BENEFITS DESIGNED WITH YOU IN MIND

2024

COFFEE REGIONAL MEDICAL CENTER

EMPLOYEE BENEFITS GUIDE

January 1, 2024 – December 31, 2024

WELCOME TO YOUR BENEFITS

Coffee Regional Medical Center is pleased to offer several benefit options that provide you with flexibility and choice. You can 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 on the CRMC MyHub Page. Go to Departments and select Human Resources.

Sincerely,

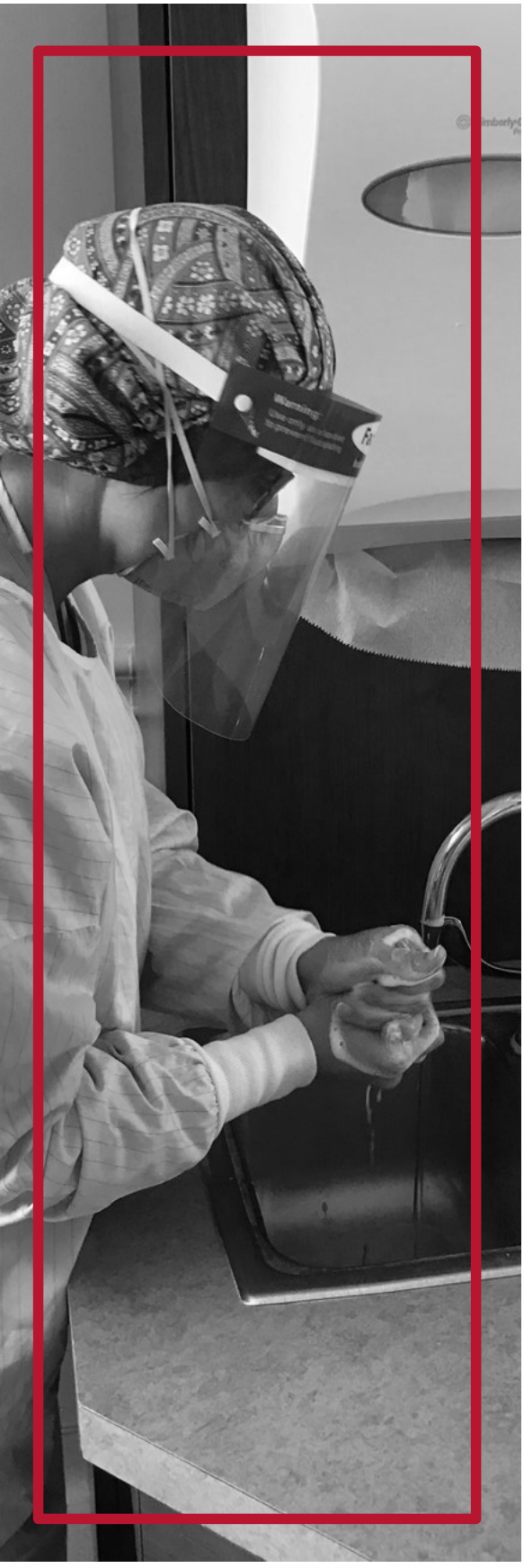
Coffee Regional Medical Center HR Team

WHAT'S INSIDE

GET CARE ANYTIME, ANYWHERE

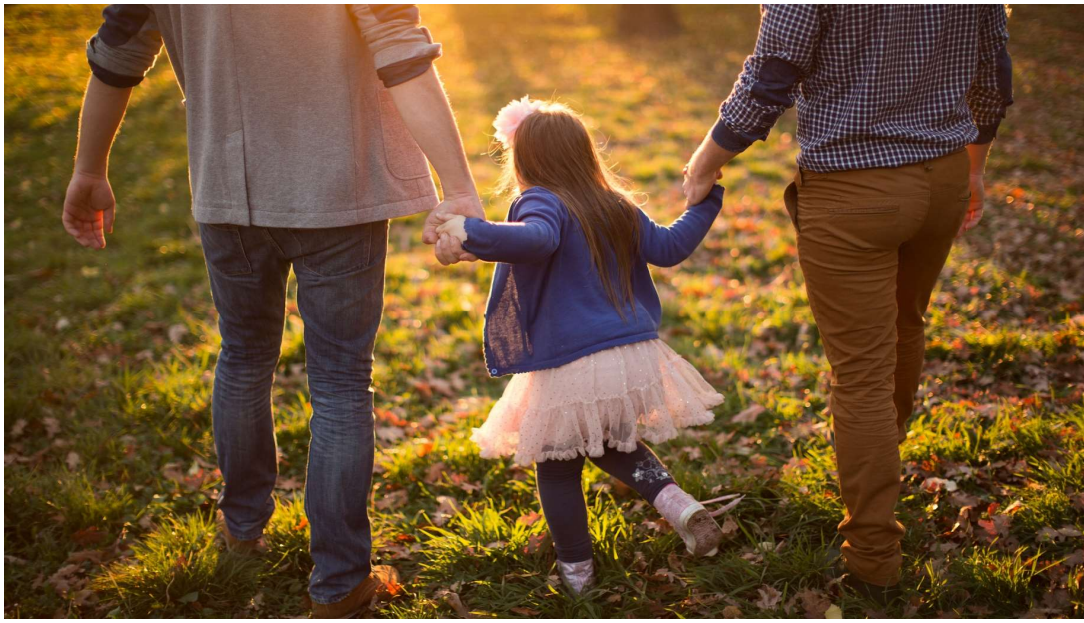
Accessing care when and where you need it is the key to a healthy life. Your Coffee Regional Medical Center benefits offers prompt care for emotional support from your computer or phone. See page 25 to learn more.

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. • 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: 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.

WHO IS ELIGIBLE?



YOU

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.

YOUR Dependents

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

- Your legal spouse – Please note: spouses that have access to health insurance through their own employer will NOT be eligible to be covered under CRMC health plan. However, any spouse that does not have access to health insurance through their employer, or a spouse that is unemployed, will continue to be eligible for coverage.
- 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.

Qualifying Events

For benefits that you pay for with pre-tax dollars, the Provisions of Section 125 of the IRS govern how and when you can make changes. The only time you may make a Change in your coverage during the year is if you experience a qualifying event. You must notify HR within 31 days of the event to make any changes.

Qualifying Events

- Marriage or divorce
- Birth or adoption of a child
- Death of spouse or child
- Spouse begins or end 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 child/ren
- Becoming eligible for Medicare or Medicaid
- Dependent child reaches age 26
- You or your spouse take an unpaid leave of absence
- Your spouse has a significant change in health coverage
- Entitlement of loss of coverage under premium subsidy plans from a State (560 days to notify)

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.

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.

THE EPO PLAN

This plan is a standard EPO 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 **CRMC Network**, go to https://chp.health. 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 within the CRMC Network you will have access to Aetna Point of Service POS II Network providers (upon medical authorization).

In this plan, the in-network hospital facilities are Coffee Regional Medical Center, St. Joseph's/Candler and Emory. Remember, Surgery Centers are NOT considered to be in-network.

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

- Copays apply to services such as office visits and prescription drugs. 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 Contributions – EPO 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 CRMC Network, follow these steps:
•Go to https://chp.health and Click on the network tab at the top to begin your provider search.
•To find Providers in the Aetna Point of Service POS ll Network, follow these steps:
•Go to www.aetna.com/docfind/custom/mymeritain and enter your zip code.

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. Remember, Surgery Centers are NOT considered to be in-network.

The in-network physicians are any physician in the **Aetna Point of Service POS II 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 Point of Service POS II Network (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 Point of Service POS II Network, follow these steps:
Go to **www.aetna.com/docfind/custom/mymeritain** and enter your zip code.

To find Providers in the CRMC Network, follow these steps:
Go to https://chp.health and Click on the network tab "CRMC" at the top to begin your provider search.

MEDICAL PLANS

MERITAIN HEALTH An Aetna Company	EPO Plan		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Single / Family)	$2,000 / $6,000 Embedded	N/A	**New Deductibles** $1,600 / $3,200 Non-embedded	N/A
Maximum Out-of-Pocket (Single / Family)	$4,400 / $12,000	N/A	$5,000 / $12,900	N/A
Preventive Care	100%	N/A	100%	N/A
Primary Care Office Visit	$15 copay – Coffee Select $35 copay – Aetna with plan approval	N/A	85% after deductible	N/A
Specialist Office Visit	$25 copay – Coffee Select $45 copay – Aetna with plan approval	N/A	85% after deductible	N/A
Allergy Testing	85% after deductible	N/A	85% after deductible	
Urgent Care	85% after deductible	N/A	85% after deductible	N/A
Emergency Services – Non-Emergent Condition	85% after deductible 50% after deductible	N/A	85% after deductible 50% after deductible	N/A
Inpatient / Outpatient	85% after Deductible	N/A	85% after deductible	N/A
Diagnostic X-Ray and Lab Services	100% to a maximum of $400; then 85% after deductible	N/A	85% after deductible	
Home Healthcare	85% after deductible		85% after deductible	
Durable Medical Equipment (DME)	85% after deductible	N/A	85% after deductible	N/A

**Please refer to the Summary Plan Description (SPD) for more information.*

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

PHARMACY PLANS

	EPO Plan Out of Pocket Maximum $1,000 individual / $2,000 family	
Plan Benefits		
Copay	30 Day Supply	90 Day Supply
Generic	$10 at preferred pharmacy / $25 at non-preferred pharmacy	$10 at preferred pharmacy 90 day retail not eligible $30 at mail order pharmacy
Brand Preferred	$35 at preferred pharmacy $60 at non-preferred pharmacy	$75 at preferred pharmacy 90 day retail not eligible $105 at mail order pharmacy
Brand Non-Preferred	$50 at preferred pharmacy $90 at non-preferred pharmacy	$100 at preferred pharmacy 90 day retail not eligible $150 at mail order pharmacy

	HDHP Plan RX/Medical Deductible Combined $1,600 individual / $3,200 family RX/Medical Out of Pocket Maximum $5,000 individual / $12,900 family	
Plan Benefits		
Copay	1-90 Day Supply	
Generic	10% after deductible has been met (plan pays 90%)	
Brand and Non Preferred	20% after deductible has been met (plan pays 80%)	
	30 Day Supply	90 Day Supply
Specialty Tier 1	$50 after deductible	Not Covered
Specialty Tier 2	After deductible, 20% to $550 maximum	Not Covered
Specialty Tier 3	After deductible, 20% to $2,000 maximum	Not Covered
Specialty Tier 4	After deductible, 20%	Not Covered
Specialty Tier 5	After deductible, 20%	Not Covered

**Please refer to the Summary Plan Description (SPD) for more information.*

CRMC NETWORK

If you choose the EPO Plan, you must seek services through the **CRMC Network**.

The **CRMC Network** is a member of the Community Health Plans Network and was developed specifically for the community services by Coffee Regional Medical Center.

There is also a defined group of physicians participating in this network.
Any provider or facility not in the CRMC 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 Point of Service POS II Network provider must be utilized.

Provider Search
To find Providers in the CRMC Network, follow these steps:
- Go to https://chp.health
- Click on the network tab at the top to begin your provider search.

The primary hospital facilities are Coffee Regional Medical Center, St. Joseph's/Candler and Emory. Remember, Surgery Centers are NOT considered to be in-network.

COFFEE SELECT

A MEMBER OF CommunityHealthPlans of GA

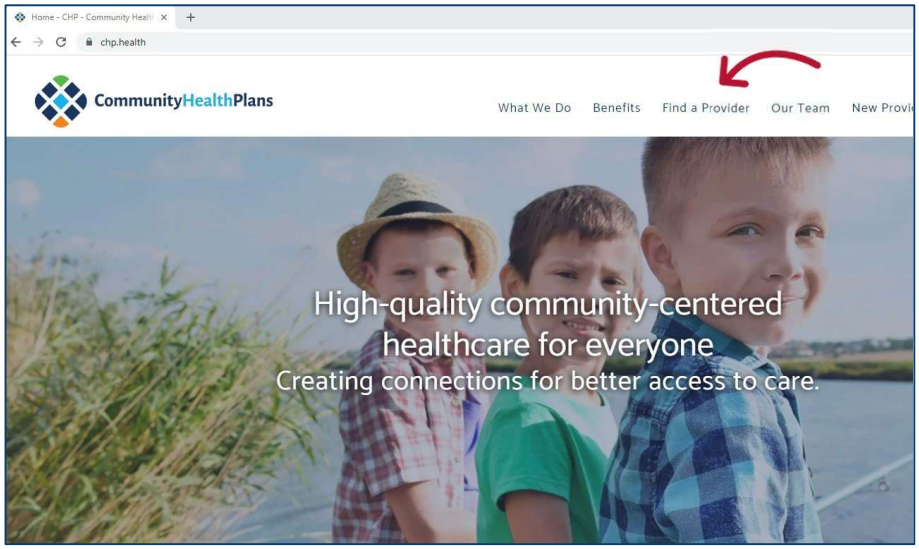
How to Find an In-Network Provider

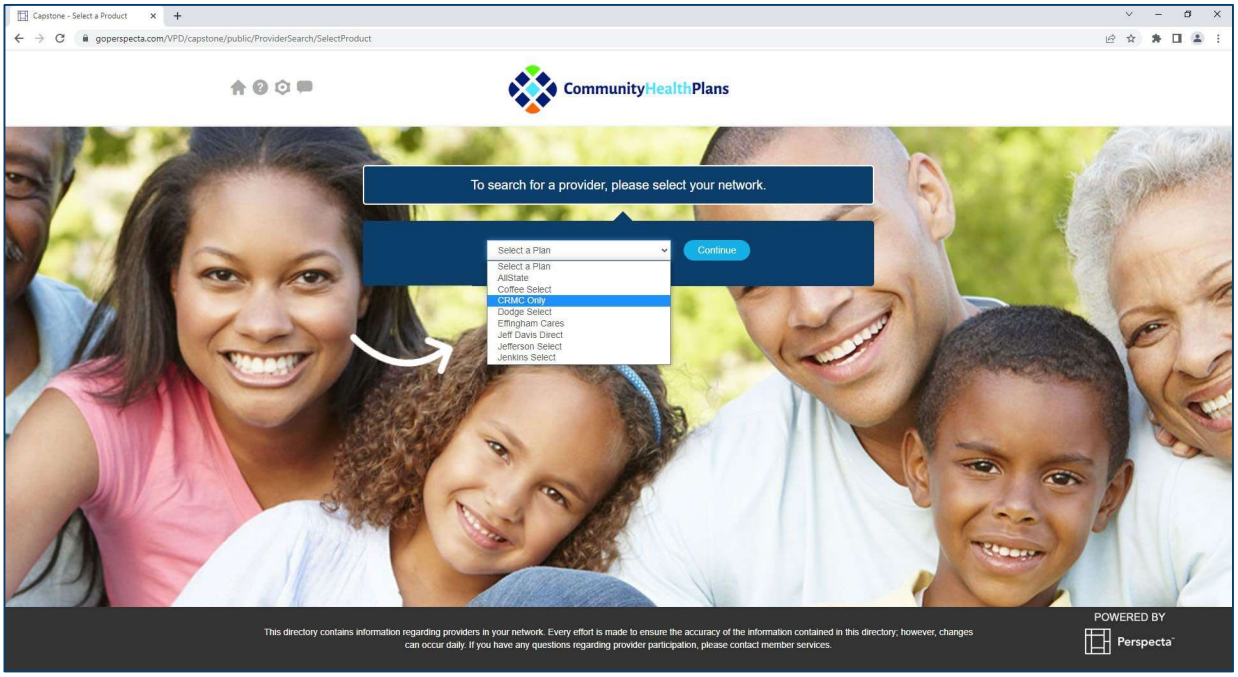
The Coffee Select Network is a member of Community Health Plans (formerly the Georgia Health Network).

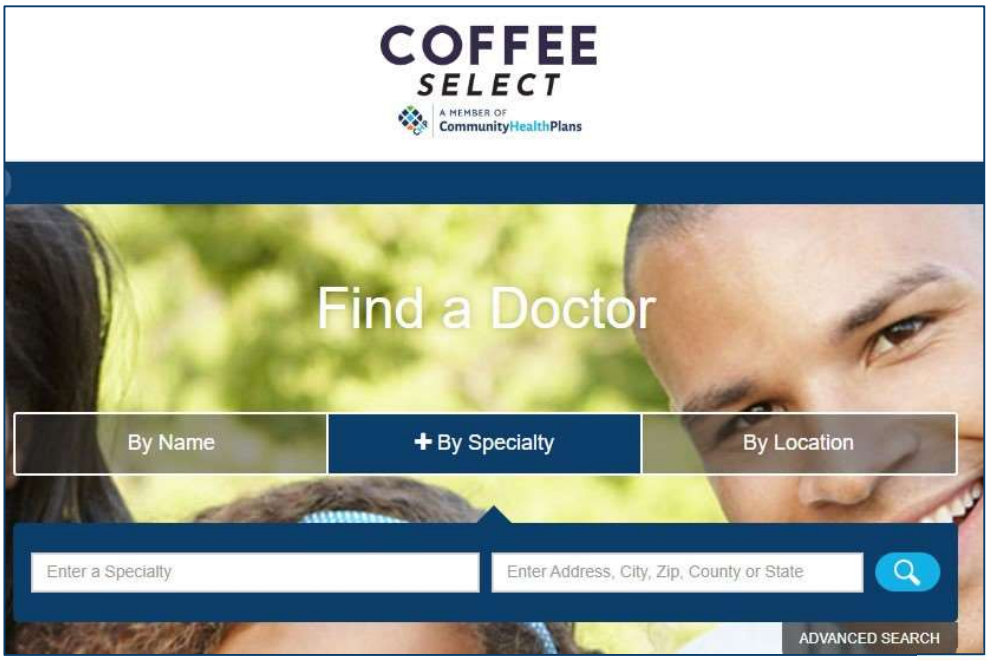
To find providers in the Coffee Select network, follow these steps:

- Go to https://chp.health
- Click on Find a Provider

On the next screen, select which plan (network) and click Continue

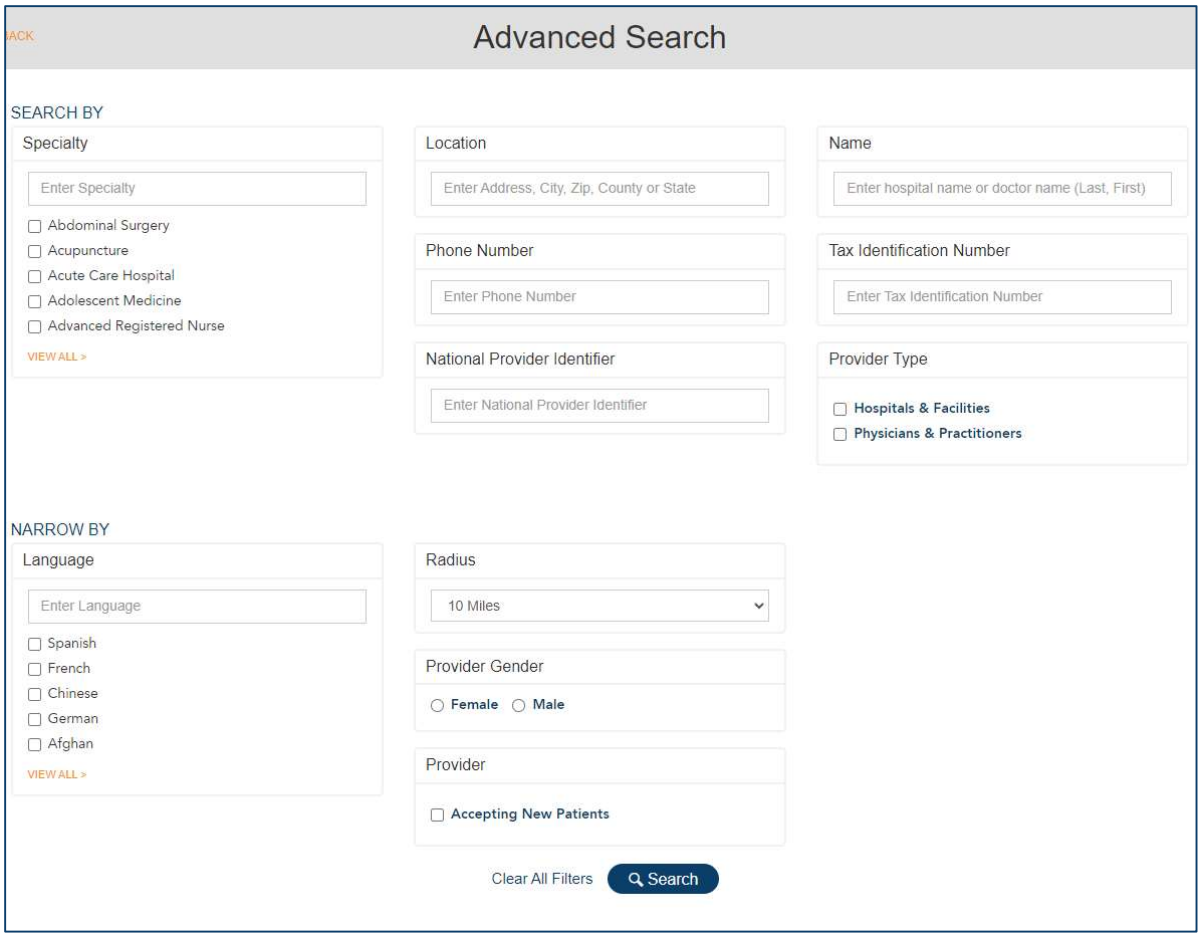






On the next screen follow the prompts to search by name, specialty and location.

You can also click on Advanced Search to narrow your selection further.



AETNA POINT OF SERVICE POS II OPEN ACCES NETWORK

Find Aetna providers online in just a few quick steps.
You can use the DocFind directory anywhere you have internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain/**
2. Key in the ZIP code, city, county or state. **of the desired geographical area in the *Enter location here* field. Click *Search***
3. Key in ***Aetna Choice POS II (Open Access)*** under ***Select a Plan***. **Or** you can select ***Aetna Choice POS II (Open Access)*** from the list of plans. Click ***Continue***.
4. **There are two options available to search for providers. The guided flow** search uses some of our most commonly **searched terms and easily organizes them for our users to find.** To use the guided search flow, choose and click on one of the categories under Find what you need by category. **Or see step five**.
5. Use the search box, which includes **type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered**. These suggested options will present an exact match or relevant providers. ***What do you want to search for near*** **(will display your chosen location).**
6. Choose your provider from the list of providers displayed on the results screen. **You can learn more about each by clicking** on the provider's name.
7. **Narrow your search results by using the *Filter & Sort option***. Choices include **Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations and Provider Type**.

If you need assistance or need to find a provider when you are not near a computer, simply call the Aetna Provider Line at: (800) 343-3140 from 8:00am to 9:00pm EST, Monday through Friday

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 2024 the maximum for a Medical FSA is **$3,200** 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 = $ Per Pay Period Contribution

Annual Amount (cannot exceed $3,050)

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

HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's EPO plan.
- You are not enrolled in Medicare or other government provided health insurance coverage.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

	Individual Plan Contribution	Family Plan Contribution
Maximum HSA Limit for 2024 Tax Year	$4,150	$8,300
Catch Up Contribution if 55 or older	$1,000	$1,000

*IRS limits are reduced by the available company contribution

If you would like to open an HSA, you must do so with Douglas National Bank.		
Douglas National Bank	912-384-2233	www.dnbdouglas.com

PRIMARY CARE OPTIONS: WHICH IS BEST?

TYPE OF CARE	WAIT TIME	COST**
Coffee Regional First Care Coffee Regional First Care is open 7 days a week 7:30 am – 7:30 pm. **When to go*** • Sprains and strains • Mild asthma attacks • Sore throats • Basic X-Ray • 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 EPO 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

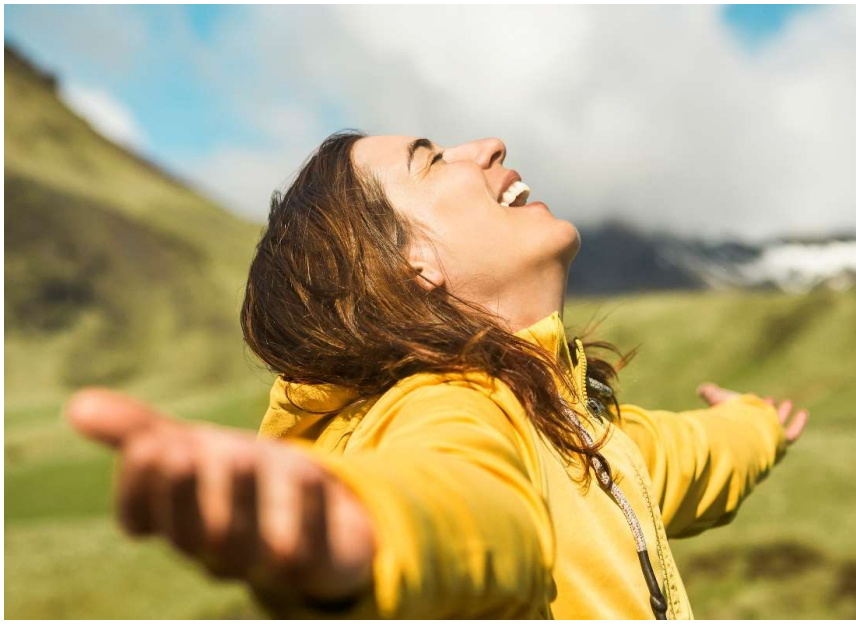
Coffee Regional First Care

The CRMC First Care 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 or colds. 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).

DENTAL INSURANCE

Your Health

Smile Starts Here



CRMC will continue to offer a competitive dental plan this year with Meritain Health. Please refer to the summary plan description (SPD) for plan details, limitations & exclusions.

	Meritain Health – Dental Plan
Plan Benefits	**In-Network**
Deductible	$50 / single $150/ family
Calendar Year Benefit Maximum (per person)	$2,000 / Person
Class A: Preventive Services	100%, deductible waived
Class B: Basic Services	80% after deductible
Class C: Major Services	50% after deductible
Orthodontia Services (children under age 19)	50% after deductible
Lifetime Orthodontia Maximum	$1,500
Bi-Weekly Employee Contributions	
Employee	$8.15
Employee & Spouse	$21.00
Employee & Child(ren)	$18.00
Family	$25.00

QUESTIONS?

Contact Meritain Health customer service at
the phone number on the back of your ID card or visit www.meritainhealth.com

YOUR VISION IS OUR FOCUS

CRMC will continue to offer you the option to elect Vision Insurance through EyeMed. The chart below is a brief outline of the plan. Please refer to the summary plan description (SPD) for complete plan details.

Please note that ID cards are not needed for your visit. The provider can confirm benefits with your social security number.

Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, you receive an amount that the provider will pay up to. You are then responsible for the difference.

	Vision Plan	Frequency of Services	
Plan Benefits	**In-Network**	**In-Network**	
Routine Exams	$10 Copay	Routine Exams	12 Months
Frames	$130 allowance; 20% off balance	Frames	24 Months
Lenses	$25 copay; covered in full after copay	Lenses	12 Months
Contact Lenses	Conventional - $0 copay; $130 allowance; 15% off balance over $130 Disposable - $0 copay; $130 allowance; plus, balance over $130	Contacts	12 Months (in lieu of glasses)
Contact Lenses (Medically Necessary)	Paid in full once every calendar year	In-Network limitations apply	
Laser Correction Surgery Discount	Discount pricing available		

Bi-Weekly Employee Contributions	
Employee	$2.45
Employee + One Dependent	$4.65
Family	$6.82

QUESTIONS?

Contact customer service at 866-939-3633 or visit www.eyemed.com .

KNOW-HOW AND SHOW-HOW

SUPPORT WHEREVER YOU ARE, WHATEVER YOU'RE DOING

Eye care is an experience. From the day you enroll to the day you find your favorite frames, we'll be part of it. Guiding. Advising. Helping you make the most of your vision benefits.

We go out of our way to make your benefits easy to understand—and even easier to experience.

MAKING LIFE EASIER EVERY DAY

WELCOME KIT

You've probably already seen your Welcome Kit in the mail. It'll give you a head start with benefit details, the 10 closest eye doctors and your ID card.

VISION AIDS

Get guidance from the vision experts at eyesiteonwellness.com. Plus learn how to maximize your benefits and get special offers when you sign up for inSIGHTS.

MEMBER APP

Our member app is like a personal assistant. Login with 1 touch. Find an eye doctor. Pull up your prescription or ID card anytime (or store it in your Wallet).*

TEX T ALERTS

Get updates and reminders,tips to maximize your benefits and extra ways to save money— right to your mobile device. **Call 844.873.7853 to opt in.** Be sure to have your 9-digit Member ID handy.

CALL CENTER

Get live help from one of America's highest-rated call centers. Our call center resolves 99.4% of issues during the first call.

MEMBER WEB

Manage your vision benefits, find an eye doctor, print ID cards, get special offers and more on eyemed.com.

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

* Touch ID, Face ID and Apple Wallet features available only on iPhones

PDF-1902-M-264

SMART TOOLS FOR SAVVY SHOPPERS

KNOW BEFORE YOU GO

With EyeMed's Know Before You Go out-of-pocket cost estimator, you can get a feel for what you might pay before you even step foot into a store or doctor's office. The tool includes simple, clear definitions of common products and add-ons, all while calculating a range of costs with each click. So you can feel confident from check-in to check-out.

1. Log into eyemed.com and find our Know Before You Go out-of-pocket cost estimator.
2. Pick the type of exam you'll need. Just need glasses or contacts? Take a look at Step 3.
3. Choose from a variety of lens types, options and add-ons. Plus, get detailed descriptions of each product so you feel confident in your choices.
4. The best part? You get a range of costs based on your choices and applied vision benefits. We do the math so you stay in-the-know before you go.

Register on **eyemed.com** to try Know Before You Go today

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

LIFE / AD&D INSURANCE

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. However, don't forget to assign a beneficiary for your Basic and Voluntary life benefits.

- ***Age reduction: at age 70, benefits will reduce by 35% of the original amount; at age 75, benefits will reduce an additional 15% of the original amount. Benefits will terminate when the Insured Person retires.***

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
- Can be contacted at 800-423-2765

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.

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 and value 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.

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 health condition such as Cancer, Heart Attack or Stoke. Benefits are paid directly to you. You can use your lump-sum cash benefit 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 an accidental injury or treatment of that injury. 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.

ACCIDENT WITH HOSPITAL RIDER INSURANCE

This rider is offered on an optional basis for an additional fee when you purchase the Accident Insurance. This rider is for Sickness only and employee's who purchase this rider will have to also be enrolled in the Accident Insurance Plan.

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

EXTRA BENEFITS

Wellness Center

At Coffee Regional Medical Center employees are eligible to receive special employee pricing on membership. When you become a member, you receive a consultation that includes a health assessment and training on all the equipment. You are invited to visit the Wellness Center for a tour of the facility.

Credit Union

The employees of Coffee Regional Medical Center may join the CRMC's Employee's Federal Credit Union. It is operated by and for the employees of our organization. You are eligible for membership and may participate in the benefits of both an interest paying savings investment and an economical and convenient means of borrowing money., Contact the Credit Union office for more specific information regarding membership services.

Employee's Club

The Coffee Regional Employee Clun is an organization to promote and foster good will among the employees of CRMC and its subsidiaries. The primary function of the club is to provide assistance to employees who have a critical and tangible need. Please see your department head for information about the Employee's Club.

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 Empower. 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
- $20,500 maximum contribution limit

Visit
www.participant.empower-retirement.com
for more information about your 401(k).
You make also call 1-877-778-2100 for more information. Representatives are available Monday through Friday, 8am to 9pm Eastern time.

EMPOWER RETIREMENT™

ANYTIME SUPPORT

Aetna Resources for Living

To access services:
1-855-283-1917; TTY: 711
Resourcesforliving.com
Username: CRMC
Password: EAP

COFFEE REGIONAL MEDICAL CENTER

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.
Services are confidential and available 24 hours a day, 7 days a week.

Emotional well-being support

You can access up to 6 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face or online with televideo. Services are free and confidential. We're always here to help with a wide range of issues including:

- Relationship support
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem and personal development

HEALTHY LIFE CLINIC

Located inside the employee pharmacy at CRMC, we provide health education on diabetes, hypertension, hyperlipidemia, and more!

Make an appointment for a wellness visit at the Healthy Life

First time visits at the Clinic are eligible for a $100 that will be applied to your reward points.

Call ext. 4151 and make your appointment, today!

COFFEE REGIONAL MEDICAL CENTER

HEALTHY MERITS

Your 2024 Wellness Program Details

Beginning January 1, 2024, CRMC Annual Wellness Program will replace our annual biometric screenings.

- Employee and spouse will complete their annual wellness visit inclusive of biometrics with their primary care physician between January 1, 2024 – August 31, 2024
  - The primary care office visit will order your labs from CRMC Laboratory, LabCorp or Quest Diagnostics to complete before your visit.
  - If you currently do not have a primary care physician and you are on the EPO plan, you may go to www.chp.health to locate a provider. If you are on the HDHP plan, you may go to www.aetna.com/docfind/custom/mymeritain to locate a provider and set up your initial visit.
- Employees and spouses will be able to access the Meritain Healthy Merits website whereby you can print a physician form to bring to the visit with you.
- All employees enrolled in the CRMC's health plan will be eligible to enjoy a discounted employee contribution for your medical plan that will be applied to the following years' benefit open enrollment.

If you are on the BCBS medical plan, you will use your four-digit employee number as your unique ID.

Healthy Merits website registration

Complete wellness activities on your Healthy Merits website at **https://crmc.healthymerits.com**. Register by using the information exactly as it appears on your Meritain Health® ID card. If you have a middle name or initial on the ID card, enter that on the first name box. Your unique ID is your member ID.

Be sure to make your wellness appointment with your primary care physician as soon as possible!

Spouse health plan registration

Spouses will need to register after the employee. Go to **https://crmc.healthymerits.com**. Select *I am related to the member*. Use the employee's email address they used during their registration process as the primary email.

Mobile app

Prefer to participate in the wellness program on your smartphone? Download the Healthy Merits app in the iOS App Store®, Google Play Store™, or by scanning the QR code below and create an account. You will need to use the company code, ***CRMC***, during registration.

Android app

Apple app

Your new 2023 wellness program details

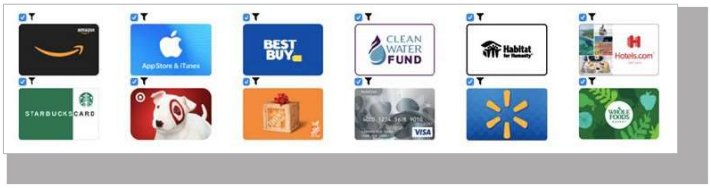
Beginning January 1, 2023 you will have access to a points program. For each wellness activity you complete, you will earn points towards earning electronic gift cards. You can earn the electronic gift cards and choose which gift cards you want to redeem for incentives right on your Healthy Merits website.

How to access your Rewards Mall

1. Click on your profile icon in the right-hand corner of your screen.
2. Click on *Redeem Rewards.*
3. Go shopping for e-gift cards.

Please note: these gift cards are subject to be included as taxable income and will be included on your 2023 W-2.

All gift cards Must be Redeemed by December 31, 2023 and or will be forfeited.



Employee activities

Qualifying activities	Description	Points	Maximum points	Rewards mall gift card amount
AgeGage—health assessment	Complete your AgeGage online health assessment at **https://crmc.healthymerits.com**.	10	10	$10
SayAah—preventive visit	Complete a preventive visit with a health care provider. Self-report at **https://crmc.healthymerits.com**.	25	25	$25
HealthyU—university courses	Complete four online university courses at **https://crmc.healthymerits.com**.	10	10	$10
Healthy Life Clinic—Initial Visit	Participate in the Healthy Life Clinic to help manage your chronic condition(s) and receive medication support. To schedule a consultation, simply call **1.912.383.5630**. Please allow four-to-six weeks for this to show as complete.	100	100	$100
Healthy Life Clinic — Follow Up Visit	Participate in follow up visits with the Healthy Life Clinic to help manage your chronic condition(s) and receive medication support. To schedule a consultation, simply call **1.912.383.5630**. Please allow four-to-six weeks for this to show as complete.	10	120	$10 visit maximum $120

Physical activity	**Please note:** You may only earn incentives for either the CRMC wellness visits or the physical activity tracking. You won't be rewarded for both activities. You may earn up to a maximum of $25 per month.			
Attend the CRMC wellness center	Exercise 10 times per month at the CRMC Wellness Center. Please allow four-to-six weeks for this to show as complete.	25 points per month	300 points	$25 per month maximum $300
Moveit or Step to it	Exercise three times per week for 30 minutes and manually track your physical activity on the Healthy Merits website or mobile app. Alternatively, sync your wearable device and achieve 30,000 steps per month.	25 points	300 points	$25 per month
Maximum Incentives Potential			**565 points**	**$565**

Spouse activities

Qualifying activities	Description	Points	Maximum points	Rewards mall gift card amount
Healthy Life Clinic—Initial Visit	Participate in the Healthy Life Clinic to help manage your chronic condition(s) and receive medication support. To schedule a consultation, simply call **1.912.383.5630**. Please allow four-to-six weeks for this to show as complete.	100	100	$100
Healthy Life Clinic — Follow Up Visit	Participate in follow up visits with the Healthy Life Clinic to help manage your chronic condition(s) and receive medication support. To schedule a consultation, simply call **1.912.383.5630**. Please allow four-to-six weeks for this to show as complete.	10	120	$10 visit maximum $120
Attend the CRMC wellness center	Exercise 10 times per month at the CRMC Wellness Center. Please allow four-to-six weeks for this to show as complete.	25 points	300 points	$25 per month maximum $300
Maximum Incentives Potential			**565 points**	**$565**

Questions?

Call Healthy Merits at **1.877.378.4533** or email **healthymerits@meritain.com**.

Follow us: @meritainhealth | Meritain Health

MERITAIN® HEALTH
An Aetna Company

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCMidwest@usi.com | Toll Free: 855-874-0829

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

WE MAKE MEDICARE EASIER FOR YOU

Medicare often leaves people confused with its complicated rules and a wide array of choices. My Benefit Advisor can help you sort through the complexities and the tough decisions to find the solution that is right for you.

Our licensed advisors will compare the price and coverage options that are available to you in the Medicare marketplace. We help guide your decisions in order to save you time and money. Best of all, there is no charge for this service and your rates are the same as buying directly from the insurance carrier.

You Can Count On Us

Education

We take the time to help you understand Medicare and listen to your specific needs before making any recommendations.

Review Plan Options

We have access to a wide variety of insurance providers and plan types to help you select the best policy for your specific needs, including Medigap Plans, Medicare Advantage Plans, Prescription Drug Plans, and more.

Simplifying Enrollment

We reduce the stress of the enrollment process with step-by-step guidance, eliminating the need for paper forms whenever possible.

Annual Review

Each year, we review your unique situation and help you identify whether your current coverage needs to be expanded, reduced, or changed to a more effective option. We are here to serve you, year after year.

If you have any questions about Medicare or need help reviewing your options, please contact Matt Bradley at (610) 897-4442.

My Benefit Advisor

YOUR BENEFIT CONTACTS

Benefit	Provider	Phone	Website or Email
Medical	Meritain Health	(800) 925-2272	www.meritain.com
Prescription Drug Plan	TrueScripts	(812) 257-1955	www.truescripts.com
Dental	Meritain Health	(800) 925-2272	www.meritain.com
Vision	EyeMed	(866) 800-5457	www.eyemed.com
Flexible Spending Account (FSA)	Meritain Health	See debit card	www.meritain.com
Health Savings Account (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 Program	Aeta Resources for Living	(855) 283-1917	www.resourcesforliving.com
Enrollment	Human Resources	(912) 383-5607	Theresa.Hepburn@coffeeregional.com
Benefit Resource Center	USI	(855) 874-0829	brcmidwest@usi.com

Questions?

Please call the USI Benefit Resource Center (BRC) if you have any questions or issues with your Benefits. The BRC is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries.

Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

BRCMidwest@USI.com | 855-874-0829
Monday through Friday, 8:00AM to 5:00PM EST.

Annual Enrollment

Annual Enrollment is Wednesday, November 1st - Friday, November 17th, 2023.

Are you ready to choose your benefits for 2024? It's simple to enroll – just follow the steps below.

Step 1: 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.
You benefits include CRMC paid life insurance, and elective voluntary life insurance. Be sure to have your beneficiaries' names and Social Security Numbers.

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

Step 2: Review plan and enrollment materials.

The decisions you make as you enroll in your health plan will affect your future healthcare and finances. Be sure to read all plan information available to determine which plan is best for you and your family. Don't enroll without understanding your options.

Step 3: Complete your enrollment.

As a reminder, we will be using ADP for your online enrollment.
Login to your ADP account. Once you are logged in, you can use the top menu to navigate to Myself>Benefits>Enrollments. This will open up the enrollment page

Keep in mind that the system will not open until November 1st for you to begin your enrollment. If you have any questions during the process, please contact Human Resources, or call the ADP My Life Advisors line.

ADP Comprehensive Services®

MyLife Advisors
Real People, Ready to Help

Always Designing for People®

(855) 547-8508
MyLifeAdvisor@adp.com

- Navigating benefits systems
- Preparing for the future
- Save more and live more
- Understanding MyLife tools

Support available in English or Spanish. M-F, 8am-11:30pm ET

COFFEE REGIONAL MEDICAL CENTER

Questions About Your Benefits?
You can also contact your Human Resources Department.

About This Guide. This brochure summarizes the benefit plans that are available to Coffee Regional Medical Center's 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. Information provided by USI Insurance Services.

Coffee Regional Medical Center

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 11 for more details.

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

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 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 after 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 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. CRMC 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 $110 per day, 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

- 10/12/2022
- Theresa Hepburn, Theresa.hepburn@coffeeregional.com

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

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 15thto 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.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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

If you decide to join a Medicare drug plan, your current Coffee Regional Medical coverage will not be affected.

PPO Plan Description 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

HDHP 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

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.

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 CRMC 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.

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

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	10/12/2022
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:	912-384-19200

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	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
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	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
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-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: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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 January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires1/31/2023)

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)