Dependent Care FSA

- The maximum you can contribute is $5,000 per year, or $2,500 if you are married and filing separate tax returns. Use the money in the account to pay for eligible 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.
- You must file reimbursement requests after you have incurred eligible expenses.

Is an 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.
- You can enroll in the Healthcare FSA even if you are not covered on the Coffee Regional medical plan.
- 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.

At the end of the plan year, any unused funds in your FSA will be forfeited. This is referred to as the "use it or lose it" rule by the IRS.

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

$ _____ / pay periods per year = $ _____

Annual Amount (cannot exceed $2,700) — Per Pay Period Contribution

Dependent Care FSA

Annual Dependent Care Expenses, such as:

Payment to a day care facility or licensed individual	$
Payment to other licensed care providers	$

Total Estimated Dependent Care Expenses

$ _____ / pay periods per year = $ _____

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

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 medical, Rx and dental).

Card front

- The customer service number and Meritain 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.

Vision Plan

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

Life Insurance

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

Coffee Regional Medical Center's Basic Life and AD&D Insurance provide important financial protection for you and your survivors. Basic Life coverage is provided for all full-time employees in the amount of $30,000. The Basic Life coverage includes AD&D coverage equal to the Life Insurance coverage amount.

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 purchase additional Term Life Insurance coverage for yourself in increments of $10,000 to a maximum of $500,000 (or 5 times your base salary, whichever is less). Any amount over $180,000 will have to be approved by Mutual of Omaha through the Evidence of Insurability (EOI) process.

The cost of this coverage is based on your age. The rates shown include both the Life Insurance and AD&D.

Dependent Life Insurance

You must have coverage for yourself in order to purchase Dependent Life insurance on your spouse and your unmarried dependent children under age 26.

- For your spouse you can elect in increments of $5,000 to a maximum of $250,000 but not more than the coverage purchased for yourself.
- Any amount over $75,000 for your spouse will have to be approved through the EOI process.
- For children, you can purchase in increments of $2,000 to a maximum of $10,000.

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

Everyday 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, crucial illness insurance can provide financial support to help you through a difficult time. It can pay you a limp-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 protections. 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 copayments, deductibles and other out-of-pocket costs. The 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.

Rates for all plans described on this page will be calculated within the enrollment system and are determined based on factors such as coverage level, age and policy type.

Qualifying Events

Qualifying Events

For benefits that you pay for with pre-tax dollars, the provisions of Section 125 of the Internal Revenue Code govern how and when you can make changes in your coverage. Under the current provisions of Section 125, you may:

"Change the level of coverage (move from individual to family coverage or vice versa), enroll for coverage, or cancel your coverage once a year, during the open enrollment period."

The only other time that you may make a change in your coverage during the year is if you experience a qualifying event. Should a qualifying event occur during the year AND you wish to make changes, you must do so within **31** days of the qualifying event.

Qualifying Events

- Marriage or divorce
- Birth, adoption or placement for adoption of a child
- Death of spouse or children
- Spouse begins or ends employment
- You or your spouse's employment status changes from full-time to part-time or vice versa
- Court decree requiring coverage of your dependent children
- Entitlement to Medicare or Medicaid
- Dependent child ceases to be an eligible dependent (i.e. reaches the maximum dependent age)
- You or your spouse take an unpaid leave of absence
- Your spouse has a significant change in health coverage directly attributable to your spouse's employment
- Entitlement of loss of coverage under premium subsidy plans from a State (60 days to notify)

You may be required to provide documentation supporting any benefit change request due to a qualifying event.

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

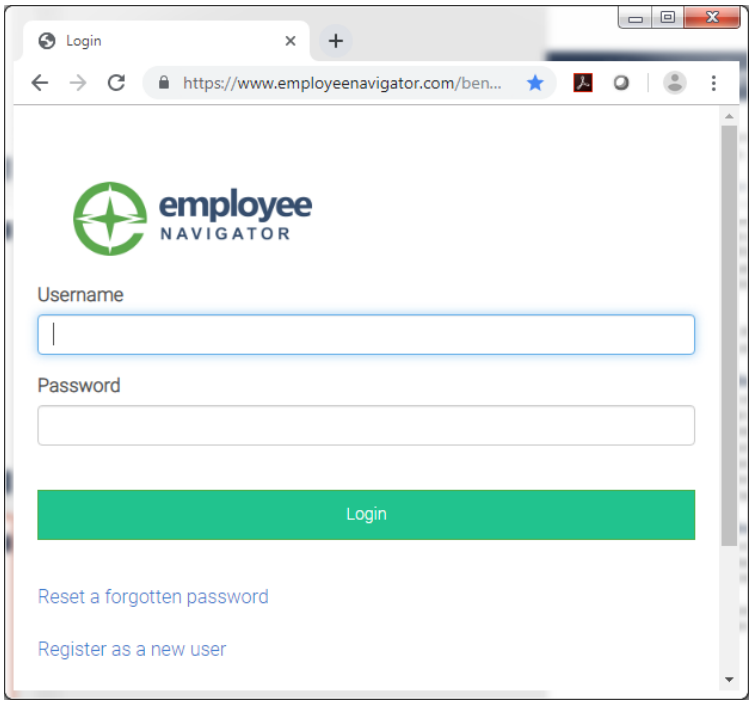
The decisions you make as you enroll will affect your benefit coverage for the coming year, as well as your finances. Be sure to read all information available to determine the best benefits for you and your family. Don't enroll without understanding your options. Consider the following:

- 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 you or your family members may have.
- Your overall budget for benefits.

Complete your enrollment

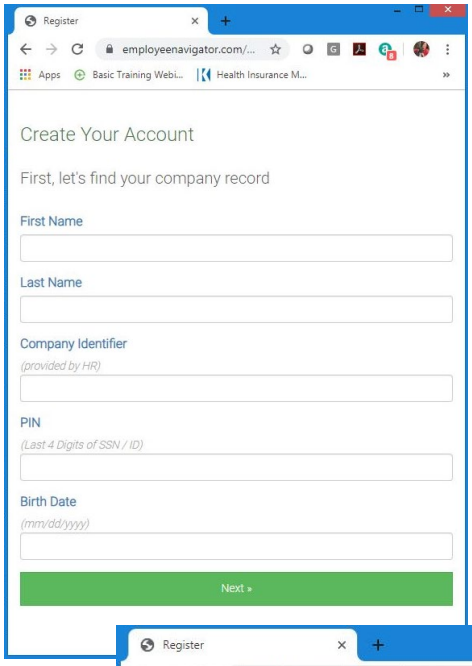
If you do not already have a login, go to www.employeenavigator.com/benefits/account/login and select "Register as a new user" then follow the instructions to complete your registration. Once you have created a login, you can move right into enrollment or come back later to finish.

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.

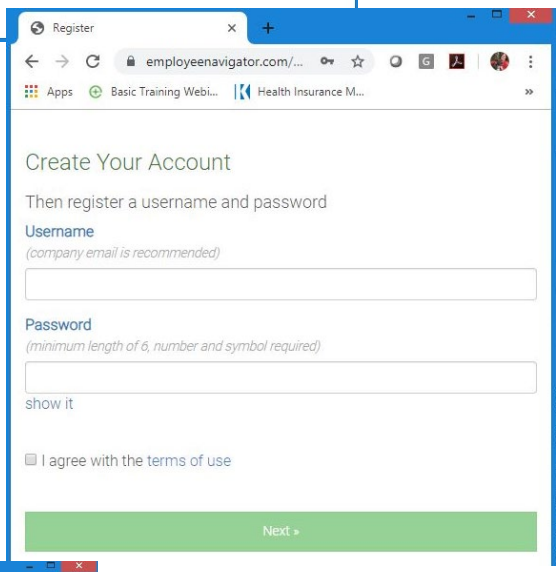


How to Enroll

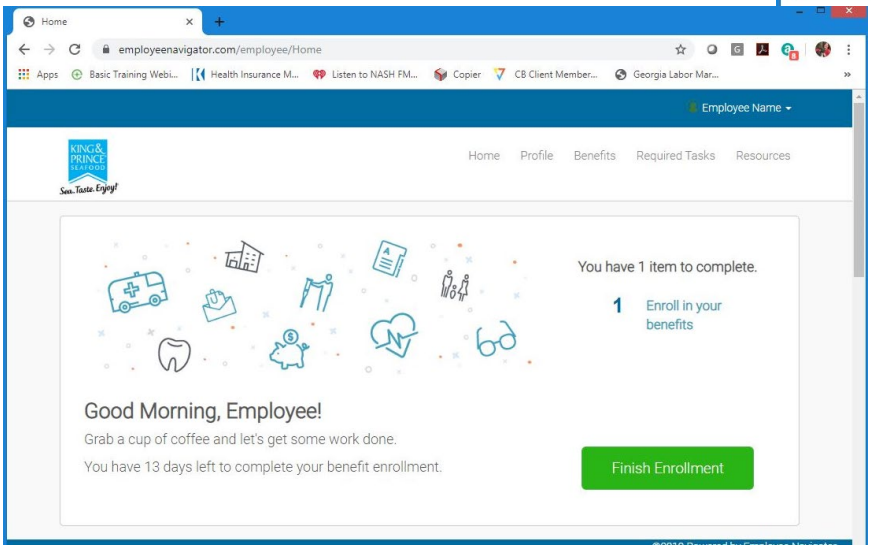
1. Complete all information on this screen and click "Next." Your company identifier is CRMCGA, and your PIN is the last 4 four digits of your Social Security Number.



2. Create a username and password, review the terms of use, then check the box and click "Next."



3. Once you have registered, you can complete your enrollment or come back later to finish. 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 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 applications.

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 Prudential. 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 Prudential at www.prudential.com/online/retirement for more information about your 401(k).

You may also call 1-877-PRU-2100 for information. Representatives are available Monday through Friday, 8 a.m. to 9 p.m. Eastern time.

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 July 31, 2019. Contact your State for more information on eligibility -

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

Notices

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
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, or 401-462-0311 (Direct RIte Share Line)

Notices

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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ 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, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction At 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 current valid OMB control number. See 44 U.S.C. 3512.

The public 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 US 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.

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 1.800.925.2272.

Newborns' and Mothers' Health Protection Act Notice

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

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 obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

Notices

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: Meritain Health.

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

Notices

Notice Regarding Wellness Program

The Coffee Regional Medical Center Strive365 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, and complete blood count. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, 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 1.800.840.6100.

The information from your HRA and the results from your biometric screening will be sued 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, the Coffee Regional Medical Center 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 accommodations 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.

Notices

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 service 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 date 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 retaliations if you choose not to participate.

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

Notes

When You Have Questions

TOPIC	CONTACT	ELEPHONE	WEBSITE/EMAIL
Medical Claims	Meritain Health	1.800.925.2272	www.meritain.com
Medical Precertification	Meritain Health	1.888.925.1799	www.meritain.com
Prescription Drug Plan	Meritain Pharmacy Solutions	1.866.475.7589	www.meritain.com
Dental	Meritain Health	1.800.925.2272	www.meritain.com
Vision	EyeMed	1.866.800.5457	www.eyemed.com
FSA	Meritain Health	See debit card	www.meritain.com
HSA	Douglas National Bank	1.912.384.2233	www.dnbdouglas.com
Basic & Term Life Insurance	Mutual of Omaha	1.800.775.8805	www.mutualofomaha.com
STD, LTD & Critical Illness Insurance	Mutual of Omaha	1.800.877.5176	www.mutualofomaha.com
Accident & Hospital Indemnity Insurance	Voya	1.800.325.4368	www.voya.com
Employee Assistance Plan	Mutual of Omaha	1.877.236.7564	www.mutualofomaha.com
Enrollment	Human Resources	1.912.383.5607	theresa.Hepburn@coffeeregional.com

CAPstone BENEFITS CONSULTING LLC

CRMC COFFEE REGIONAL MEDICAL CENTER

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.