COFFEE REGIONAL MEDICAL CENTER

2021 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 S Drive.

Table of Contents

Terms to Know

Co-pay	Flat dollar amount member is responsible for at the time of service. The plan usually pays 100% of the remaining balance.
Deductible	Amount member is responsible for before the plan pays for certain services. • 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: 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.
Coinsurance	Percentage of payment shared between the member and the plan for certain services after the deductible has been met.
Out-of-Pocket Maximum	Member's total payments for deductible, coinsurance and co-pays to stated maximum per plan year. Once reached, the plan will pay 100% for eligible expenses for the rest of the plan year.
High Deductible Health Plan (HDHP)	Qualified plan as defined by the IRS. No first dollar benefits, all services are subject to the deductible before the plan will pay. Exception is Routine Preventive Care as defined by the IRS – covered at 100%.
Health Savings Account (HSA)	Tax Free account that is established by the employee that is covered by a High Deductible Health Plan (HDHP).
Flexible Spending Account (FSA)	Accounts allowing you to set aside pre-tax money to pay for eligible healthcare and/or dependent care expenses.
Network Provider	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.
Primary Care Physician (PCP)	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

Eligible Employees:

You may enroll in the Coffee Regional Medical Center Employee Benefits Program if you are a Full-Time employee working at least 30 Hours per Week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include:

- 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.

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.

Family Status Change:

Coffee Regional Medical Center utilizes an online enrollment system called Employee Navigator. Please refer to pages 23 and 24 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; 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 January 1 effective date. In addition, if you experience a qualifying event during the year you may make changes within 31 days of that event. Refer to page 2 for additional information about qualifying events.

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.

Please note: 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 elect your CRMC paid life insurance beneficiary and to decline enrollment.

Wellness Program

Coffee Regional Medical Center offers 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 goal.

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.

Member Website (https://chcw.com)

- 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.

The PPO Plan

This plan is a standard PPO Plan (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**, go to www.georgiahealthnetwork.com. When you choose in-network providers, you will have office visit copays, and then the deductible and coinsurance will apply to hospitalizations. The plan does not have out-of-network benefits however if a service is not available at Coffee Select Network you will have access to Aetna Select Open Access Network providers (upon medical authorization). In this plan, the in-network hospital facilities are Coffee Regional Medical Center, St. Joseph's/Candler and Emory.

Your Copay, Deductible and Out-of-Pocket Maximum on the PPO Plan

- 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-picket 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 your 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 + Child(ren)	$96.92	$62.31
Family	$260.72	$226.10 (1 Goal Achiever) $186.87 (2 Goal Achievers)

Provider Search

To find Providers in the Coffee Select network, follow these steps:

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

To find Providers in the Aetna Select Open Access network, follow these steps:

- Go to **www.aetna.com/docfind/custom/mymeritain** and enter your zip code.

PPO Plan Summary

	Meritain Health - PPO Plan	
	In-Network Benefits	Out-of-Network Benefits
Deductible (Individual/Family)	$2,000/$6,000	NA
Out-of-Pocket Maximum (Individual/Family)	$4,400/$12,000	NA
Preventive Care	100%	NA
Primary Care Office Visit	$15 copay	NA
Specialty Care Office Visit	$25 copay	NA
Allergy Testing	85% after deductible	NA
Emergency Services – Medical Emergency	85% after deductible	NA
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
Diagnostic X-Ray and Lab Services	100% to a maximum of $400; then 85% after deductible	NA
Occupational, Physical and Speech Therapy	100% to a 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
Prescription Drugs	**CRMC Pharmacy**	**Retail Pharmacy**
Out-of-Pocket Maximum (Individual/Family)	$1,000/$2,000	
30 Day Supply Generic Preferred Non-Preferred	$10 Copay $35 Copay $50 Copay	$25 Copay $60 Copay $90 Copay
90 Day Supply Generic Preferred Non-Preferred	$10 Copay $75 Copay $100 Copay	NA

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The High Deductible Health Plan

This high deductible health plan (HDHP) will offer 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. This means you will have lower contributions out of each paycheck. The plan also offers a Health Savings Account (HSA) to help you pay for eligible expenses before and after you reach your deductible.

In this plan, the in-network hospital facilities are Coffee Regional Medical Center, St. Joseph's/Candler and Emory. 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, St. Joseph's/Candler or Emory, you will have access to Aetna Select Open Access facilities (upon medical authorization).

Bi-Weekly 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 + Child(ren)	$69.19	$46.12
Family	$178.29	$155.29 (1 Goal Achiever) $131.91 (2 Goal Achievers)

Provider Search

To find Providers in the Aetna Select Open Access network, follow these steps:

- Go to **www.aetna.com/docfind/custom/mymeritain** and enter your zip code.

To find Providers in the Coffee Select network, follow these steps:

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

Health Savings Account (HSA)

WHAT IS AN HSA?

A Health Savings Account (HSA) is a type of account you can use to pay for certain out-of-pocket healthcare expenses if you are enrolled in a high deductible health plan (HDHP). HSAs are tax-advantaged, which means you don't pay taxes on contributions or withdrawals on qualified expenses.

Examples of expenses you can use your HSA funds to pay for include medical expenses not covered by your plan, dental care, vision care, prescription drugs, orthodontics, over the counter medication and physical therapy.

HSA ADVANTAGES

SECURITY – Your HSA can provide a savings buffer for unexpected or high medical bills.

AFFORDABILITY – In most cases, you can lower your monthly health insurance premiums when you switch to health insurance coverage with a higher deductible, and these HDHPs can be paired with an HSA.

SAVINGS – You can save the money in your HSA for future medical expenses, all while your account grows through tax-deferred investment earnings.

TAX SAVINGS – An HSA provides you with triple tax savings:

- Tax deductions when you contribute to your account
- Tax-free earnings through investment
- Tax-free withdrawals for qualified medical expenses

PORTABILITY – Accounts are completely portable, meaning you can keep your HSA even if you change jobs, change medical coverage, become unemployed or move to another state.

OWNERSHIP – Funds remain in the account from year to year, just like an IRA. There are no "use it or lose it" rules for HSAs, making it a great way to save money for future medical expenses.

Douglas National Bank HSA

- If you want to open an HSA, you must 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 banking information must be provided to CRMC Accounting/Payroll department prior to the first pay period of 2021. Thereafter, as soon as enrolled in benefits.

HDHP Summary

	Meritain Health – HDHP	
	In-Network Benefits	Out-of-Network Benefits
Deductible (Individual/Family)	$1,400/$2,800	NA
Out-of-Pocket Maximum (Individual/Family)	$5,000/$12,900	NA
Preventive Care	100%	NA
Primary Care Office Visit	85% after deductible	NA
Specialty Care Office Visit	85% after deductible	NA
Allergy Testing	85% after deductible	NA
Emergency Services – Medical Emergency	85% after deductible	NA
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
Diagnostic X-Ray and Lab 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
Prescription Drugs	**CRMC Pharmacy**	**Retail Pharmacy**
Out-of-Pocket Maximum (Individual/Family)	$1,000/$2,000	
30 Day Supply Generic Preferred Non-Preferred	90% after deductible 80% after deductible 80% after deductible	90% after deductible 80% after deductible 80% after deductible
90 Day Supply Generic Preferred Non-Preferred	90% after deductible 80% after deductible 80% after deductible	NA

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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 services by Coffee Regional Medical Center. The primary hospital facilities are Coffee Regional Medical Center, St. Joseph's/Candler and Emory. 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:

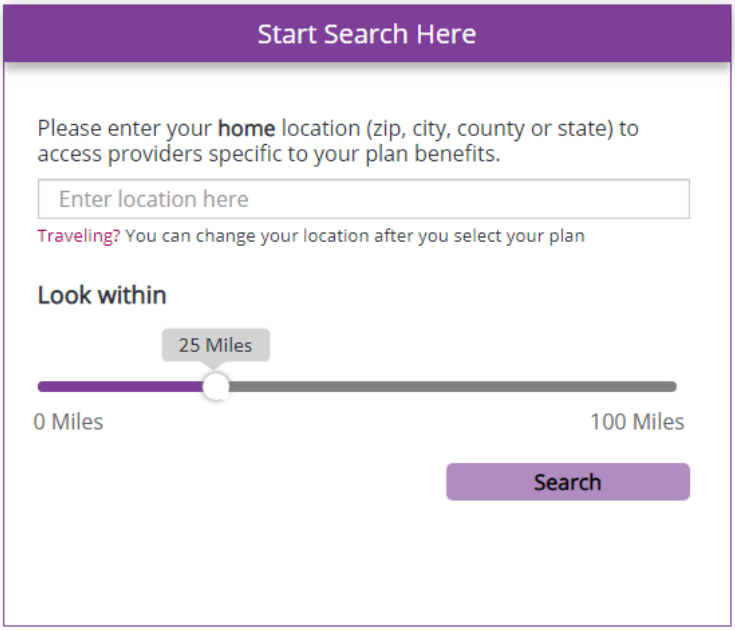
- Go to www.georgiahealthnetwork.com
- Click on the network tab at the top to begin your provider search.

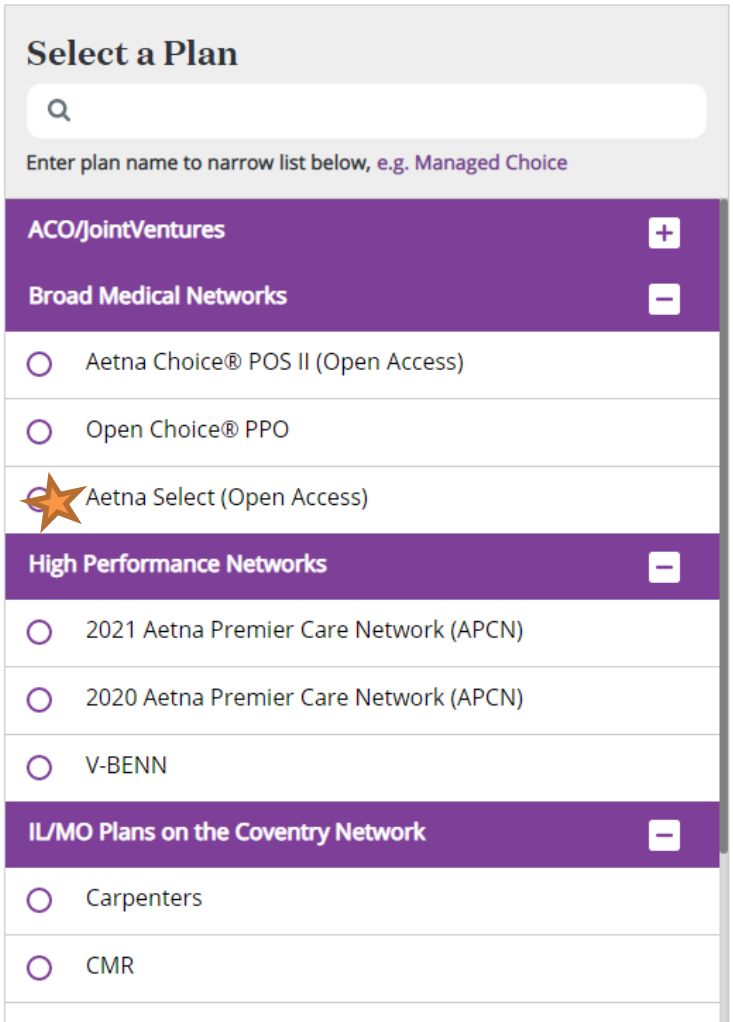
Aetna Select Open Access Network

Provider Search:

To find providers in the Aetna Select Open Access 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 in the circle. Click "Continue"

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

- 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 8:00am to 9:00pm EST.

Primary Care Options: Which is Best?

TYPE OF CARE	WAIT TIME	COST**
 **Urgent care/walk-in clinic** Urgent care centers, sometimes called walk-in clinics, are often open in the evenings and on weekends. **When to go*** • Sprains and strains • Mild asthma attacks • Sore throats • Minor broken bones or cuts • Minor infections or rashes • Earaches	**20-30 minutes** Approximate wait time	**$150 -200** Average cost
 **Clinical care** (your doctor's office) Seeing your doctor is important. Your doctor knows your medical history and any ongoing health conditions. **When to go*** • Preventive services and vaccinations • Medical problems or symptoms that are not an immediate, serious threat to your health or life	**1 week or more** Approximate wait time for an appointment	**$15** Copay on PPO Plan **$100-150** Average cost
 **Emergency room (ER)** Visit the ER only if you are badly hurt. If you are not seriously ill or hurt, you could wait hours and your health plan may not cover non-emergency ER visits. **When to go*** • Sudden change in vision • Sudden weakness or trouble talking • Large, open wounds • Difficulty breathing • Severe head injury • Heavy bleeding • Spinal injuries • Chest pain • Major burns • Major broken bones	**3 to 12 hours** Approximate wait time for non-critical cases	**$1,200-$1,500** Average cost

**Costs are approximate. These will fluctuate based on plan and facility chosen.

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 7:30am to 7:30pm (closed for lunch from 12:30pm to 1:30pm).

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.

- Generic - A generic drug is one that meets the same standard as brand names drugs for safety, purity, strength and effectiveness. You pay less when you choose generic drugs.

- Preferred Brand - A preferred brand name drug is a brand name drug that is listed on the preferred list (often referred to as formulary). These drugs are determined to be the first drug choice for certain conditions and may not have generic equivalents.

- Non-Preferred Brand - A non- preferred brand name drug is a brand name drug that is listed on the preferred list and usually has less costly generic or preferred brand alternative. These prescriptions are usually covered at the highest copay or coinsurance level.

- Specialty - 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 by 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% 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 make 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 the 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 Insurance

Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many six years to your life? Brushing and flossing your teeth, combined with regular dental check-ups, may also help 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.

Plan Details	Meritain Health – Dental Plan
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
Class C: Major Services	50% after deductible
Orthodontic Services (children under age 19)	50% after deductible
Lifetime Orthodontia Maximum	$1,500

Bi-Weekly Contributions – Dental

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

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Vision Insurance

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 go to www.eyemed.com and select the INSIGHT network.

Vision Plan Summary

Plan Details	EyeMed - Vision Plan
Vision Exams (Every 12 months)	$10 copay
Frames (Every 24 months)	$130 allowance 20% off balance over $130
Lenses (Every 12 months)	Single Vision: $25 Copay Lined BiFocal: $25 Copay Lined TriFocal: $25 Copay
Contacts Lenses (Every 12 months) In lieu of glasses	Conventional: $130 allowance; 15% off balance over $130 Disposable: $130 allowance, plus balance over $130 Medically Necessary: Paid in full

Bi-Weekly Contributions – Vision

Employee	$2.72
Employee & 1 Dep	$5.16
Employee & 2+ Deps	$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.

How it works?

You will determine how much money you'd like to set aside each year for your Medical FSA and your Dependent Care FSA or one or the other.

Like a Health Savings Account, an FSA has maximum contributions in place for participants. For 2021 the IRS maximum for a Medical FSA is **$2,750** per participant. For a Dependent Care FSA, the maximum is **$5,000** for single or married employees filing joint tax returns or **$2,500** for married filing separate tax returns. You will set your contributions during Open Enrollment. Contributions cannot be changed unless a qualifying life event occurs. If you decide to enroll in one or both of these accounts, your contributions are taken out of each paycheck (26 pay periods)—before taxes—in equal installments throughout the plan year. These dollars are then placed into your FSA. When you have an eligible health care or dependent care expense, you must submit a claim form along with an itemized receipt to be reimbursed from your account.

The medical FSA will reimburse you for the full amount of your annual election (less any reimbursement already received), at any time during the plan year, **regardless of the amount actually in your account**. The Dependent Care FSA will only reimburse you for the amount that is in your account at the time you make a claim. Both of these accounts are administered through Meritain.

IS an FSA right for you?

- The Healthcare FSA might 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

Important Notes

- If you participate in the HDHP, you cannot participate in the Healthcare FSA (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 with 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 a Coffee Regional medical plan
- You will gain the most savings if you plan carefully. You can use worksheet on the next page to help you determine how much to contribute to either FSA

FSA's are "use it or lose it" plans. Any unused funds at the end of the year will be forfeited. This is why it is very important to plan wisely for your contributions!

FSA Worksheet

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 Contributions

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

Pay Period Contribution

Life and AD&D

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

Coffee Regional Medical Center provides Basic Life and AD&D insurance to you and your dependents through Lincoln Financial Group. Basic Life and AD&D insurance provides important financial protection for you and your dependents should you pass away while enrolled on the plan. Basic Life coverage is provided for all fulltime 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 are eligible from birth to age 26 in the amount of $2,000.

You are automatically enrolled in Basic Life and AD&D coverage and do not need to elect this benefit.

With the Basic Life, you and your family also have access to Lincoln Financials **Employee Assistance Program (EAP**) through *EmployeeConnect*. There is no cost to you for utilizing EAP Services. Services include:

- Access to EAP professionals 24 hours a day, seven days a week
- Robust network of licensed mental health professionals
- Up to 5 face-to-face sessions with a counselor (per person, per issue, per year)
- Legal assistance and financial resources

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 5x your base salary, whichever is less). Any amount over $300,000 will have to be approved by Lincoln Financial through the Evidence of Insurability (EOI) process.

The cost of this coverage is based on your age during enrollment of the plan. The rates can be found on the enrollment system and include both the Life Insurance and AD&D.

Dependent Life Insurance

You must have Voluntary Term coverage for yourself in order to purchase Dependent Life insurance on your spouse and 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 you purchased for yourself.
- Any amount over $30,000 for your spouse will require EOI
- For children, you can purchase $250 for children ages 15 days to 6 months and units of $1,000 up to $10,000 for children 6 months to 26 years.

Taxes and Life Insurance

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.

Lincoln Financial Group®

Other Insurance Offerings

Short-Term Disability Insurance

Coffee Regional Medical Center offers a short-term disability option through Lincoln Financial Group that can pay up to 70% of your income should you become disabled and unable to work. If you elect coverage you can choose a monthly benefit of 60% or 70% of your income up to a maximum of $1,200 per week. You also have the option to elect a 7- or 14-day benefit waiting period.

Long-Term Disability Insurance

Long Term Disability can pay up to 60% of your income to provide you financial support should your disability become long term and ongoing. The monthly Long-Term Disability benefits will be 60% of your 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

Critical Illness Insurance will provide financial relief should you be diagnosed with a serious illness. It can pay you a lump-sum cash benefit, which you can use any way you'd like including hospital costs, travel costs for second opinions, childcare and medical benefits not covered by your plan. To help prevent illness, this plan can also pay you an annual cash benefit when you take a covered health screening test.

Accident Insurance

Accident Insurance pays a benefit directly to you if you have a covered injury and need treatment. You can also get coverage for your spouse and dependents. Accident Insurance can help supplement rising healthcare costs and add another layer of financial protection. This plan also provides an annual cash benefit when you take a covered health screen test to help prevent future illnesses.

Hospital Indemnity Insurance

A trip to the hospital can be stressful, and so can the bills. Even with medical insurance, you may still be responsible for copayments, deductibles and other out-of-pocket costs. The Hospital Indemnity plan through Lincoln Financial Group pays a cash benefit directly to you whenever you or a covered dependent are admitted to the hospital. Whether you're being treated on an impatient or outpatient basis, this coverage can help you manage your expenses.

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

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 application.

The full Educational Assistance Program Policy can be obtained through Human Resources or 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 www.prudentual.com/online/retirement for more information about your 401(k).

You make also call 1-877-PRU-2100 for more information. Representatives are available Monday through Friday, 8am to 9pm Eastern time.

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 plan 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 even occur during the year AND you wish to make changes, you must do so within 31 days of the qualifying event.

Qualifying Events Include:

- 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
- Becoming eligible for Medicare or Medicaid
- Dependent child reaches maximum age of 26
- 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.

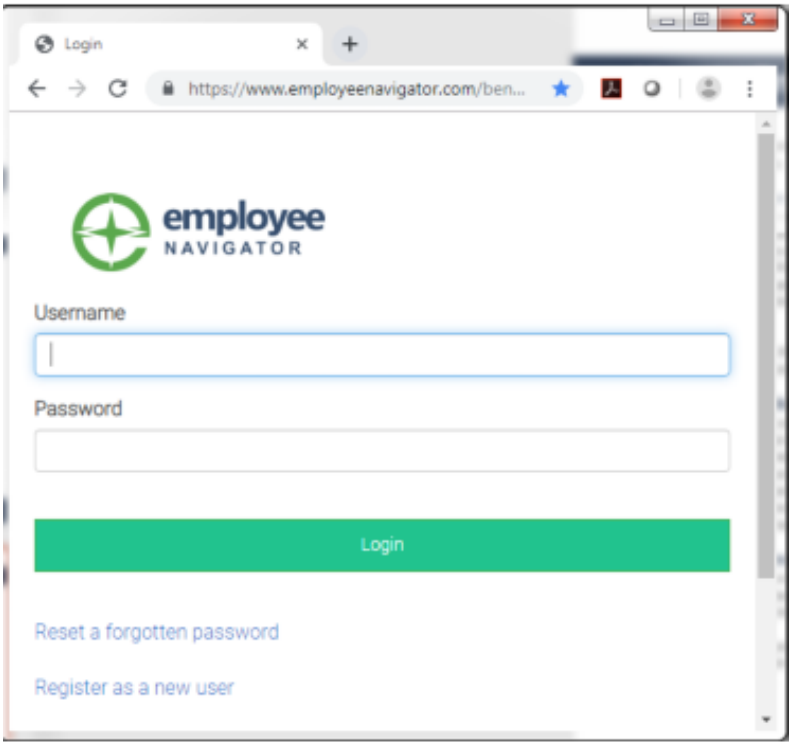
Review plan and enrollment materials

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 health of your family members
- Medical, Dental and Vision expenses that you can predict for the upcoming year for you or your family members
- If Other benefits you or your family members may have
- Your overall budget for benefits

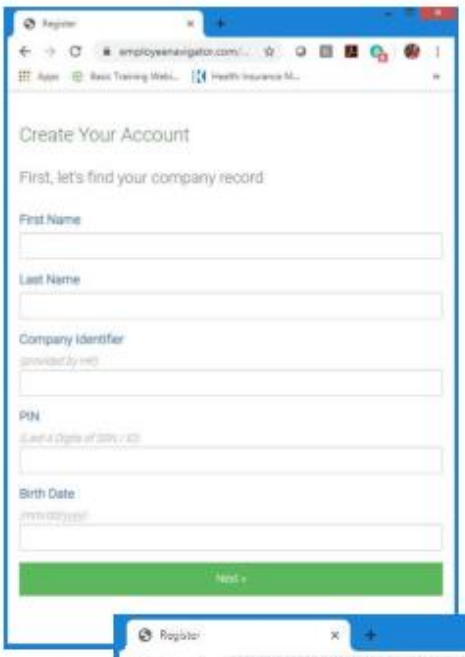
Complete your enrollment

If you do not already have a login, go to www.emloyeenavigator.com/benefits/account/login and select "Register as 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.

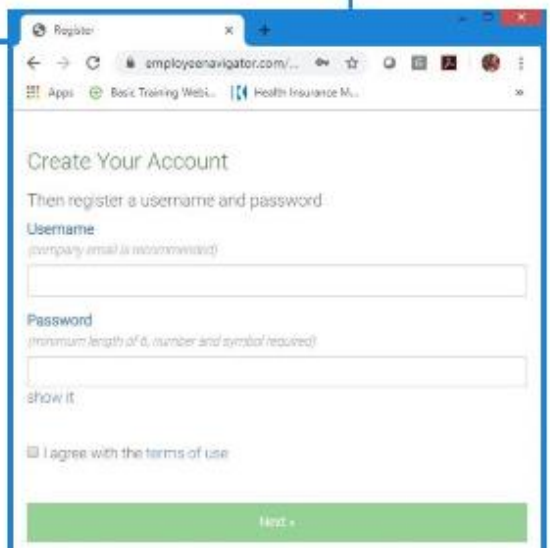


How to Enroll (Continued)

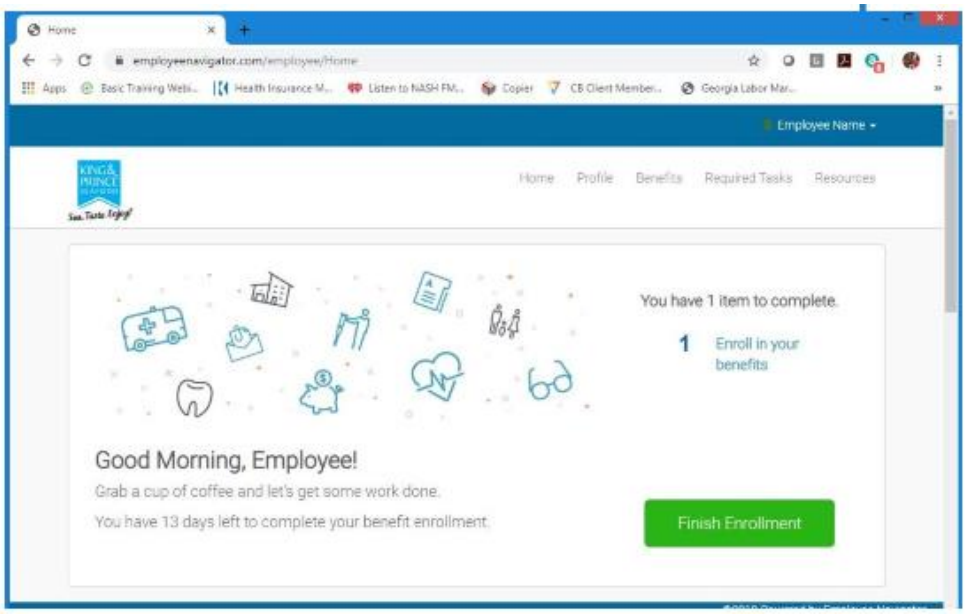
1. Complete all information on this screen and click "Next." Your company identifier is **CRMC-GA**, and your PIN is the last 4 digits of your Social Security Number.



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, reach out to Human Resources.



Bi-Weekly Employee Rates

Medical Plans

PPO Plan	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 + Child(ren)	$96.92	$62.31
Family	$260.72	$226.10 (1 Goal Achiever) $186.87 (2 Goal Achievers)
HDHP	**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 + Child(ren)	$69.19	$46.12
Family	$178.29	$155.29 (1 Goal Achiever) $131.91 (2 Goal Achievers)

Dental Plan

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

Vision Plan

Employee	$2.72
Employee & 1 Dep	$5.16
Employee & 2+ Deps	$7.58

Voluntary Insurance Plans

Rates will vary based on election levels, age and policy types. See the enrollment system for calculated rates.

Contact Information

TOPIC	CARRIER	PHONE NUMBER	WEBSITE
Medical Claims	Meritain Health	1.800.925.2272	www.meritain.com
Prescription Drug Plan	ApproRx	866.900.3711	www.approrx.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	912.384.2233	www.dnbdouglas.com
Basic & Term Life Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
STD, LTD, & Critical Illness Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
Accident & Hospital Indemnity Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
Employee Assistance Plan	Lincoln Financial Group / EmployeeConnect	8883628.4824	www.guidanceresources.com
Enrollment	Human Resources	912.383.5607	Theresa.hepburn@coffeeregional.com

This brochure summarizes the benefit plans that are available to Coffee Regional Medical Center eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Required Notifications

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

- All 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. Therefore, the following deductibles and coinsurance apply: HDHP: $1,400/$2,800 deductible; 85/15% coinsurance. PPO Plan: $2,000/$6,000 deductible; 85/15% coinsurance.

NEWBORNS ACT DISCLOSURE - FEDERAL

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 30 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 30 days the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

Healthy Merits 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. 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 lower premiums. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive lower premiums.

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]. 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 CRMC may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Merits 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 is (are) a doctor 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.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 912-383-5607 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Teri Hepburn
11101 Ocilla Road
PO Box 1287
Douglas, GA 31534
912-383-5607
theresa.hepburn@coffeeregional.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date: 1/1/2021

Important Notice from Coffee Regional Medical Center About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Coffee Regional Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Coffee Regional Medical Center has determined that the prescription drug coverage offered by the Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Coffee Regional Medical Center coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Coffee Regional Medical Center coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Coffee Regional Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Coffee Regional Medical Center changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2021
Name of Entity/Sender:	Coffee Regional Medical Center
Contact--Position/Office:	Theresa Hepburn
Address:	11101 Ocilla Road, PO Box 1287, Douglas, GA 31534
Phone Number:	912-384-1900

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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 1210-013

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

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

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 11101 Ocilla Road, PO Box 1287	6. Employer phone number 912-384-1900	
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)	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:
  - ☒ Some employees. Eligible employees are:
    Full time employees working 30 or more hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Legal spouse, children- natural and adopted, step children
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* 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 (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)