Employee Benefits Guide

Medicare D Coverage Disclosure is Located on Pages 24-25.
WELCOME
To Your 2019 BENEFITS!

As a benefit-eligible employee of CGH Medical Center, you have the chance to take part in your choice of many excellent benefits. This guide has been specially prepared to summarize the highlights of your CGH Employee Benefits Package.

As a New Hire, right now is your chance to elect benefits for the coming year.

All employees must log in to the Aflac At Work system to either elect or decline coverage. The choices you make now will remain with you for all of 2019 and no changes are allowed - unless you experience a qualifying life event as detailed on page 4. If you decline some benefits now (upon hire) you will not have another chance to elect them without medical questions in the future. Please review this guide, share it with your family, and make your benefit decisions before your New Hire Enrollment deadline!

You have 30 days from your hire date to complete benefit enrollment. After that, no changes until the Open Enrollment period at the end of the year.

Employee Self Service Website Enrollment:

Step 1: Connect to the website through your web browser at https://www.aflacatwork.com/Enroll.
Step 2: At the “Employee Login” screen, enter your Social Security Number and your personal identification number (PIN). Your PIN is a combination of the last 4 digits of your Social Security Number and the 2-digit year of your birth. For example, if the last 4 digits of your SSN are 3214 and you were born on September 21, 1968, your PIN would be “321468”. All PINs have been reset. Be sure to make note of the new secure PIN for future use. If you are having trouble logging on the system, contact your HR department.
Step 3: When the CGH Medical Center Welcome Page appears on your screen that means you are in! Follow the onscreen instructions to enroll in your benefits, find answers to your questions, download forms and more.

Please make sure to enroll or make benefit changes before the deadline and come to us with any question you have before that time. Thank you again for your service to the Team!

Sincerely,
CGH Medical Center

All benefits EXCEPT retirement options will be available on the AFLAC portal. Please see page 19 for instructions to login to cghretirement.org where you will make your retirement elections.
BE PREPARED
What you need to know before you enroll in benefits.

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BE COVERED
The details of your benefit options and plan choices.

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The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the company HR Department.
ELIGIBILITY, ENROLLMENT & CHANGES

ELIGIBILITY FOR BENEFITS
Employees who work 20 hours (0.5 FTE) or more per week are eligible to participate in benefits and must enroll within 30 days of hire or wait until the next Open Enrollment Period - unless you experience a qualifying life event.

YOUR ELIGIBLE DEPENDENTS
The Employee’s legally married spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse.

Spousal Provision: If your spouse’s employer offers health insurance, then your spouse is only eligible to enroll in the CGH Plans as secondary coverage.

Children up to age 26 as defined below.
- Natural-born children.
- Stepchildren
- Legally adopted children and children placed with you for adoption. Date of placement means the assumption and retention by a person of a legal obligation in anticipation of adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligation.
- Children who are required to be covered by reason of a Qualified Medical Child Support Order (“QMCSO”), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an Order qualifies as a QMCSO. You and your family members can obtain, without charge, a copy of such procedures from the Plan Administrator.
- Children up to age 26 whose primary residence is with the employee and who depend upon the employee for support and maintenance, for whom the employee or employee’s spouse has been named legal guardian. The company will require proof of legal responsibility in order for them to become an eligible family member.
- Disabled children age 26 and over, subject to the plan requirements for eligibility.*

*See your Summary Plan Description, available from Human Resources for full disabled child eligibility requirements and definitions.

BENEFIT ELECTION CHANGES DURING THE YEAR MAY BE MADE FOR THE FOLLOWING REASONS:

| Changes in the Employee’s legal marital status such as marriage, divorce, or the death of a spouse. | A change in the number of dependents such as birth, death, or adoption. | A dependent becomes eligible or ceases to be eligible for coverage due to age or employment status. |

An election change must be made within 30 days of the qualifying event.

PRETAX ELECTIONS
Some Employee premiums will be deducted on a pre-tax basis through payroll deduction. Due to IRS rules, elections cannot be revoked or changed during the plan year, unless you experience a qualifying event or “Status Change” as described above.
## BENEFIT CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Carrier</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>Self-Funded Administered by UMR</td>
<td>800-826-9781 <a href="http://www.umr.com">www.umr.com</a></td>
</tr>
<tr>
<td>Locate In-Network Providers</td>
<td>UMR</td>
<td>800-346-2126 (Option 1) <a href="http://www.ebcflex.com">www.ebcflex.com</a></td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>UMR</td>
<td>815-626-8760</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>Employee Benefits Corporation</td>
<td>800-346-2126 (Option 1) <a href="http://www.ebcflex.com">www.ebcflex.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Moeller, Myers &amp; Associates, PC</td>
<td>815-626-8760</td>
</tr>
<tr>
<td>Additional Company Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Voluntary Benefits</td>
<td>See CGH Medical Center Human Resources</td>
<td></td>
</tr>
</tbody>
</table>

### CGH Medical Center Human Resources

**Tracey McCaslin**  
**Benefits Administrator**

<table>
<thead>
<tr>
<th>PHONE</th>
<th>ADDRESS</th>
</tr>
</thead>
</table>
| 815.625.0400 x5664  
815.625.6175 (FAX) | 100 E. Le Fevre Rd.  
Sterling, IL 61081 |

**EMAIL:** Tracey.Mccaslin@cghmc.com
HOW MY MEDICAL PLAN WORKS

Participating Provider Option (PPO) Plan

The CGH Medical Center Health Plans use a PPO Network, which is all about choice. You get to choose which providers to visit each time you need care, and you can help control your own medical costs by choosing providers from within the PPO. When you go out-of-network, you can visit any doctor or hospital you want, but you pay a greater portion of the cost.

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you visit a provider that is within the PPO network, you will maximize the benefits of your medical plan. You do not have to select a Primary Care Physician, nor do you need a referral to see a specialist. Simply visit any doctor you choose within the PPO network for your medical need.</td>
<td>Your plan allows you to visit any provider you want, even if they are not within the PPO network. However, you will pay more for the services of any provider who is out-of-network, and you will have to satisfy your out-of-network deductible before the plan’s coinsurance kicks in.</td>
</tr>
<tr>
<td>Even within the PPO Network, you are responsible for the annual deductible before your plan begins paying coinsurance for most benefits. After your deductible is met, you are only responsible for your portion up to your annual out-of-pocket maximum.</td>
<td>When you visit an out-of-network provider, the plan bases its payments on what it considers the usual &amp; customary rate (U&amp;C) for each service provided. If the charge incurred is more than the U&amp;C limit set forth by the plan, you are responsible for paying the full difference between the charge and what the plan pays.</td>
</tr>
</tbody>
</table>

*All services under the PPO Plan must be provided by participating providers to be covered at the In-Network benefit level. Services received elsewhere will be paid at the Out-of-Network level of benefits.*

Locate a participating provider at [www.umr.com](http://www.umr.com) or call UMR at 800-826-9781.

Pre-Certification Process

**Why do we have a Pre-Certification Requirement?**
In order to ensure that all covered members are receiving the necessary and appropriate health care while providing the most cost effective alternatives and avoiding unnecessary expenses.

**What Treatment Requires Pre-certificate?**
Inpatient Hospitalization, including:
- Inpatient maternity stays over 48 hours for normal delivery and 96 hours for C-section
- Inpatient behavioral health
- Transplant and related services
- Skilled nursing facility (extended care)
- Residential treatment

**When must I pre-certify?**
At least 2 business days in advance of a scheduled in-patient admission or within 2 business days of an emergency admission.

**Who must pre-certify?**
You (the plan member), your family member, or your physician may pre-certify your treatment. However, you are responsible for ensuring pre-certification happens. Pay close attention if you use out-of-network providers --they will normally NOT pre-certify for you by default.

**How do I pre-certify?**
Call 866-494-4502 BEFORE you/your family member has a procedure done. Have your insurance card and ID number available.
**MEDICAL “BASE” PLAN SUMMARY & RATES**

*Please reference the Summary Plan Description for full benefits and exclusions of the Plan.*

<table>
<thead>
<tr>
<th>Network Provider: UHC Choice Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>$750</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td><strong>Coinsurance (You Pay)</strong></td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td><strong>Out-Of-Pocket Maximum</strong></td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overview of Benefits Paid by Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGH*</td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

*Services provided by an in-network provider that are not available at CGH will be paid as part of CGH benefit level.*

<table>
<thead>
<tr>
<th>Preventative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td>(PCP) $25 Copay</td>
</tr>
<tr>
<td>(SPC) $25 Copay</td>
</tr>
<tr>
<td>Emergency Room Services</td>
</tr>
<tr>
<td>(MUST be a true emergency)</td>
</tr>
<tr>
<td>You Pay 20%</td>
</tr>
<tr>
<td>Deductible Waived if Admitted</td>
</tr>
<tr>
<td>Emergency Transportation</td>
</tr>
<tr>
<td>You Pay 20%</td>
</tr>
<tr>
<td>Deductible Waived</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>(Facility) 100% Covered</td>
</tr>
<tr>
<td>(Physician) You Pay 20%</td>
</tr>
<tr>
<td>Urgent Care</td>
</tr>
<tr>
<td>You Pay 20%</td>
</tr>
<tr>
<td>You Pay 30%</td>
</tr>
<tr>
<td>You Pay 50%</td>
</tr>
</tbody>
</table>

Check for Doctors, Hospitals, and Clinics Covered by our CGH Plan by using [www.umr.com](http://www.umr.com) or 800-826-9781

<table>
<thead>
<tr>
<th>Prescription Drug Benefits (Out-of-Network is Not Covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGH Pharmacy Price per 31 day supply</td>
</tr>
<tr>
<td>Pharmacy Annual Out-of-Pocket Maximum: $4,350 (single) / $8,700 (family)</td>
</tr>
<tr>
<td><strong>Generic</strong></td>
</tr>
<tr>
<td>$4 Copay</td>
</tr>
<tr>
<td>$35 Copay</td>
</tr>
<tr>
<td><strong>Preferred Brand, Formulary</strong></td>
</tr>
<tr>
<td>$15 Copay</td>
</tr>
<tr>
<td>$50 Copay</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand, Non Formulary</strong></td>
</tr>
<tr>
<td>You Pay 50%</td>
</tr>
<tr>
<td>You Pay 50%</td>
</tr>
<tr>
<td><strong>Specialty Drugs</strong></td>
</tr>
<tr>
<td>Must be reviewed and approved by PBM before purchase! Must be obtained through CGH Pharmacy for benefits to apply. Refer to SBC for details.</td>
</tr>
<tr>
<td>You Pay 50%</td>
</tr>
<tr>
<td>You Pay 50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per-Paycheck Employee Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>FT No Tobacco</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Single + Child(ren)</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

7
MEDICAL “VALUE” PLAN SUMMARY & RATES

Please reference the Summary Plan Description for full benefits and exclusions of the Plan.

<table>
<thead>
<tr>
<th>Network Provider: UHC Choice Plus</th>
<th>CGH</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$5,000</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Coinsurance (You Pay)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>You Pay 30%</td>
<td>You Pay 40%</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>You Pay 30%</td>
<td>You Pay 40%</td>
<td></td>
</tr>
<tr>
<td><strong>Out-Of-Pocket Maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,500</td>
<td>$6,000</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$12,000</td>
<td></td>
</tr>
<tr>
<td><strong>Overview of Benefits Paid by Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CGH*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Services provided by an in-network provider that are not available at CGH will be paid as part of CGH benefit level.

Preventative Care

- No Charge
- No Charge
- Not Covered

Office Visits

- (PCP) $35 Copay
- (SPC) $35 Copay
- (PCP) $100 Copay
- (SPC) $125 Copay
- Not Covered

Emergency Room Services (MUST be a true emergency)

- You Pay 30%
- Deductible Waived if Admitted
- You Pay 30%
- Deductible Waived if Admitted
- Not Covered

Emergency Transportation

- You Pay 30%
- Deductible Waived
- You Pay 30%
- Deductible Waived
- Not Covered

Hospitalization

- You Pay 30%
- You Pay 40%
- Not Covered

Urgent Care

- You Pay 30%
- You Pay 40%
- Not Covered

Check for Doctors, Hospitals, and Clinics Covered by our CGH Plan by using www.umr.com or 800-826-9781

<table>
<thead>
<tr>
<th>Prescription Drug Benefits (Out-of-Network is Not Covered)</th>
<th>CGH Pharmacy Price per 31 day supply</th>
<th>Rx Benefits Network Pharmacy Price per 31 day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacy Annual Out-of-Pocket Max: $3,350 (single) / $7,700 (family)</td>
<td>Pharmacy Annual Out-of-Pocket Max: $850 (single) / $1,700 (family)</td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$10 Copay</td>
<td>$50 Copay</td>
</tr>
<tr>
<td><strong>Preferred Brand, Formulary</strong></td>
<td>$30 Copay</td>
<td>$75 Copay</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand, Non Formulary</strong></td>
<td>You Pay 50%</td>
<td>You Pay 50%</td>
</tr>
</tbody>
</table>

**Specialty Drugs**

Must be reviewed and approved by PBM before purchase! Must be obtained through CGH Pharmacy for benefits to apply. Refer to SBC for details.

- You Pay 50%
- You Pay 50%

<table>
<thead>
<tr>
<th>Per-Paycheck Employee Premiums</th>
<th>FT No Tobacco</th>
<th>FT Tobacco</th>
<th>PT No Tobacco</th>
<th>PT Tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$14.69</td>
<td>$36.70</td>
<td>$41.11</td>
<td>$58.72</td>
</tr>
<tr>
<td>Single + Child(ren)</td>
<td>$30.24</td>
<td>$89.36</td>
<td>$86.27</td>
<td>$133.11</td>
</tr>
<tr>
<td>Family</td>
<td>$40.86</td>
<td>$100.57</td>
<td>$95.54</td>
<td>$143.31</td>
</tr>
</tbody>
</table>
CGH Medical Center offers you two different FSA options: a Medical Reimbursement Account and a Dependent Care Reimbursement Account. By using these accounts, you can save money and bring home more of your income by paying for medical care and dependent care expenses using PRE-TAX dollars from your payroll.

You can put up to the IRS maximum allowed contribution amount per year in your medical flexible spending account and dependent care account.

**IMPORTANT TO NOTE:**
- You must enroll within 30 days from date of hire, or wait until the next Open Enrollment period.
- FSA elections do not roll over from year to year. If you would like to continue your FSA, you must re-elect this benefit yearly.

The following chart illustrates the financial benefits of participating in these accounts when you have out-of-pocket medical and dependent care expenses.

In this example, an employee who puts aside money in the medical and dependent care FSAs will bring home $1,500 more per year than they would without the FSAs! This is an example for reference only, and your actual savings will vary based on your income, expenses, FSA election amounts, and tax rate.

This is an example for your reference only and actual amounts will vary based on your income, expenses, FSA election amount and tax rates.

<table>
<thead>
<tr>
<th>Pre-tax Savings Example</th>
<th>Without Flex Accounts</th>
<th>With Flex Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Monthly Salary</td>
<td>$3,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>Pre-Tax Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Dental Premiums</td>
<td>($125)</td>
<td>($125)</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>$0</td>
<td>($100)</td>
</tr>
<tr>
<td>Dependent Care Expenses</td>
<td>$0</td>
<td>($400)</td>
</tr>
<tr>
<td>Resulting in Taxable Monthly Income</td>
<td>$3,375</td>
<td>$2,875</td>
</tr>
<tr>
<td>Taxes: federal, state, FICA at 25 combined%</td>
<td>($844)</td>
<td>($719)</td>
</tr>
<tr>
<td>Out of pocket medical expenses</td>
<td>($100)</td>
<td>Already deducted</td>
</tr>
<tr>
<td>Out of pocket dependent care expenses</td>
<td>($400)</td>
<td>Already deducted</td>
</tr>
<tr>
<td>Resulting in Monthly Take-Home Pay</td>
<td>$2,031</td>
<td>$2,156</td>
</tr>
<tr>
<td>Annual Take-Home Salary</td>
<td>$24,372</td>
<td>$25,872</td>
</tr>
</tbody>
</table>


FLEXIBLE SPENDING ACCOUNT FAQS

WHY DO I WANT TO PARTICIPATE?
By signing a participating agreement, you agree to have your salary reduced by the agreed upon amount. Therefore, you are not responsible for federal income tax withholding or FICA on the amount of the reduction, thereby saving you 7.65% on FICA, plus whatever income tax you would be obligated to pay on this amount. Another advantage of using an FSA is that the entire amount you elect to contribute for the plan-year is available for you to use at the start of the year even though you have not actually contributed it yet.

WHEN DO I MAKE MY ELECTION?
You need to make your election during Open Enrollment at your employer. This usually occurs once per year prior to the start of the new plan year. The start of the plan year may vary.

CAN I CHANGE MY BENEFIT ELECTION MID-YEAR?
Medical reimbursement accounts can be changed with a qualifying event (i.e. marriage, divorce, death or a spouse or child, birth or adoption of a child, termination of employment of your spouse, or a change in work schedule). You may change your reimbursement election if you were enrolled in the plan prior to the qualifying event and you wish to change your election.

Changes must be made within 30 days of the event.

Dependent care reimbursement accounts can be changed with a qualifying event (i.e. birth or death of a child, adoption of a child, dependent is no longer eligible for daycare, change in employment status thus changing the need for daycare, changing daycare providers, or a cost increase or decrease in daycare).

WHAT HAPPENS IF MY REIMBURSEMENT REQUEST EXCEEDS THE BALANCE IN MY ACCOUNT?
Your medical reimbursement account claims will be paid in full, up to the annual amount you have elected to have withheld for that plan year.

WHAT HAPPENS TO THE MONEY IN MY ACCOUNT IF I SHOULD TERMINATE EMPLOYMENT?
You would be entitled to reimbursement for expenses which were incurred within the same plan year and before your termination date. Your plan allows you to submit claims up to 180 days after termination in the plan.

WHAT HAPPENS TO ANY MONEY LEFT OVER AT THE CLOSE OF THE PLAN YEAR?
Your plan allows a “Grace Period” of 2.5 months so you may use any remaining money between January 1st and March 15th following the close of the plan-year (December 31st).

All receipts for expenses incurred during the plan year and grace period are due by March 31st. Any money left in your account after the grace period ends is forfeited to your employer.

WHEN CAN I INCUR CLAIMS?
Your plan year allows you to incur claims from January 1st - December 31st, each year. There is an additional “Grace Period” allowing you to incur claims through March 15th, of the next plan year.

For example: You may incur claims January 1st, 2019 - December 31st, 2019. Using the “grace period” you may continue to incur claims up until March 15th, 2020.

WHAT IS THE FILING DEADLINE FOR CLAIMS SUBMISSION?
You may file claims up through March 31st of the year following the end of the plan-year.

For example: If you incur claims January 1st, 2019 - December 31st, 2019, you will have until March 31st, 2020 to submit claims.
CGH Medical Center offers you the option to buy affordable Dental Insurance through UMR.

On this plan, you may visit any dentist you choose - there is no “network!” However, the plan does base its payments off price levels it considers “usual & customary” so if your dentist charges more than the plan allows for a specific service, you will receive a bill for the remaining balance.

Please refer to your plan documents for a full list of covered benefits listed under each class of service.

<table>
<thead>
<tr>
<th>Dental Benefit Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum Benefit for Class I, II, III services combined</td>
<td>$1,800</td>
</tr>
<tr>
<td>Orthodontia Maximum Lifetime Benefit</td>
<td>$1,500 (Covered dependent children under age 19)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I: Diagnostic &amp; Preventative Care</td>
<td>Covered 100% - No deductible</td>
</tr>
<tr>
<td>Like cleanings, exams, x-rays</td>
<td></td>
</tr>
<tr>
<td>Class II: Basic Restorative Services</td>
<td>Covered 80% - No deductible</td>
</tr>
<tr>
<td>Like cavity fillings</td>
<td></td>
</tr>
<tr>
<td>Class III: Major Restorative Services</td>
<td>Covered 50% - No deductible</td>
</tr>
<tr>
<td>Like root canals, crowns, implants</td>
<td></td>
</tr>
<tr>
<td>Class IV: Orthodontic Services</td>
<td>Covered 50% - No deductible</td>
</tr>
<tr>
<td>For covered dependent children only</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per-Paycheck Employee Premiums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$3.70</td>
</tr>
<tr>
<td>Family</td>
<td>$11.86</td>
</tr>
</tbody>
</table>

**BE SMILEY!** It’s important to see a dentist twice a year, and not just for your teeth! Did you know that gum disease has been linked to heart disease, strokes, osteoporosis, diabetes, and Alzheimer’s? Taking care of your mouth is taking care of your body.
Company-Paid Life/AD&D Plan: All active (non IMRF participating) full time employees regularly working over 20 hours per week will be enrolled in the CGH Group Life and AD&D Insurance plan through Symetra. This coverage is provided by CGH at no cost to you. Your Company-Paid Life and AD&D benefit is in the amount of 1X earnings to $200,000. This benefit the policy pays more money if you die in a covered accident. If you survive a serious accident, it can pay you money for certain severe injuries, such as loss of vision, hearing and limbs. Employees participating in IMRF receive a Life Insurance benefit through IMRF and are not eligible for this benefit.

If you do not update your beneficiaries it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically! You may do so by visiting www.aflacatwork.com.

Voluntary Life/AD&D Plan: Symetra’s Group Voluntary Term Life Insurance provides term life insurance at affordable group rates. Your employer may offer basic term life, but it may not be enough for your needs. Symetra’s Term Life Insurance can help protect your loved ones if you die during your working years. They can use it to help pay for housing and other expenses, including your final arrangements. If the plan includes an Accidental Death and Dismemberment (AD&D) benefit, the policy pays more money if you die in a covered accident. If you survive a serious accident, it can pay you money for certain severe injuries, such as loss of vision, hearing and limbs. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck. Both IMRF and non-IMRF participating employees may choose voluntary life/AD&D coverage.

Employees must be legally authorized to work in the U.S. and actively working at a U.S. location. Spouses and dependents must live in the U.S. to receive coverage.

*Important Note about Voluntary Life Coverage:
As a new hire, this is your chance to elect up to the guarantee issue amount without answering medical questions. If you decline coverage now, your future approval will be subject to medical underwriting.

<table>
<thead>
<tr>
<th>Term Life/AD&amp;D Coverage Amounts</th>
<th>Employee: $10,000 - $500,000 in $10,000 increments, up to 5x your earnings.</th>
<th>Spouse: Elect from $5,000 - $100,000 in $5,000 increments, not to exceed 50% of employee’s benefit amount.</th>
<th>Child(ren)*: $10,000. *To age 19, 25 if a full-time student.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantee Issue Amount*</td>
<td>Employee: $150,000, if you are under age 60; $40,000 if you are between age 60 to 69 years of age; $20,000 if you are age 70 and over.</td>
<td>Spouse: $50,000 if your spouse is under age 60; $20,000 if your spouse is between age 60 to 69.</td>
<td>Child: $10,000 (6 months to 19 years or 25 if full-time student)</td>
</tr>
<tr>
<td>Reduction in Coverage Due to Age</td>
<td>The Life Insurance Benefit and Principal Sum will reduce by the percentage indicated below. This reduction will be effective on the Policy Anniversary Date following the date you attain the age shown below. These reductions also apply if 1) you become covered under the Policy or 2) your coverage increases.</td>
<td>Your Age</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Your % Reduction</td>
<td>35%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>The reduced amount of coverage will be rounded to the next higher multiple of $500, if not already a multiple of $500 and an appropriate adjustment in premium will be made.</td>
<td>*Your Spouse’s coverage terminates when he or she attains age 70.</td>
<td></td>
</tr>
</tbody>
</table>

Employee Deferred Effective Date Provision: If, on the date you are to become covered on the Policy, for increased benefits or for a new benefit; you are not Actively at Work due to a physical or mental condition such coverage will not start until the date you are Actively at Work.

Spouse/Dependent Deferred Effective Date Provision: If, on the date your Dependent is to become covered under the Policy, for increased benefits or for a new benefit; he or she is confined in a hospital or confined elsewhere; such coverage will not start until he or she is discharged from the hospital or is no longer confined elsewhere and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days. *This Deferred Effective Date provision will not apply to Disabled children who qualify under the definition of Dependent Child.

Additional Features: Waiver of Premium, Accelerated Benefit, Conversion and Portability

Employee Cost: Login to www.aflacatwork.com to learn your personalized rate.
The following Disability Insurance options are for non-IMRF participating employees only. If you participate in IMRF, your disability benefit will be through IMRF and you are not eligible for these coverages.

**Company-Paid Long-Term Disability Plan:** Unum’s Long Term Disability Insurance can pay you a percentage of your gross monthly earnings (up to the maximum allowed by your plan) if you become ill or injured and can’t work for an extended period. It can help you pay your bills and protect your finances at a time when you have extra medical costs but don’t get a paycheck. The amount of benefit you receive from the plan may be reduced or offset by income from other sources — such as Social Security Disability Insurance. The length of time you can receive benefits is based on your age when you become disabled.

**Employees must be legally authorized to work in the U.S. and actively working at a U.S. location. Spouses and dependents must live in the U.S. to receive coverage.**

<table>
<thead>
<tr>
<th><strong>Company-Paid Long-Term Disability</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Benefit Amount</strong></td>
</tr>
<tr>
<td><strong>Benefit Duration</strong></td>
</tr>
<tr>
<td><strong>Pre-Existing Condition Exclusion</strong></td>
</tr>
<tr>
<td><strong>Elimination Period</strong></td>
</tr>
</tbody>
</table>

**Voluntary Short-Term Disability Plan:** Unum’s Short Term Disability Insurance can pay you a percentage of your gross weekly earnings (up to the maximum allowed by your plan) if you are unable to work for a few weeks or months due to an illness or injury — or childbirth. It can help you cover your expenses and protect your finances at a time when you’re not getting a paycheck and have extra medical bills. The amount of benefit you receive from the plan may be reduced or offset by income from other sources.

You can take advantage of affordable group rates and your cost is conveniently deducted from your paycheck. Employees must be legally authorized to work in the U.S. and actively working at a U.S. location.

**Important Note about Voluntary STD Coverage:**
As a new hire, this is your chance to elect short-term disability without answering medical questions. If you decline coverage now, your future approval will be subject to medical underwriting.

<table>
<thead>
<tr>
<th><strong>Voluntary Short-Term Disability</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weekly Benefit Amount</strong></td>
</tr>
<tr>
<td><strong>Benefit Duration</strong></td>
</tr>
<tr>
<td><strong>Pre-Existing Condition Limitations</strong></td>
</tr>
<tr>
<td><strong>Elimination Period</strong></td>
</tr>
<tr>
<td><strong>Employee Cost</strong></td>
</tr>
</tbody>
</table>
Introducing added protection for life’s unexpected moments.

If you’re like most people, you don’t budget for life’s unexpected moments.

But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

That’s the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.

But it doesn’t stop there. The group Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

The Aflac group Accident Advantage Plus plan benefits:

- A Wellness Benefit for covered preventive screenings
- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

How it works:

Aflac group Accident Advantage Plus High plan is selected.
You injure your leg in a covered accident and go to the hospital via ambulance.
The emergency room doctor diagnoses a fracture and treats you.
You leave the hospital on crutches.
The Aflac group Accident Advantage Plus High Plan pays: $2,930

This is only a brief overview of the products offered to you. For full plan documents, all details, exclusions, limitations, and other provisions, and to enroll, visit www.aflacatwork.com/Enroll
VOLUNTARY CRITICAL ILLNESS INSURANCE

Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who’s been diagnosed with a critical illness. You can’t help notice the difference in the person’s life—both physically and emotionally. What’s not so obvious is the impact a critical illness may have on someone’s personal finances.

That’s because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That’s the benefit of an Aflac Group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

This is a brief overview!

Critical Illness Insurance includes even more! See your rates, plan details, and enroll online at:

www.aflacatwork.com/Enroll

View Aflac’s Video:
http://www.aflac.com/videos/cIM/

But it doesn’t stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

How it works

Aflac Group Critical Illness Advantage pays a First Occurrence Benefit of $10,000
Hospital Indemnity Insurance helps cover your portion of the out-of-pocket costs associated with a stay in the hospital. This benefit can pay for needs that your medical insurance wouldn’t cover such as travel, lodging, or other daily living expenses you incur while you are hospitalized.

**Benefits Overview**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission Benefit per confinement (once per covered sickness or accident per calendar year for each insured)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Payable when an insured is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.</td>
<td></td>
</tr>
<tr>
<td>Hospital Confinement per day (maximum of 31 days per confinement for each covered sickness or accident for each insured)</td>
<td>$150</td>
</tr>
<tr>
<td>Payable for each day that an insured is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</td>
<td></td>
</tr>
<tr>
<td>Hospital Intensive Care Benefit per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)</td>
<td>$150</td>
</tr>
<tr>
<td>Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital’s Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital’s Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. <strong>This benefit is payable in addition to the Hospital Confinement Benefit.</strong></td>
<td></td>
</tr>
<tr>
<td>Intermediate Intensive Care Step-Down Unit per day (maximum of 10 days per confinement for each covered sickness or accident for each insured)</td>
<td>$75</td>
</tr>
<tr>
<td>Payable for each day when an insured is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital’s Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. <strong>This benefit is payable in addition to the Hospital Confinement Benefit.</strong></td>
<td></td>
</tr>
</tbody>
</table>

In order to receive benefits for accidental injuries due to a covered accident, an insured must be admitted within six months of the date of the covered accident (in Washington, twelve months).

**How it works**

Amount payable was generated based on benefit amounts for: Hospital Admission ($1,000), and Hospital Confinement ($150 per day).

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

*This is only a brief overview of the products offered to you. For full plan documents, all details, exclusions, limitations, and other provisions, and to enroll: visit www.aflacatwork.com/Enroll*
CGH Medical Center is proud to offer our employees the following additional benefits at no cost to you! All benefits are paid by the company and you will be automatically enrolled when eligible.

**EARNED TIME OFF (ETO)** (Based on actual hours worked up to 40 hours per week)

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 8</th>
<th>Year 9</th>
<th>Year 10-14</th>
<th>Year 15-20</th>
<th>Year 21+</th>
</tr>
</thead>
</table>

ETO covered vacation, sick days, holidays, and bereavement days.

ETO may be accrued to max of 480 hours (If your accrual exceeds 480 hours, it is paid out in cash the first pay period in July.

If you have 200 or more hours of ETO, you can cash in 20 hours per pay period (80 hours per year is the max cash in allowance.)

You also may “donate” ETO to other employee in time of need as long as you have over 200 hours in your ETO Bank and they are on approved leave.

**EMPLOYEE ASSISTANCE PROGRAM (EAP)**

<table>
<thead>
<tr>
<th>What is an EAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGH Medical Center provides you with professional assistance to identify and resolve personal problems that may interfere with your well-being and job performance. EAP counselors are available to offer you confidential assistance or referral information. Two free visits per year are included in this benefit and your insurance will continue covering mental health after that.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family and marital issues</td>
</tr>
<tr>
<td>• Emotional strains and stress</td>
</tr>
<tr>
<td>• Chemical dependency</td>
</tr>
<tr>
<td>• Alcohol dependency</td>
</tr>
<tr>
<td>• Financial concerns</td>
</tr>
</tbody>
</table>

Below is a list of CGH Medical Center option benefits that are offered to eligible employees. These are offered to employees at group and/or discounted rates. These benefits are paid for 100% by the employee.

**CORPORATE FITNESS OPTIONS**

Employees of CGHMC are eligible to join the Sterling Park District sports facilities at a special rate which will be payroll deducted from your paychecks.

If you choose to join a variety of other local fitness establishments, CGHMC will reimburse 25% of your membership cost.

**ADDITIONAL OPTIONAL BENEFITS**

More information is available in the “For Your Benefit” booklet or see HR for details

- Verizon Discount
- US Cellular Discount
- Tuition Reimbursement
- Travel Discounts

If you have questions regarding your additional benefits, contact Human Resources.
CGH Medical Center wants our employees to be secure in retirement. That’s why we offer the choice of two great retirement plans, as outlined below. Employees working 20 hours per week (.5FTE) or more are eligible to participate in the retirement plans. **This benefit is not limited to open enrollment: You may enroll and make changes at any time.**

If you choose the CGH Medical Center **Defined Contribution Pension Plan through One America**, you will automatically receive an annual contribution of 3% of your gross salary into your account from CGH Medical Center. On top of that, if you make elective contributions to this account, CGH will match 50% of your contribution up to the first 8% of your salary that you contribute (equaling an additional 4% of your salary). Your elective contributions are always yours to keep and the contribution made by CGH Medical Center become fully vested after you complete 3 years of service. One America enrollment can be completed online at www.cghretirement.org.

If you choose the **Defined Benefit Pension Plan through Illinois Municipal Retirement Fund (IMRF)** then you will contribute 4.5% of your gross annual salary per year. The amount that CGH contributes to the account varies each year and the actual value of your account is calculated at retirement. Your contributions are always yours to keep and the CGH contributions are 100% vested after you complete 10 years of service. **NOTE: Once you are in IMRF, you CANNOT opt out while still employed.** The IMRF enrollment form is located on Lifeline.

**PLEASE NOTE: YOU MAY PARTICIPATE IN BOTH PLANS AT THE SAME TIME, HOWEVER IF YOU DO SO, YOU WILL ONLY RECEIVE CONTRIBUTIONS FROM CGH TO THE IMRF PLAN. YOUR ONE AMERICA PLAN WOULD RECEIVE NO CGH CONTRIBUTIONS.**

Please refer to the chart below and on the following page for a side-by-side comparison between plans.

<table>
<thead>
<tr>
<th></th>
<th>ONE AMERICA</th>
<th>IMRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Code</td>
<td>401(a)/457(f)</td>
<td></td>
</tr>
<tr>
<td>Vesting</td>
<td>3 year cliff vesting</td>
<td>10 year cliff vesting</td>
</tr>
<tr>
<td>Pension Type</td>
<td>Defined Contribution - Contributions invested as directed by participant. Accumulation in account is available for retirement income.</td>
<td>Defined Benefit - Pension amount is calculated at retirement and depends on years of service and earnings later in career.</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Age 18</td>
<td>Age 18</td>
</tr>
<tr>
<td>Enrollment</td>
<td>May enroll at time of hire or any time thereafter.</td>
<td>May enroll at time of hire or any time thereafter.</td>
</tr>
<tr>
<td>Employee Contribution</td>
<td>Up to IRS limits</td>
<td>4.5% of earnings</td>
</tr>
<tr>
<td>Employer Match</td>
<td>3% to all participants regardless of their contribution. Matches 50% up to 8% employee contributions (maximum 7% employer contribution)</td>
<td>N/A</td>
</tr>
<tr>
<td>Normal Retirement</td>
<td>Age 62</td>
<td>Age 67</td>
</tr>
</tbody>
</table>
## RETIREMENT PLAN OPTIONS CONTINUED

<table>
<thead>
<tr>
<th></th>
<th>ONE AMERICA</th>
<th>IMRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Retirement</td>
<td>N/A</td>
<td>Retire between age 62-67 with less than 30 years service credit --&gt; Pension reduced 1/2% for each month under age 67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retire between age 62-67 with at least 30 but less than 35 years service credit --&gt; Pension reduced by lesser of 1/2% for each month under age 67 OR service credit &lt; 35 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retire with 35 or more years service credit and at least age 62 --&gt; No reduction</td>
</tr>
<tr>
<td>Pension Payment</td>
<td>Choices to participant - Include lump sum payment and various annuity options</td>
<td>Formula considers length of time in plan and earnings late in career.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calculated benefit increases each year by lesser of 3% or 1/2 of increase in Consumer Price Index for preceding year.</td>
</tr>
<tr>
<td>Withdrawals</td>
<td>Penalty and taxes would apply</td>
<td>No early withdrawal provisions</td>
</tr>
<tr>
<td>Early Retiree Health Continuation</td>
<td>COBRA coverage only</td>
<td>May continue on health plan by paying full premium</td>
</tr>
<tr>
<td>Separation Before Fully Vested</td>
<td>Prior to 3 years of service, employer portion lost.</td>
<td>Prior to 10 years employee contributions only are returned to employee - no investment earnings.</td>
</tr>
<tr>
<td>Post Retirement Death Benefit</td>
<td>No specific benefit</td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td>Undistributed money may be inherited by survivors depending on retirement choices</td>
<td>Surviving spouse may be eligible to receive 662/3 % of pension amount for rest of life.</td>
</tr>
<tr>
<td>Loan Provision</td>
<td>50% of Employee Contributions available for loan. Other terms and provisions apply.</td>
<td>No loan provision</td>
</tr>
</tbody>
</table>

### Logging into your OneAmerica account

**Go to:** [www.cghretirement.org](http://www.cghretirement.org)

**Verify your identity with your plans by providing:**
- Social Security Number
- Date of Birth
- Zip Code

**You will then be prompted to setup your new User ID and Password.** If you have more than one account, you do not need to login twice! You can toggle between accounts using the dropdown box found in the upper- left corner of your screen in the blue title bar.

**To reach a live operator at OneAmerica call:**
1-800-858-3829
Monday-Friday: 6am and 10pm Central Time Saturday: 7am and 1pm Central Time

**For investment related questions, contact:**
The Klaas Group/UBS (877) 846-9827
Karoline.oconnor@ubs.com
303 E. Main St., 3rd Floor Barrington, IL 60010
employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA

Premium Assistance Under Medicaid and The Children’s Health Insurance Program (CHIP) – Applies to Group Health Plans Only
If an Employee or the Employee’s child(ren) are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from State Medicaid or CHIP programs. If the Employee or his/her child(ren) aren’t eligible for Medicaid or CHIP, they won’t be eligible for these premium assistance programs but may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If the Employee or his/her dependents are already enrolled in Medicaid or CHIP and live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

If the Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer’s plan, the employer must allow the Employee to enroll in the employer plan if not already enrolled. This is called a “special enrollment” opportunity, and the Employee must request coverage within 60 days of being determined eligible for premium assistance. If the Employee has questions about enrolling in their employer’s plan, contact the Department of Labor at www.askebda.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861

Email: CustomerService@MyAKHiPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarh Hipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHIP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
State Relay 711

FLORIDA – Medicaid
Website: http://filemedicaidrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid
Website: http://dhfs. iowa.gov/mime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

REQUIRED NOTICES
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-serve/seniors/health-care/health-care-programs/programs-and-services/medicaid-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-8553
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalearn/index.htm
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-5075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care-program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyqualitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebisa
1-866-444-EBISA (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

Important Disclosures

Women’s Health and Cancer Rights Act of 1998
The Federal Women’s Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

a. Reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay
Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCOSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCOSO is a state court or administrative agency order that requires an employer’s medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer’s plan. QMCOSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCOSO applies, the employee must pay for the child’s medical coverage and will be required to join the Plan if not already enrolled.
The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The 2018 open enrollment period for health insurance coverage through the Marketplace began on Nov. 15, 2017, and ended on Feb. 15, 2018. Individuals must have enrolled or changed plans prior to Dec. 15, 2017, for coverage starting as early as Jan. 1, 2018. After Feb. 15, 2018, individuals can get coverage through the Marketplace for 2018 only if they qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

*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% of such costs.

HIPAA Notice of Privacy Practices
The CGH Medical Center Group Medical Plan (the "Plan"), which includes medical, dental and flexible spending account coverages offered under the CGH Medical Center Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of your personally identifiable health information. This Notice is being provided to inform you of the policies and procedures CGH Medical Center has implemented and your rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of your health information.

Use and Disclosure of Your Health Information by the Plan that Do Not Require Your Authorization:
The plan may use or disclose your health information (that is protected health information (PHI), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits. Your health information may also be used or disclosed in order for the Plan to carry out its own operations regarding the administration of the Plan and provide coverage and services to the Plan's participants. For example, the Plan may use your health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other
proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to your health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to you to allow you to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If you are an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation: As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to you on health-related benefits and services that may be of interest to you.

Notice in Case of Breach
CGH Medical Center is required maintain the privacy of your PHI; provide you with this notice of its legal duties and privacy practices with respect to PHI; and to notify you of any breach of your PHI.

Use and Disclosure of Your Health Information by the Plan that Does Require Your Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Your Rights with Respect to Your Health Information: You have the following rights under the Plan’s policies and procedures, and as required by HIPAA’s privacy rule:

Right to Request Restrictions on Uses and Disclosures: You may request the Plan to restrict uses and disclosures of your health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by you out of your own pocket. If you wish to request a restriction, please send it in writing to HIPAA Privacy Officer, at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400.

Right to Inspect and Copy Your Health Information: You may inspect and obtain a copy of your health information the Plan maintains. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400. Your request may be denied in whole or part and, if so, the Plan will provide you with a written explanation of the denial.

Right to an Accounting of Disclosures: You may request a list of disclosures made by the Plan of
your health information during the six years prior to your request (or for a specified shorter period of time), however, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which you provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting your HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400. The accounting will be provided within 60 days from your submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: You may request that the Plan communicate with you about your health information in a certain way or at a certain location if you feel the disclosure could endanger you. You must provide the request in writing to your HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: You may request a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. Please contact your HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400 to make this request.

The Plan’s Duties: The Plan is required by law to maintain the privacy of your health information as related in this Notice and to provide this Notice to you of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If you wish to exercise your rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, please contact the HIPAA Contact Person, at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081 815.625.0400. You may also file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated.

Important Notice from CGH Medical Center About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

It is important to note that both medical plans are considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CGH 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. CGH Medical Center has determined that the prescription drug coverage...
offered by the CGH Medical Center Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current CGH Medical Center coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current CGH 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 CGH Medical Center and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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