CHSGa

Innovating • Navigating • Aligning • **Healthcare**

Navigating Your Benefits

2022

Welcome

We are happy you are part of the CHSGa family! We believe the associates are the heart of the organization and you make the difference in the lives of people. As part of CHSGa's continued investment in people, each year we strive to offer a comprehensive benefit package that meets your and your family's needs and benefits the organization. This 2022 benefits guide will assist you in ***Navigating Your Benefits***. Please review the benefits guide carefully as you prepare to make your elections for the upcoming plan year. We have also included some helpful hints on utilizing and maximizing your benefits. As always, thank you for all you do!

About this Benefits Guidebook

This Benefits Guidebook describes the highlights of the benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this guidebook. If there is any discrepancy between the descriptions of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of our benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by the organization. To find the official plan documents, please visit your intranet site, which is listed on page **27** of this booklet.

CHSGa
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Participating Organizations

Affinis Hospice ...adding more life to each day
CHSGa Home Health
Community Ambulance
Community Health Foundation
ECP Distributors Setting the Standard in Service
Eldercare Pharmacy
Ethica Patients First
GA MedGroup
Health Pathway Care Coordination & Pharmacy Services
Health Systems Development, LLC
HelpLink Personal Emergency Response System
Integra Rehabilitation Your Pathway to Recovery
NextStep Care Options for You
System Administrative Services SAS

Community
HEALTH FOUNDATION

Community Health Foundation's (the Foundation) purpose is to provide ministry and support across the system to associates during a life crisis. Associates can donate through a voluntary tax-deductible contribution. You can elect to make this donation when selecting your benefit elections. One hundred percent of all donations made to the Foundation go to the Hearts to Hands Program.

The Hearts to Hands Program provides meaningful financial assistance to fellow associates by assisting them with their critical needs during life crises.

If you would like to help make a difference, you can elect to contribute when making your benefit selections.

For additional information about the Foundation please visit our web page at **http://www.chs-ga.org/OurFoundation**

Community Health Foundation's mission is to serve others through positive change by

- Helping to shape and model a servant leadership culture throughout the organization
- Serving as the organization's primary vehicle for ministry and associate support

Associate Benefits Eligibility

Benefit	Regular Full-Time (30+ hours per week)	Regular Part-Time (20-29 hours per week)	Temporary	PRN
Benefits Begin Immediately				
401(k)	✓	✓	✓	
Employee Assistance Program (EAP)	✓	✓	✓	✓
Benefits begin the first of the month following 60 days of employment				
Medical	✓			
Dental	✓			
Vision	✓	✓		
Employer Paid Life Insurance	✓			
Employer Paid Short-term Disability (STD)	✓			
Voluntary Life & AD&D	✓	✓		
Voluntary Short-term Disability (STD)		✓		
Voluntary Long-term Disability (LTD)	✓	✓		
Voluntary Critical Illness	✓	✓		
Flexible Spending Accounts (FSA)	✓			
NEW HIRES: You have 30 days from your hire date to login to Workday and make your benefit elections.				

Dependent Benefits Eligibility

Associates who are eligible to participate in our benefit programs may also enroll their dependents. For the purposes of our benefit plans, your dependents are defined as follows:

- Your spouse: legal spouse (spouses with access to medical and/or dental coverage through his or her employer are not eligible to participate in our plans),
- For medical, dental and vision: your dependent children to age 26 (your dependent children are eligible for medical coverage until the end of the month in which they turn 26, regardless of student status, marital status, residency or financial dependency),
- For additional voluntary term life insurance: your unmarried children age 14 days to 26 years,
- Your children over age 26 who are mentally or physically disabled and dependent upon you for support (proof of condition and dependence must be submitted); and/or,
- Your children who are covered by a Qualified Medical Child Support Order (QMCSO)

1095-C

We will be sending out your personalized 2021 Form 1095-C, an Affordable Care Act form. The organization is required to furnish these forms to associates who worked an average of 30 hours during 2021, as well as anyone who enrolled in our medical plan during any month of 2021.

Form 1095-C provides information about the health coverage offered by the organization and, if applicable, about whether you enrolled in this coverage. You do need to retain this form with your tax records.

To ensure you receive the form with correct information, your name and the name of your covered dependents (spouse and/or children) needs to match exactly what is on your and your dependent's social security cards to what is in Workday®.

Contact your benefits representative if you need to make an update.

For more details about the Form 1095-C you may visit the IRS website at: https://www.irs.gov/forms-pubs/about-form-1095-c

Dependent Verification

Upon enrollment in the medical and/or dental plan, all dependents will be subject to a dependent verification process through our partner, Alight.

If you enroll in dependent coverage, you will receive a packet to your home address outlining the steps you need to follow to validate your dependents. This is referred to as the verification process, which will last for a period of six weeks. Alight provides three methods for submitting required documentation: online, mail or fax.

Failure to complete and submit all required documentation by the deadline listed in the packet will result in the dependents being deemed ineligible and removed from coverage. Alight will provide assistance and resources to those associates who are interested in locating coverage for the dependents deemed ineligible.

Why Do I Pay For Some Benefits With Pre-tax Dollars?

While not all benefits qualify for pre-tax contributions, there is a definite advantage for those that do. Taking the deductions out before taxes are calculated lowers the amount of your taxable income. Therefore, you pay less in taxes.

The organization shares the cost of some benefits with you. The part of the cost you are responsible for will be automatically deducted from your paycheck either before or after your taxes are calculated. Please see chart below:

Benefits	Pre-tax or Post-tax?	Who pays the cost?
Medical	Pre-tax	Organization and You
Dental	Pre-tax	Organization and You
Vision	Pre-tax	You
Organization Paid Basic Life Insurance	N/A	Organization
Organization Paid Short-term Disability	N/A	Organization
Health Savings Account (HSA)	Pre-tax	You
Flexible Spending Account (FSA)	Pre-tax	You
401(k) Retirement Plan	Pre-tax	You
Voluntary Term Life/AD&D	Post-tax	You
Voluntary Short-term Disability (part-time only)	Post-tax	You
Voluntary Long-term Disability	Post-tax	You
Voluntary Critical Illness	Post-tax	You

Medical Coverage

Medical Plans

The organization values the health of associates and their families. We review the plans regularly and make adjustments when needed to help balance increased healthcare costs and expenses imposed under the Affordable Care Act, while continuing to offer quality benefit plans.

For 2022 we will be offering three medical insurance plans administered by Benefit Administrative Systems (BAS) and Fairos utilizing an open access plan. We have eliminated the traditional network for medical facilities and physicians allowing you to seek care at any provider you choose. You now have one level of benefits and there are no reduced out of network benefits.

BAS & FAIROS will be our Medical Plan Partners, with BAS continuing to be your first point of contact. Keep their number handy (1-800-843-3831) for any needs, including:

- Locating providers
- Questions about your coverage
- Verifying eligibility with a provider
- Personal Assistant Service: Available to help you or a covered family member navigate your healthcare plan and manage any medical bills following a serious accident or catastrophic health condition.
- All medical billing issues including:
  - Reviewing your claims for discrepancies or duplications
  - Obtaining any information needed to process outstanding/pending claims
  - Explain benefit payments and true patient balance due if any after medical benefit have been paid

BAS has partnered with FAIROS to ensure hospital, facility and provider charges do not exceed the Organization's health plan's limits and that they are for services rendered and nothing more. Please note, you will need to present your new ID card to your provider after 1/1/2022 and let them know your new plan allows you to seek care from any provider.

If the provider has any questions they should call BAS Customer Service immediately at 800-843-3831. This phone number will also be listed on your ID card. You should only pay your copay upfront (if applicable). If a provider requests full payment up front have them call BAS Customer Service so they can explain the benefits under the plan. Once services are rendered, your provider will need to submit the claim to the address on the back of your ID card. Once BAS processes your claim you will receive an Explanation of Benefits that will have your responsibility listed in a yellow highlighted box. You will need to pay this amount to the provider. If a provider sends you a statement that is for more than the patient responsibility on your Explanation of Benefits this is considered a balance bill. If you receive a balance bill, please call BAS customer service. The BAS customer service representative will review the statement with you and confirm if it is a balance bill. If it is a balance bill BAS will connect you with a Member Advocate at Fairos who will work with your provider to resolve the additional billing.

Certain procedures and/or treatments require precertification in order to be covered under the plan. If you have questions about which procedures require prior authorization, please call the number on your medical ID card.

Medical Plan Comparison

1 Option 1: Traditional Copay Plan

The Traditional Copay Plan works more like a conventional medical plan where members pay copays for some services (copays are fixed fee amounts you pay at the time you receive services). The Traditional Copay Plan also uses co-insurance for some services (co-insurance is the portion of expense you must pay for care, in most cases, after meeting your deductible). The deductible is a set amount that typically you must pay before co-insurance starts. See table on next page for deductible amounts.

2 Option 2: Qualified High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Plan

The Qualified HDHP with HSA Plan puts you in charge of how your health care dollars are spent. It is very important that you understand you are responsible to pay the first dollars until you meet your $2,800 deductible. This includes office visits, prescriptions, and inpatient/outpatient procedures - there are no medical copayments on this plan.

3 Option 3: Basic Medical Plan

The Basic Medical Plan offers only the minimum benefits required under the Affordable Care Act (ACA). This plan provides ACA minimum essential actuarial value of 60% and meets the ACA affordability standards according to the Federal Poverty Line Safe Harbor.

It is very important you understand the basic medical plan and you are responsible to pay the first dollars until you meet your $6,250 deductible. This includes office visits, prescription drugs and inpatient/outpatient procedures. There are no copayments on this plan.

Medical Overview	Option 1: Traditional Copay Plan	Option 2: HDHP with HSA Plan	Option 3: Basic Medical Plan
Calendar Year Deductible			
Associate	$2,500	$2,800	$6,250
Associate + 1	$5,000	$5,600	$12,500
Family (Associate + 2 or more)	$7,500	$5,600	$12,500
Preventive Care	100%	100%	100%
Coinsurance	Plan pays 80% after $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible
Copays			
PCP Office Visit	$30	No copays. Pay $2,800 deductible then plan pays 80%	No copays. Must pay $6,250 deductible then plan pays benefits
Specialist Office Visit	$50		
Urgent Care Facility	$65		
Out-of-Pocket Max (includes copays)			
Associate	$6,850	$6,550	$6,250
Family	$13,700	$13,100	$12,500
Inpatient			
Facility Charges	Plan pays 80% after $1,700 copay and $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible
Physician Charges	Plan pays 80% after $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible
Outpatient			
Facility Charges	Plan pays 80% after $500 copay and $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible
Physician Charges	Plan pays 80% after $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible
Emergency Room (for emergency use only) NOTE: plan will not pay any benefit for non-emergency use	Plan pays 80% after $400 copay and $2,500 deductible	Plan pays 80% after $2,800 deductible	Plan pays benefits after $6,250 deductible

Associate contributions for medical can be found on page 21.

Medical Coverage

Benefit Administrative Systems, LLC

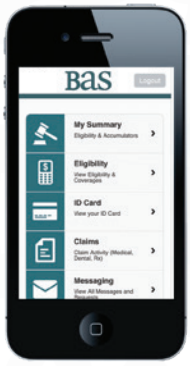
Medical Plans

The third-party administrator, BAS has developed a three-tiered approach to customer care for our members. Their customer care unit is a team of specialists with extensive experience and knowledge of claims processing and benefit plan language. When you call our toll free number you'll be greeted by a live receptionist who will transfer your call to the appropriate specialist.

Toll free number: 800.843.3831

BAS Member Outreach and Education on Balance Billing

BAS has assembled a special team dedicated to connect with members who have recently had services provided in a hospital setting. This outreach will be via text message and live phone calls from the BAS Member Service Team. The Team will educate members on how to identify a potential "Balance Bill" and what the next steps will be.



Download the BAS Mobile App Today!

The BAShealth app connects members to key information regarding their benefits through their smartphone. Similar to the information in the BAS portal, members also have access to their personal ID card, and can email the card directly from their phone. Anytime the member has a question, you can click contact us to be connected to BAS.

To register use group number:
112722 (live in Georgia)
112721 (live outside of Georgia)

IT portal support is 708.647.4444

3 Levels of Care

LEVEL 1: CUSTOMER CARE AGENT

Customer care agents can provide essential benefit information including provider lookups, coverage details and pre-certification questions.

- Questions regarding the health coverage,
- Questions regarding how a claim was billed and/or paid,
- Questions & assistance with services requiring pre-certification or pre-determinations,
- Assistance with locating a preferred provider,
- Providing contact information for community or government sponsored programs, such as Medicaid, Medicare, American Lung Society, etc.

LEVEL 2: MEMBER ADVOCATE

Member advocates provide advanced guidance through challenging health benefit issues. Member advocates offer objective guidance to empower you to make informed decisions.

- Helping members understand tests, treatments, and medications recommended or prescribed by their physicians,
- Help make an appointment,
- Assist through complex medical conditions,
- Assist members in arranging for home-care equipment following a discharge from the hospital,
- Coordinating hospice and other services for terminally ill members

LEVEL 3: PERSONAL ASSISTANT SERVICE

The personal assistant service is a unique program offering outbound calls to members identified as experiencing a catastrophic illness or injury. The personal assistant service will help with all aspects of the treatment plan, including coordinating calls with the case manager and physician. We want you to focus on recovering if a catastrophic illness or injury occurs – that's why our personal assistant service will be with you throughout your treatment plan to ease the burden of coordinating care.

- Proactive approach focusing on getting the member healthy following a catastrophic illness or injury,
- Assisting a member with reconciling all claim activity,
- Working with providers to resolve balance due and duplicate billing issues,
- Coordinate payments between multiple benefit plans and Medicare,
- Coordinate care with the case manager and physician, if necessary

Prescription Drug Coverage

Prescription drug coverage is provided automatically when you enroll in one of the medical plan options. For 2022, the prescription drug plan will be offered through MAXORplus.

You are encouraged to ask your doctor if a generic equivalent is available when receiving a prescription; this will save you money.

Also partnering on the prescription drug coverage is RxResults, which is an evidence-based prescription drug program designed to control cost. You may receive communications in the mail from MAXORplus or RxResults with notifications of changes and/or cost saving strategies.

External Retail Pharmacy Traditional Copay Plan		
	30 day	90 day
Tier 1	$20.00	$60.00
Tier 2	$55.00	$165.00
Tier 3	$90.00	$270.00
Tier 4	20% up to $120.00	N/A
HDHP with HSA Plan		
You pay 100% of the prescription cost until the deductible is met. Then, you pay the copays listed above until the out-of-pocket maximum is met. Once the out-of-pocket maximum is met, the plan pays 100%.		
Basic Medical Plan		
You pay 100% of the prescription cost until the deductible is met. Once the deductible is met, then the plan pays 100%.		

Health Pathway Pharmacy

Health Pathway Pharmacy (HPP), is pleased to offer a special benefit to our members again this year. **For those enrolled in the organization's medical plans**, specific generic drugs will be available to you in a 90-day supply at a $0 copay.

This plan offers a significant copay savings if you take generic medications for diabetes, cholesterol, hypertension, depression, anti-inflammatory, asthma, allergies, antineoplastic, estrogens, genitourinary, gout, prenatal vitamins, thyroid and ulcers. For the qualified high deductible and the basic medical plans medications for anti-inflammatory, gout, men's health and thyroid are excluded per the IRS.

See pages **9** and **10**.

The $0 copay will only be available for members enrolled in the organization's medical plans through Health Pathway Pharmacy.

To determine whether or not your generic prescription is included, please contact the pharmacy at 877.371.0735.

Member Prescription Discount Plan

Associates enrolled in the organization's health plan coverage are eligible for a tier discount on prescriptions. Member prescription discounts:

	30 day	90 day
Tier 1 copay	$15	$45
Tier 2 copay	$50	$150
Tier 3 copay	$80	$240

Call toll free 877.371.0735

Generic Savings Plan

HealthPathway Care Coordination & Pharmacy Services
a member benefit of CHSGa

$0 Copay Rx

Allergies/Asthma

Monotelukast chew 4mg tablets
Monotelukast chew 5mg tablets
Monotelukast 10mg tablets

Arthritis and Pain

Ibuprofen 600mg tablets
Ibuprofen 800mg tablets
Meloxicam 15mg tablets
Meloxicam 7.5mg tablets
Naproxen 250mg tablets
Naproxen 375mg tablets
Naproxen 500mg tablets

Anxiety/Depression

Bupropion XL 150mg tablets
Bupropion XL 300mg tablets
Citalopram 10mg tablets
Citalopram 20mg tablets
Citalopram 40mg tablets
Escitalopram 10mg tablets
Escitalopram 20mg tablets
Fluoxetine 10mg capsules
Fluoxetine 20mg capsules
Paroxetine 10mg tablets
Paroxetine 20mg tablets
Paroxetine 30mg tablets
Paroxetine 40mg tablets
Sertraline 100mg tablets
Sertraline 50mg tablets
Trazodone 100mg tablets
Trazodone 150mg tablets
Trazodone 50mg tablets

Cholesterol

Atorvastatin 10mg tablets
Atorvastatin 20mg tablets
Atorvastatin 40mg tablets
Atorvastatin 80mg tablets
Lovastatin 10mg tablets
Lovastatin 20mg tablets
Lovastatin 40mg tablets
Pravastatin 10mg tablets
Pravastatin 20mg tablets
Pravastatin 40mg tablets
Pravastatin 80mg tablets
Rosuvastatin 10mg tablets
Rosuvastatin 20mg tablets
Rosuvastatin 40mg tablets
Rosuvastatin 5mg tablets
Simvastatin 10mg tablets
Simvastatin 20mg tablets
Simvastatin 40mg tablets
Simvastatin 5mg tablets
Simvastatin 80mg tablets

Diabetes

Glimepiride 1mg tablets
Glimepiride 2mg tablets
Glimepiride 4mg tablets
Glipizide 10mg tablets
Glipizide 5mg tablets
Glipizide ER&XL 10mg tablets
Glipizide ER&XL 2.5mg tablets
Glipizide ER&XL 5mg tablets
Glyburide 1.25mg tablets
Glyburide 2.5mg tablets
Glyburide 5mg tablets
Glyburide micro 3mg capsules
Metformin 1000mg tablets
Metformin 500mg tablets
Metformin 850mg tablets
Metformin ER 500mg tablets
Metformin ER 750mg tablets
Pioglitazone 15mg tablets
Pioglitazone 30mg tablets
Pioglitazone 45mg tablets

Diabetic Supplies

Glucose Meter
(1 per member per year)
Glucose test strips 50 ct
(6 boxes/90 days)
Insulin syringes (200/90 days)
Insulin pen needles (200/90 days)

Gastrointestinal

Omeprazole 20mg capsules
Pantoprazole 40mg tablets

Gout

Allopurinol 100mg tablets
Allopurinol 300mg tablets

Men's Health

Tamsulosin 0.4mg capsules

Thyroid

Levothyroxine 100mcg tablets
Levothyroxine 112mcg tablets
Levothyroxine 125mcg tablets
Levothyroxine 137mcg tablets
Levothyroxine 150mcg tablets
Levothyroxine 175mcg tablets
Levothyroxine 200mcg tablets
Levothyroxine 25mcg tablets
Levothyroxine 300mcg tablets
Levothyroxine 50mcg tablets
Levothyroxine 75mcg tablets
Levothyroxine 88mcg tablets

Minerals/Electrolytes:

Potassium Chloride 10meq tablets
Potassium Chloride 20meq tablets

Women's Health

Anastrozole 1mg tablets
Estradiol 0.5mg tablets
Estradiol 1mg tablets
Estradiol 2mg tablets
Prenatal Vitamin Plus Low Iron tablets
Tamoxifen 20mg tablets

90 Day Supply!

Health Pathway
Care Coordination & Pharmacy Services
a member benefit of CHSGa

Heart Health/ Blood Pressure

Amlodipine 10mg tablets
Amlodipine 2.5mg tablets
Amlodipine 5mg tablets
Amlodipine/Benazepril 10/20mg capsules
Amlodipine/Benazepril 10/40mg capsules
Amlodipine/Benazepril 2.5/10mg capsule
Amlodipine/Benazepril 5/20mg capsules
Amlodipine/Benazepril 5/40mg capsules
Atenolol 100mg tablets
Atenolol 25mg tablets
Atenolol 50mg tablets
Atenolol/Chlorthalidone 100/25mg tabs
Atenolol/Chlorthalidone 50/25mg tablets
Benazapril 10mg tablets
Benazapril 20mg tablets
Benazapril 40mg tablets
Benazapril 5mg tablets
Bisoprolol/HCTZ 10/6.25mg tablets
Bisoprolol/HCTZ 2.5/6.25mg tablets
Bisoprolol/HCTZ 5/6.25mg tablets
Carvedilol 12.5mg tablets
Carvedilol 25mg tablets
Carvedilol 3.125mg tablets
Carvedilol 6.25mg tablets
Clopidigrel 75mg
Clonidine 0.1 mg tablets
Clonidine 0.2mg tablets
Furosemide 20mg tablets
Furosemlde 40mg tablets
Furosemide 80mg tablets
Guanfacine 1 mg tablets
Guanfacine 2mg tablets
HCTZ 12.5mg capsules
HCTZ 25mg tablets
HCTZ 50mg tablets
Hydralazine 100mg tablets
Hydralazine 10mg tablets
Hydralazine 25mg tablets
Hydralazine 50mg tablets
Lisinopril 10mg tablets
Lisinopril 2.5mg tablets
Lisinopril 20mg tablets
Lisinopril 30mg tablets
Lisinopril 40mg tablets
Lisinopril 5mg tablets
Lisinopril/HCTZ 10/12.5mg tablets
Lisinopril/HCTZ 20/12.5mg tablets
Lisinopril/HCTZ 20/25mg tablets
Losartan 100mg tablets
Losartan 25mg tablets
Losartan 50mg tablets
Losartan/HCTZ 50/12.5mg tablets
Losartan/HCTZ 100112.5mg tablets
Losartan/HCTZ 100125mg tablets
Metoprolol tartrate 100mg tablets
Metoprolol tartrate 25mg tablets
Metoprolol tartrate 50mg tablets
Metoprolol succinate ER 100mg tablets
Metoprolol succinate ER 200mg tablets
Metoprolol succinate ER 25mg tablets
Metoprolol succinate ER 50mg tablets
Nifedipine ER 30mg tablets
Nifedipine ER 60mg tablets
Nifedipine ER 90 mg tablets
Sotalol 80mg tablets
Spironolactone 25mg tablets
Terazosin 10mg capsules
Terazosin 1 mg capsules
Terazosin 2mg capsules
Terazosin 5mg capsules
Triamterene/HCTZ 37.5/25 tabs & caps
Valsartan 160mg tablets
Valsartan 320mg tablets
Valsartan 40mg tablets
Valsartan 80mg tablets
Valsartan/HCTZ 160/12.5mg tablets
Valsartan/HCTZ 160/25mg tablets
Valsartan/HCTZ 320/12.5mg tablets
Valsartan/HCTZ 320/25mg tablets
Valsartan/HCTZ 80/12.5mg tablets

This program is only available through Health Pathway and for members who have insurance through the Organization's medical plan. Plan includes up to a 90 day supply for specified generic drugs at commonly prescribed dosages for a copay of $0. This list may change due to market pricing and availability.

Some medications on this list are excluded from the qualified high deductible plan with the health savings account and the basic medical plan. Contact Health Pathway for more information.

Health Pathway is committed to maintaining the confidentiality and privacy of all member information. Contact Health Pathway toll free at **877.371.0735**

FREE,CONFIDENTIAL support for members enrolled in the CHSGa medical plan.

STOP the Habit

with the Tobacco Cessation Program

If you have been thinking about taking charge of your health and kicking the habit of tobacco, please consider this free benefit that can assist you in reaching your desired goal. It's a 6-8 week tobacco cessation program that is designed to help you quit tobacco, and if you are enrolled in the organization's medical plan, it will not cost you a penny!

Program Benefits:

- ✓ Nurse care coordinator to support you in your progression through the program
- ✓ 8 weeks of nicotine replacement therapy while enrolled in the program
- ✓ Program assistance available by phone, email or online
- ✓ Free if you, your spouse, or dependent are enrolled in the CHSGa medical plan
- ✓ Enroll at any time!

Each tobacco user who completes the tobacco cessation program as certified by Health Pathway will have the $100 tobacco surcharge removed for the remainder of the plan year.

Health Pathway
Care Coordination & Pharmacy Services
a member benefit of CHSGa

If you're ready to get started, call today!

Contact Health Pathway toll free at 877.371.0735 to confidentially discuss your questions regarding this program.

Act on Your Health

CHSGa cares about your health! Why not Act on Your Health and be rewarded with a $600 medical premium reduction?

If you are on the CHSGa medical plan all you have to do is have your free annual wellness exam and have your physician return the **Act on Your Health** physician form to Vital Incites. Below are the general instructions and the Act on Your Health physician form can be obtained from your human resources or benefits team member.

Schedule an appointment with a primary care provider for an annual wellness visit. If you do not have a primary care provider, contact Health Pathway at 877.371.0735 for assistance in finding one.

Take the **Act on Your Health** physician form with you to your scheduled appointment.

The required tests and labs indicated on the **Act on Your Health** physician form must be completed by the physician/provider. Required labs must be completed by November 30, 2021. Labs dated from **December 1, 2020 through November 30, 2021** will be accepted.

Completed forms must be sent to Vital Incite by email, fax or mail no later than December 15th, 2021. Additional instructions for delivery are indicated on the form. Please contact human resources for the physician/provider form.

A grace period of December 1, 2021 to February 28, 2022 will be allowed for those who had a screening from December 1, 2020 to February 28, 2021. Under the medical plan you are eligible for a wellness exam at least one year apart. Please take the Physician/Provider Form to be updated with the new labs. The completed form needs to be received by Vital Incite no later than March 15, 2022. If received by March 15, 2022, any missed premium reductions will be corrected.

If you had premium reductions that started on or after March 1, 2021, your current reduction will continue until the same month in 2022, at which time you will need to have another wellness exam and submit a form with updated labs.

Please see the frequently asked questions for additional information which can be obtained from human resources.

Support for everyday issues. Every day.

SupportLinc is the EAP for associates and their immediate family members.

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc will be there to help. The SupportLinc Employee Assistance Program (EAP) is a company-sponsored resource that helps you deal with life's challenges and the demands that come with balancing home and work. SupportLinc provides confidential, professional counseling for a wide array of personal and work-related concerns.

SupportLinc provides confidential, professional referrals and up to five (5) face-to-face counseling sessions per presenting issue for a wide array of personal and work-related concerns, such as:

Stress and Anxiety • Depression • Marriage and Relationship Problems • Grief and Loss • Substance Abuse • Legal Services • Anger Management • Work-Related Pressures • Education Guidance • Child Care Referrals • Financial Planning • Elder and Adult Care Referrals • Family Issues • Identity Theft Recovery

Referrals, Consultation and Other Resources

Whether you are a new parent, a caregiver, selling your home or looking for legal advice, you're likely to need guidance and referrals to expert resources. SupportLinc's work-life specialists are here to help. The program includes the following work-life services:

- **Legal Assist:** Free Telephonic or Face-to-Face Legal Consultation
- **Financial Assist:** Expert Financial Planning and Consultation
- **Family Assist:** Consultation and Referral Services for Daily Living Issues, Such as Dependent Care, Auto Repair, Pet Care and Home Improvement

Technology

eConnect®

- Scheduled Video, Telephonic and Web Chat Counseling Sessions on the SupportLinc Website
- Mobile App for On-The-Go Program Access

Additional Web-Based Services

- Thousands of Helpful Articles and Tip Sheets for Personal and Work-Related Topics
- Search Engines and Directories for Child Care, Elder Care, Education, Legal, Financial and Convenience Services
- Discounted Fitness Center Memberships
- Skill Builders: 20-Minute eLearning Modules
- Bilingual Content (English and Spanish)

myStrength

- Online and Mobile Platform Intended to Improve Emotional Health and Overall Wellbeing
- Personalized eLearning Programs, Exercises and Daily Inspirations
- Log in to the SupportLinc Website and Click on the 'myStrength' Tab at the Top of the Page to Get Started

1-888-881-LINC (5462)

24 Hours a Day, 365 Days a Year

www.supportlinc.com

Username: chs

SUPPORT LINC
EMPLOYEE ASSISTANCE PROGRAMS

Dental

Dental

Taking care of your teeth is just as important as taking care of the rest of your body. The dental plan provided through Delta Dental offers two plan options, a Low Plan and a High Plan. The High Plan offers a wider range of benefits than the Low Plan.

Both plans grant you the freedom to obtain services from an in-network or an out-of-network provider. The level of benefits is the same for in and out-of-network services; however, utilizing a participating in-network dentist will result in savings for you because participating dentists have agreed to accept the insurance carrier's fees as full payment for covered services. There is no balance billing for covered services when they are provided by a participating dentist, so you will usually pay the least when you visit an in-network dentist.

To find an in-network dentist, please visit www.deltadentalins.com, and in the Find a Dentist tool, select between Delta Dental PPO (best coverage) and Delta Dental Premier.

Delta Dental In-Network Benefits		
Plan Features	**Low Plan**	**High Plan**
Preventive and Diagnostic: Exams, Cleanings, X-rays	100%	100%
Calendar Year Deductible	$75/$225	$75/$225
Annual Maximum Benefit	$1,000	$1,500
Basic Services: Fillings, Oral Surgery, Simple Extractions, Periodontics	80%	80%
Major Services: Root Canal, Crowns, Inlays, Endodontics	50%	50%
Orthodontic Services	50%	50%
Ortho Lifetime Max	$1,000	$1,500
Ortho Coverage	Child(ren) Only	Adult & Child(ren)
Wait Periods		
Oral Surgery, Endodontics, Periodontics	None	None
Major Restorative, Prosthodontics	12 Months	None
Orthodontics	None	None

Associate contributions for dental can be found on page 21.

Vision

As part of maintaining your overall health, routine eye exams should be scheduled on a regular basis. The vision plan provided through VSP Vision offers one plan option with both in-and out-of-network benefits.

The VSP Vision Plan provides you with access to affordable, quality vision care coverage. This plan allows you to receive a complete eye examination and materials (if needed). You can choose to receive care from a VSP participating provider (in-network) or from any doctor of your choosing (out-of-network). Dollar for dollar, you get the best value from your vision benefit when you visit a VSP participating provider. If you decide to see an out-of-network provider, you will receive a lesser benefit and typically pay more out-of-pocket.

You do not need and will not receive an ID card for this benefit. Your provider can verify coverage using your social security number.

VSP Vision Plan		
Plan Features	**In-Network**	**Out-of-Network**
Exam Frequency	Once per 12 months	Once per 12 months
Exam Copay	$0	$45
Standard Lens Cost		
Single Vision	$0	$30
Bifocal	$0	$50
Trifocal	$0	$65
Frame Frequency	Once per 12 months	Once per 12 months
Standard Lens and Contact Lens Frequency	Either standard lens or contact lens once per 12 months	Either standard lens or contact lens once per 12 months
Frame Cost	$180 retail allowance and 20% off above $180. Additional $20 towards featured brand	$70
Contact Lens Frequency	Once per 12 months	Once per 12 months
Contact Lens Elective Cost	Fitting not to exceed $60; $180 towards materials	$105

Associate contributions for vision can be found on page 21.

Health Savings Accounts

HSA vs. FSA: Which Option is Best for You?

Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) are two ways for you to set aside pre-tax money from your paycheck to use for qualified medical expenses. The biggest difference between the two types of accounts is how and when you can use them. An HSA is a *savings* account whereas an FSA is a *spending* account. You cannot be enrolled in both an HSA and a Health Care FSA, according to IRS rules.

Description	HSA	Health Care FSA
Available if enrolled in…	Qualified HDHP	Traditional copay or basic medical plan
Who owns it	You	Organization, but it's your money
What if I do not spend it all in 2021?	Money stays in account until you use it. You can save it and use it into retirement.	Use it or lose it
Can I keep the account if I leave the organization? What happens to the money?	Yes, you own the account and keep the money	No, organization keeps the money (IRS regulated)
When can I begin using funds?	Works like a checking account, funds are available only as they are deposited.	Access to entire annual deferred amount January 1
What can I pay for with it?	Qualified medical expenses determined by the IRS, including services covered by the health, dental, vision Section 213(d) IRS Code	Qualified medical expenses determined by the IRS, including services covered by the health, dental, vision Section 213(d) IRS Code

Health Savings Account (HSA)

If you enroll in the High Deductible Health Plan (HDHP), you may be eligible to participate in a Health Savings Account (HSA). An HSA is a personal bank account that allows you to put aside pre-tax dollars from your paycheck to help pay for qualified medical expenses. Because of the tax advantage, the IRS limits the amount you can contribute to an HSA. In 2022, the maximum amount you can contribute to your HSA is $3,650 (associate) and $7,300 (family). In addition, if you are age 55 or older and not enrolled in Medicare, you can contribute an additional $1,000 to your HSA, known as the catch-up contribution. Our HSA is offered through Optum Bank.

HSAs have a couple other advantages as well – your unused funds roll over from year to year and your account is portable. Each year, you are able to contribute up to the IRS limit to your Health Saving Account, tax free. You have the option of using the money to pay for eligible medical expenses or saving it for future eligible expenses.

There are certain standard fees associated with the Health Savings Account. There is a $1.00 monthly maintenance fee if your average balance is below $500.00. The fee is waived if your average balance is $500.00 or more. Additional fees include $2.50 per ATM transaction, $20.00 per outbound transfer or rollover to another HSA Custodian. If you open an investment account there is a $3.00 monthly investment fee.

You are responsible for maintaining records. If you were to be audited by the IRS, you will need to provide documentation to prove the money was spent on only eligible medical expenses. The plan does not monitor your spending to determine eligibility. If HSA funds are spent on non-qualified expenses, you could pay a tax penalty as well as standard taxes on the ineligible expenses.

The tier of coverage you elect determines your maximum contribution to the HSA. Regardless of which tier of coverage you elect, you can use the HSA funds to pay for eligible expenses for any tax dependents, even if they are not covered on your plan. If you choose to open a Health Savings Account, please consult your tax advisor.

Flexible Spending Account (FSA)

If you are a regular, full-time associate scheduled in Workday with 30 or more weekly hours, you are eligible to participate in a Flexible Spending Account (FSA). An FSA is funded with money you contribute on a pre-tax basis. You can use FSA funds to pay for qualified out-of-pocket health care costs for you and your eligible dependents and/or dependent day care charges.

The organization offers two FSAs through BAS and its partnership with HealthEquity a Health Care FSA and Dependent Care FSA. If you enroll in the HealthEquity Health Care FSA plan, you will receive a debit card.

Health Care FSA

A Health Care FSA provides you with the ability to set aside money on a pre-tax basis for any IRS-allowed health expenses not covered by your health care coverage. These expenses include, but are not limited to, deductibles, copayments, coinsurance, and out-of-pocket dental, vision and hearing care expenses (e.g. eyeglasses, contact lenses, hearing aids and orthodontia expenses). With a Health Care FSA, you can be reimbursed an amount up to the total annual contribution you have elected, and can begin to use all or some of the total amount elected as soon as the plan year begins. At the time of printing of this guide, the maximum annual amount you can deposit into a Health Care FSA for 2022 is $2,850.

For Orthodontia Services

The FSA will only reimburse orthodontic services based on when actual services are received, not when payment is made. A down payment can be reimbursed in the plan year in which the braces are applied to the teeth. While your provider may offer a discount for prepaying the full amount due, the FSA will not reimburse the full amount up front. After the down payment, additional reimbursements are based on when actual services are received, usually monthly.

Dependent Care FSA

A Dependent Care FSA provides you with the ability to set aside money on a pre-tax basis for day care expenses for your child, disabled parent or spouse. Generally, expenses will qualify for reimbursement if they are the result of care for your children under the age of 13 for whom you are entitled to a personal exemption on your federal income tax return; and your spouse or other dependents, including parents, who are physically or mentally incapable of self-care. With a Dependent Care FSA, you will be reimbursed only for dependent care services you have already received and can only be reimbursed for funds that you have already had deducted.

The maximum annual amount you can deposit into a Dependent Care FSA for 2022 is $2,500 (married and filing individually) or $5,000 (single or married and filing jointly).

Use It or Lose It!

You will be able to use any remaining balance in your Health Care FSA at the end of 2022 to pay for expenses incurred through February 14, 2023. Any 2022 Health Care FSA funds not used by February 14, 2023, will be forfeited.

If you have a Dependent Care FSA, you do not have a grace period in which to use remaining previous year balances. All expenses must occur before December 31, 2022 and claims for 2022 Dependent Care FSA must be filed no later than February 14, 2023, to receive reimbursement.

Termination of Employment

If you terminate in the middle of the year, your Health Care and Dependent Care FSA ends on your date of termination. Any expenses after your date of termination are not eligible for reimbursement. You do have 45 days from the date of termination to file any current year expenses that occurred prior to your termination date.

NOTE: associates enrolled in the HSA are not eligible for the Health Care FSA, but may participate in the Dependent Care FSA.

401(k) Retirement Savings Plan

401(k) Retirement Savings Plan

Building a healthy financial future is another important step in taking care of the needs of you and your family. That's why we are proud to offer associates a 401(k) Retirement Savings Plan through Principal℠.

Regular, temporary, full-time and part-time associates who are age 18 or older are eligible to participate upon date of hire with no waiting period. At any time during the year, you may enroll, increase or decrease your deferrals. Employer matching begins after one year of service. The organization will match dollar for dollar up to 4% of your deferral. Associates are immediately 100% vested in employer contributions from day one. This is a great benefit that will help you reach your retirement goals more quickly. For 2022, you may defer a maximum of $20,500. If you're age 50 or older, you may defer an additional catch-up amount of $6,500.

Important Facts

- You are not taxed on the amounts in your retirement plan accounts until they are distributed to you,
- You are 100% vested in your retirement plan accounts at all times,
- You determine how the contributions to your retirement plan accounts are invested by choosing among available investment options. You may reallocate funds in your account (subject to any restrictions particular to that fund) and also change the allocation of future contributions. Keep in mind that all investments have some degree of risk. You are responsible for your investment decisions,
- Your retirement plan accumulations are intended to provide you and your family with income in your retirement. The organization's contributions are not available for disbursement until you separate employment. Voluntary contributions may be withdrawn beginning at age 59 ½,
- Prior to age 59 ½, you may withdraw a portion of your contributions through a hardship withdrawal subject to approval under IRS guidelines. Contact Principal directly to apply,

- If you should die before receiving the money in your accounts, payment will be made to your beneficiary(ies). Please be sure that your beneficiaries are up to date. If you are married and wish to name someone other than your spouse as your primary beneficiary, your spouse will have to sign the spousal waiver on the beneficiary form, and it will have to be notarized.

Principal℠

For 24-hour account access visit
www.principal.com
or call
1.800.547.7754
Plan #613011

Changing Your Benefits (Qualifying Life Events)

The Internal Revenue Service (IRS) states that associates enrolled in pre-tax benefit plans may only make benefit elections to these plans once a year. As such, your medical, dental, vision and Flexible Spending Account benefit choices are binding through December 31. The following special circumstances are the only reasons you may change your benefits during the plan year:

- Marriage, divorce, legal separation or annulment,
- Birth, adoption or placement for adoption of an eligible child,
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan; a significant change in your or your spouse's health coverage attributable to your spouse's employment; the reduction or increase in hours of employment or other changes in employment category for you or your spouse or dependent, including a change between part-time and full-time,
- Gain or loss of other coverage for your adult child,
- Death of a spouse or dependent,
- Loss of dependent status,
- Change in place of residence that affects eligibility,
- Becoming eligible for Medicare or loss or gain of Medicaid during the year,
- Receiving a Qualified Medical Child Support Order (QMCSO)

These special circumstances often referred to as qualifying life events or life event changes, will allow you to make plan changes during the plan year in which they occur. For any allowable changes, you must notify your benefits representative within 31 calendar days of the event and provide proof of the Qualifying Life Event, or you must wait until the following Open Enrollment to make changes. An election change must be consistent with the change in status. Changes that are requested due to a change of mind are not allowed until the next annual Open Enrollment period.

Documentation is Required for all Qualifying Events

For birth, adoption or placement for adoption, the acquired dependent of a covered associates will be covered effective the day of the event, provided that enrollment for the dependent is submitted within 31 days from the date of the event and all applicable documents submitted to the benefits department. For all other events, coverage changes will be effective the first of the month following the date of the qualifying event.

Continuing Your Coverage Under COBRA

Under certain circumstances, you may continue certain benefit coverages when they would otherwise end. This is referred to as COBRA coverage. COBRA stands for Consolidated Omnibus Budget Reconciliation Act (COBRA). Continuation of coverage will be offered if a qualifying event occurs which causes you and/or your covered dependents to lose coverage. You are eligible to continue medical, dental, vision and healthcare FSA coverage under COBRA, if coverage is lost because:

- Your employment ends for any reason other than gross misconduct,
- Your work hours are reduced,
- You die,
- You or your dependent become entitled to and enroll in Medicare or Medicaid prior to losing coverage,
- You divorce or become legally separated from your spouse,
- Your dependents lose dependent status

Associate Contributions

	Traditional Copay Plan	Monthly	Semi-monthly	Bi-weekly	Weekly
Wellness Medical	Associate Only	$121.61	$60.81	$56.13	$28.06
	Associate + Spouse	$612.04	$306.02	$282.48	$141.24
	Associate + Child(ren)	$347.83	$173.92	$160.54	$80.27
	Family	$1,015.53	$507.77	$468.71	$234.35
	HDHP with HSA Plan	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$121.61	$60.81	$56.13	$28.06
	Associate + Spouse	$612.04	$306.02	$282.48	$141.24
	Associate + Child(ren)	$347.83	$173.92	$160.54	$80.27
	Family	$1,015.53	$507.77	$468.71	$234.35
	Basic Medical Plan	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$53.14	$26.57	$24.53	$12.26
	Associate + Spouse	$612.04	$306.02	$282.48	$141.24
	Associate + Child(ren)	$347.83	$173.92	$160.54	$80.27
	Family	$1,015.53	$507.77	$468.71	$234.35
Non-Wellness Medical	**Traditional Copay Plan**	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$174.61	$87.31	$80.59	$40.29
	Associate + Spouse	$665.04	$332.52	$306.94	$153.47
	Associate + Child(ren)	$400.83	$200.42	$185.00	$92.50
	Family	$1,068.53	$534.27	$493.17	$246.58
	HDHP with HSA PLAN	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$174.61	$87.31	$80.59	$40.29
	Associate + Spouse	$665.04	$332.52	$306.94	$153.47
	Associate + Child(ren)	$400.83	$200.42	$185.00	$92.50
	Family	$1,068.53	$534.27	$493.17	$246.58
	Basic Medical Plan	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$103.14	$51.57	$47.60	$23.80
	Associate + Spouse	$665.04	$332.52	$306.94	$153.47
	Associate + Child(ren)	$400.83	$200.42	$185.00	$92.50
	Family	$1,068.53	$534.27	$493.17	$246.58
Dental Rates	**Dental Low Plan**	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$7.46	$3.73	$3.44	$1.72
	Associate + Spouse	$14.27	$7.13	$6.59	$3.29
	Associate + Child(ren)	$14.16	$7.08	$6.53	$3.27
	Family	$21.50	$10.75	$9.93	$4.96
	Dental High Plan	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$9.97	$4.99	$4.60	$2.30
	Associate + Spouse	$18.27	$9.13	$8.43	$4.22
	Associate + Child(ren)	$18.15	$9.08	$8.38	$4.19
	Family	$27.95	$13.98	$12.90	$6.45
Vision Rates	**VSP Vision Plan**	**Monthly**	**Semi-monthly**	**Bi-weekly**	**Weekly**
	Associate Only	$9.22	$4.61	$4.26	$2.13
	Associate + Spouse	$17.88	$8.94	$8.25	$4.13
	Associate + Child(ren)	$15.42	$7.71	$7.12	$3.56
	Family	$24.00	$12.00	$11.08	$5.54

Life Insurance

The organization provides organization-paid basic life and accidental death and dismemberment insurance to all regular full-time associates with 30 or more scheduled weekly hours. The coverage amount is one times (1X) your base annual salary rounded up to the next $1,000 (up to a maximum of $100,000). You can find more information and examples in the box below.

Life and AD&D Insurance

- New hires will be enrolled the first of the month following 60 days of employment,
- Hourly associate makes $15 per hour and has 35 scheduled weekly hours according to their Workday profile – life insurance amount is $28,000 ($15 x 35 hours per week x 52 weeks = $27,300 rounded up to $28,000),
- Hourly associate makes $15 per hour and has 40 scheduled weekly hours according to their Workday profile – life insurance amount is $32,000 ($15 x 40 hours per week x 52 weeks = $31,200 rounded up to $32,000),
- Salaried Associate makes $35,000 per year – life insurance amount is $35,000

Short-term Disability (STD)

Organization-paid short-term disability (STD) is provided to all regular full-time associates with 30 or more scheduled weekly hours. You can find more information in the box below and further instructions on how to file a claim.

Short-term Disability Program

- New hires will be enrolled first of the month following 60 days of employment,
- Benefit provides 60% of the your weekly base pay up to $1,500 per week,
- 30 day elimination period (payments begin on 31st consecutive day of illness/injury),
- Maximum duration is 13 weeks (including the elimination period)

Short-term Disability Claims

Convenient Telephonic System

If you have a short-term disability claim, it can be filed with ease by using the telephonic claims system. Simply go to matrixabsence.com or call 866.533.3437. Please be prepared to supply the following information:

- Your name, last four digits of your Social Security number and the company name, CHS,
- Your supervisor's name and telephone number,
- Your treating physician's name, address, telephone number and fax number,
- A description of your illness or injury,
- A description of your occupation

Voluntary Life Insurance and Benefits

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Voluntary Benefits

The following pages include options for voluntary benefits. The organization does not sponsor or endorse these voluntary plans. They are made available to you through payroll deductions, if you choose to enroll, and are deducted on a post-tax basis. They are completely voluntary.

- Voluntary Term Life and AD&D Insurance,
- Voluntary Short-term and Long-term Disability Plans,
- Critical Illness

Voluntary Term Life Insurance

Voluntary Term Life Insurance is available for you, your spouse and your dependent children. As an associate, you may purchase Voluntary Term Life Insurance for yourself in increments of $5,000, not to exceed $500,000. Additionally, if you purchase coverage for yourself, you may also purchase Voluntary Term Life Insurance for your dependents:

- Spouse: available in increments of $5,000, not to exceed $500,000,
- Children (including step children & foster children): ages 14 days up to 6 months the benefit is $1,000; from 6 months to age 26 the benefit is $10,000.

The Voluntary Term Life plan offers a certain amount of coverage on a guaranteed issue basis (no medical questions or underwriting required) at your initial enrollment as a new hire. Coverage applied for over the guaranteed issue amount or after your initial enrollment will be subject to certain health questions.

- New Hire: A new hires guaranteed issue amount is $250,000
- New Hire: Spouse life coverage guaranteed issue amount is $250,000

Voluntary Accidental Death and Dismemberment (AD&D)

Choose up to $500,000 of AD&D in increments of $10,000.

- Individual Plan,
- Family Plan*

*Spouse benefit = 50% of associate's benefit,
*Spouse with children = 40%; each child = 10%,
*Children only = 15%,
*Children are covered from 14 days until age 26

Voluntary Disability Insurance

A disabling injury or illness that keeps you out of work could have a devastating impact on your income, jeopardizing your ability to cover normal household expenses. If you elect Voluntary Short-term Disability (STD) or Long-term Disability (LTD) coverage through Reliance Standard, you may be able to supplement your income if you are disabled and unable to work due to a non-occupational injury, illness or childbirth.

Coverage will be subject to the pre-existing condition exclusion. You may have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines three months prior to your effective date of coverage and become disabled in the first 12 months after your effective date of coverage.

Pre-existing Clause Examples:

Example #1: let's use 01/01/2022 as the effective date of enrollment. If I were to file a claim on 05/01/2022, the insurance carrier would "look back" at my medical records beginning 10/01/2021 (three months before my effective date) to 1/1/2022 to determine whether I had this condition prior to my effective date of coverage. If it is determined to be a pre-existing condition, then the claim would be denied. If determined to not be pre-existing, then the claim would be considered for approval. Once coverage has been in place for 12 months, the pre-existing clause would be lifted and any legitimate claim would be considered for approval.

Example #2: if during open enrollment I decide to increase my existing coverage, the pre-existing clause will apply only to the increased portion. So, if I had elected a $500/week benefit during 2021, but increased it to $600/week during the 2022 open enrollment period, only the additional $100 will be subject to a pre-existing review.

When Are You Disabled?

You are considered disabled if you are unable to perform the material and substantial duties of your regular job due to your sickness or injury, and you are under the regular care of a doctor. If you have lost your professional or occupational license because of your injury or illness, you may not necessarily be considered disabled.

Plan Feature	Short-term Disability (Part Time Only)	Long-term Disability
Elimination Period Before Payment Begins	14 Days	90 calendar days
Maximum Benefit Payable	Up to a maximum of $1,400 per week	Up to a maximum of $6,000 per month
Deduction Type	After-tax	After-tax
Maximum % of Earnings Covered	60% of weekly earnings	65% of monthly earnings
Benefit Period	13 weeks	Up to 5 years

Voluntary Critical Illness Insurance

Voluntary Critical Illness Insurance

Critical Illness Insurance provides a lump sum benefit paid directly to you following a positive diagnosis of each covered critical illness. You may elect in increments of $1,000 from a minimum of $5,000 to a maximum of $50,000. Any amounts over $20,000 are subject to approval after completing an evidence of insurability form. During open enrollment spouses 60 and older at the time of open enrollment will require evidence of insurability for any amount elected. If you elect coverage for children, the amount is 25% of your approved amount. Coverage for the associate and spouse will reduce by 50% at age 70.

Covered Critical Illnesses	
Cancer	100% of Insurance Amount
Carcinoma in SITU	25% of Insurance Amount
Heart Attack	100% of Insurance Amount
Coronary Artery Bypass Surgery	25% of Insurance Amount
Stroke	100% of Insurance Amount
Major Organ Transplant	100% of Insurance Amount
Kidney (Renal) Failure	100% of Insurance Amount
Paralysis, Coma, Brain Damage, Blindness, Ruptured Cerebral Carotid or Aortic Aneurysm	100% of Insurance Amount

$50 Health Screening Benefit

This pays $50 for one health screening benefit per insured* performed during a twelve month period.

Covered Health Screening Tests Included:

- Breast ultrasound or mammography
- Blood test for lipids LDL, HDL and triglycerides
- Chest x-ray
- Colonoscopy
- Pap smear
- PSA (blood test for prostate cancer)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Bone marrow testing
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Serum Protein Electrophoresis (blood test for myeloma)

*One health screening will be paid per 12 months for dependent children as a group.

Subsequent Occurrence Benefit (different category)
If you collect full benefits for a critical illness and later are diagnosed with one of the other covered illnesses, you will receive a second full benefit amount for the subsequent illness, as long as the dates of diagnosis are at least six months apart and the subsequent critical illness is not caused by or contributed to by a prior critical illness that was previously paid.

Recurrence Benefit (same category)
If you collect full benefits for a covered critical illness and are later diagnosed with the same condition, you will receive another full benefit, as long as the dates of diagnosis are at least 12 months apart, or in the case of cancer - as long as the recurrence occurs after 12 months without treatment.

Pre-existing Exclusions:
Coverage will be subject to the pre-existing conditions exclusion. You may have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines within 12 months prior to your effective date of coverage. After 12 months of coverage, the pre-existing condition clause expires.

Health Pathway
Care Coordination & Pharmacy Services
a member benefit of CHSGa

Rx2Go

An easy way to locate and connect to Health Pathway Pharmacy (HPP), Rx2Go makes it quick and convenient to refill your prescriptions. Once the app is enabled, use the pharmacy search feature to locate HPP in Hawkinsville, Georgia.

Save HPP's information for future refill requests. You may then submit a refill request using the prescription number and the patient's last name or by scanning the Rx barcode.

You will receive an immediate response confirming validity of the prescription number and when it will be ready to be picked up at the pharmacy, or contact HPP for delivery options in your area. In addition, you will have access to more online features.

HealthEquity®
Building Health Savings℠

HealthEquity Mobile App

The HealthEquity mobile app helps you to manage your healthcare FSA no matter where you are. With the app (available at iTunes App Store and Google Play), you can:

- Check your account balance
- Submit eligible claims
- Upload receipts or documentation

Sign up for electronic funds transfer (EFT) to get reimbursed sooner and to avoid the $2.00 check fee for payments to members.

For more details, please visit www.myhealthequity.com

myMaxorLink by MaxorPlus

myMaxorLink is a web-based mobile engagement platform used by MaxorPlus, our Pharmacy Benefits Manager, to help you maximize your pharmacy benefits and improve your health.

How it works

myMaxorLink sends an SMS text message to your mobile device. Click the hyperlink in the message to go to the secure myMaxorLink portal. You may receive messages regarding:

- Prescription cost savings opportunities,
- Relevant disease and drug education,
- Important annual reminders (e.g. flu shots),
- Benefit and formulary changes

Enroll in myMaxorLink

You will have multiple opportunities to enroll in this program throughout the year. MaxorPlus and/or CHSGa will send you enrollment information at the appropriate time.

Opt Out of myMaxorLink

You can opt out of the program via the MaxorPlus member portal, MaxorPlus customer service, or by texting STOP to 73529.

Useful Tools

Benefits Intranet

There are many documents available in electronic form at http://my.chs-ga.org/benefits. Please visit the website to view these documents or if you would like a printed copy of the documents, please contact your benefits department.

Touchpoints PocketPal Mobile App and Web Portal

All you need to know about your benefits is now at your fingertips via online or an easy to use app on your mobile phone.

Have you ever . . .

- Forgotten your ID Card or misplaced it?
- Needed help finding an in-network doctor or dentist?
- Been asked about your copay or coinsurance but were unable to locate the information when needed?

You will now have all of this information available instantly with the web-based dashboard and mobile app.

Web-based Dashboard

The quickest way to get started is to visit the web-based portal at: http://www.mychsgabenefits.com

Pocketpal App

Search for “The Pocketpal” in the Google Play or Apple App Store and install. Once downloaded, you will need this information:

- Click create account; Company ID is: chsga,
- Name and email address,
- List of the 2022 benefits in which you are enrolled,
- Your ID Card (follow the instructions in the app to have your ID Card downloaded and readily available)

Compliance Notices

COMPLIANCE NOTICES

The following notices are required to be provided to you as part of your welfare plan. Please review the provisions below and contact the Plan Administrator with any questions. Summary Plan Descriptions are available in either paper or electronic format from the benefits coordinator in your location.

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 your plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, you or your eligible dependent may enroll in the plan if: 1) you or your dependent are covered under a Medicaid plan or a State Child Health Insurance Program (CHIP) plan, you lose eligibility for that coverage, and you request enrollment in this plan within 60 days after the Medicaid or CHIP coverage is terminated; or 2) you or your dependent becomes eligible for Medicaid or CHIP premium assistance and you request enrollment in this plan within 60 days after the date you or your dependent is determined to be eligible for the premium assistance.

To request special enrollment or obtain additional information, you may contact Benefit Administrative Systems, LLC (BAS) at 1.800.843.3831 or go to the BAS website at www.bashealth.com and request your changes within 31 days of the date you lost other coverage or you gained a new dependent (or 60 days from the Medicaid/CHIP special enrollment event). Even if you are enrolled in family coverage, you must contact (BAS) at 1.800.843.3831 or go to the BAS website at www.bashealth.com to request to make the election changes for any new dependent within 31 days of gaining any new dependent. Note: due to the national emergency caused by COVID-19, the deadline for you to request special enrollment may be extended. While we urge you not to delay, if the applicable deadline has passed, you should contact BAS to find out if you have additional time to request special enrollment.

Women's Health and Cancer Rights Act

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your plan. Therefore, the deductible and co-insurance you will be subject to depends on which medical plan option you choose.

Newborns and Mothers Health Protection Act

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).

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 are 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 are not eligible for Medicaid or CHIP, you will not 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, you can 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, you can 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, you can 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 are not 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 by calling toll-free 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 State information is current as of July 31, 2021. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1.855-692.5447
FLORIDA – Medicaid
Website: www.myflfamilies.com/service-programs/Medicaid Phone: 1.877.357.3268
GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp Phone: 678.564.1162 Ext. 2131
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1.888.549.0820

To see if any other states have added a premium assistance program since July 31, 2021, 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

Compliance Notices

NOTICE OF PRIVACY PRACTICES REGARDING YOUR HEALTH INFORMATION

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

We understand that your health information is private, and we are committed to maintaining the privacy of your health information.

CHSGa offers its employees a number of health benefits, including medical, dental, vision, employee assistance programs, a health care flexible spending account, and other health benefits that may be offered from time to time (referred to as the "Plan"). This notice describes the ways in which the Plan may use and disclose your health information. This notice also describes your rights regarding the use and disclosure of your health information.

The Plan is required by law to maintain the privacy of your health information, provide you with certain rights with respect to your health information, to provide you with this notice about the Plan's legal duties and privacy practices with respect to your health information, and to abide by the terms of this notice as it is currently in effect.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your health information. In general, the Plan will only use or disclose your health information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure. The Plan does not operate by itself but rather is operated and administered by CHSGa through the CHSGa Health and Welfare Benefits Committee (the "Company") acting on the Plan's behalf. As a result, health information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing health information on behalf of the Plan. As a result, health information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the health information on behalf of the Plan. As a result, references to the Plan in this Notice of Privacy Practices should also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

The health plans identified above may share your health information with each other to carry out treatment, payment, and health care operations.

PERMITTED USES AND DISCLOSURES

The following categories describe different ways that the Plan may use or disclose your health information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Primary Uses and Disclosures of Your Health Information

Treatment
The Plan may use or disclose your health information to facilitate medical treatment or services by providers. The Plan may disclose your health information to providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative of prior prescriptions.

Payment
The Plan may use and disclose your health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. The Plan may also share health information with a utilization review or precertification service provider. Likewise, the Plan may share health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations
The Plan may use and disclose your health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use health information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to health information other than health information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for

stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends
The Plan may disclose your health information to your family members, relatives, or close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for your care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected. The Plan may also disclose your health information if you are not able to agree or object or are not present if it has determined that the disclosure is in your best interests.

Personal Representatives
You may exercise your rights regarding your health information through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health information or allowed to take any action for you. The Plan retains discretion to deny access to your health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Company
The Plan may disclose your health information to the Company for Plan administration purposes.

Business Associates
The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your health information, but only after they agree in writing to safeguard your health information. For example, the Plan may disclose your health information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records.

Covered Entities
The Plan may use and disclose your health information to assist health care providers with their treatment or payment activities, or to assist other health plans or health care clearinghouses with payment activities and certain health care operations. For example, the Plan may disclose your health information to a health care provider to conduct health care operations in the areas of quality assurance, accreditation, licensing, etc. This also means that the Plan may disclose your health information to other health plans and/or insurance carriers to coordinate benefits, if you have coverage through another health plan or insurance carrier.

Other Possible Uses and Disclosures of Your Health Information

As Required by Law
The Plan may use or disclose your health information when required to do so by federal, state, or local law. For example, the Plan may disclose health information for the following purposes:

For judicial and administrative proceedings pursuant to legal authority if certain conditions are met relating to notice to you and an opportunity for you to object to the disclosure.
To report information related to victims of abuse, neglect, or domestic violence.
To assist law enforcement official in their law enforcement duties.

Aversion of a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, the Plan may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ/Tissue Donation
If you are an organ donor, the Plan may disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Government Functions
The Plan may disclose your health information for specialized government functions, such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation
The Plan may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health
The Plan may disclose your health information for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Department of Health and Human Services
The Plan will disclose your health information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Decedents
The Plan may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release health information to funeral directors as necessary to carry out their duties.

Other Benefits
The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

OTHER USES OF HEALTH INFORMATION

Any uses and disclosures of health information other than those listed above will be made only with your written authorization. If you provide the Plan authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Access and Copy
The Plan will make your health information available to you for inspection and copying upon your written request. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. If the Plan maintains any of your health information in an electronic health record, you can get a copy of that information in electronic format.

The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed in certain circumstances.

Right to Request an Amendment
If you feel that the health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for the Plan. Any request to amend your health information must be made in writing. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.

The Plan may deny your request for an amendment in certain circumstances, including your failure to request the amendment in writing or to include a reason to support the request, or, for example, if the information to be amended was not created by the Plan or is accurate and complete.

Right to an Accounting of Disclosures
If you wish to know to whom your health information has been disclosed, you may make a written request to the Plan. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.

Your request must state the time period for which you would like the accounting, and cannot include dates prior to the six year period ending on the date of your request (in other words, if your request is dated January 1, 2012, you cannot request an accounting of disclosures for time periods prior to January 1, 2006). Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, the Plan may charge you for the costs of providing the accounting. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosures for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing or for certain other purposes.

Right to Request Restrictions
You may request that the Plan restrict or limit the use or disclosure of your health information for treatment, payment, or health care operations. In addition, you may request that the Plan limit disclosures of your health information to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request a restriction or limitation, please contact the individual listed below under the section titled "For More Information." Your request must be in writing. In your request, you must specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Please note that the Plan is not required to agree to your request, unless your request is to restrict disclosures to another health plan for payment or plan operations purposes and the health information pertains solely to a health care item or service for which you have already paid a health care provider out-of-pocket in full.

Right to Request Confidential Communications
If the disclosure of your health information could endanger you, you may request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may request that the Plan only contact you at work or by mail. To request confidential communications, please contact the individual listed below under the section titled "For More Information." Your request must specify how or where you wish to be contacted. The Plan will only accommodate requests for confidential communications if the disclosure of the information would endanger you.

Right to be Notified of a Breach
You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured health information.

Right to a Paper Copy of this Notice
You may ask the Plan for a copy of this notice at any time by contacting the individual listed below under the section titled "For More Information." Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. You may also obtain a copy on your organization's intranet.

CHANGES TO THIS NOTICE

The Plan reserves the right to modify this notice at any time. The Plan also reserves the right to make the revised or changed notice effective for health information it already has about you, as well as any information received in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To register a complaint with the Plan, please contact the individual listed below under the section titled "For More Information." All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

NO GUARANTEE OF EMPLOYMENT

Nothing contained in this Notice of Privacy Practices shall be construed as a contract of employment between the Company and any associate, nor as a right of any associate to be continued in the employment of the Company, nor as a limitation of the right of the Company to discharge any of its associates, with or without cause.

NO CHANGES TO PLAN

Except for the privacy rights described in this Notice of Privacy Practices, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plan. You should refer to the Plan documents for complete information regarding any rights or obligations you may have under the Plan.

FOR MORE INFORMATION

If you have any questions about this notice, please contact:

Ms. Jenna Greene, Benefits Manager
478.621.2260
jgreene@sas-ga.org

EFFECTIVE DATE

August 1, 2019

Compliance Notices

NOTICE REGARDING WELLNESS PROGRAM

CHSGa Act On Your Health Wellness Program is a voluntary wellness program available to all associates who participate in CHSGa medical plans. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate 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 meet with your physician to complete a biometric screening, which will include a blood test for levels of glucose, high-density lipoproteins ("HDLs"), low-density lipoproteins ("LDLs"), total cholesterol, and triglycerides. You are not required to participate in the blood test or other medical examinations.

However, associates who choose to participate in the wellness program will receive an incentive of $600 annual premium reduction for completion of the biometric screening and blood test, and submission of the blood test results by your physician no later than December 15, 2021. A grace period will be allowed for labs completed no later than February 28, 2022 and received by March 15, 2022. Although you are not required to participate in the biometric screening, only associates who do so will receive the $600 annual premium reduction.

The information and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as assistance obtaining prescriptions through Community Care Pharmacy, chronic condition support and answering medical or pharmacy questions. 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 CHSGa may use aggregate information it collects to design a program based on identified health risks in the workplace, the CHSGa Act On Your Health Wellness Program will never disclose any of your personal information either publicly or to the organization, 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) Registered Nurses and Certified Case Managers for Health Pathway in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jenna Greene, Benefits Manager at jgreene@sas-ga.org or 478.621.2260.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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 for coverage starting as early as January 1, of the following year.

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 associate 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 Jenna Greene at 478.621.2260.

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.

Glossary

Open Enrollment
The annual period during which you may choose to make changes in your benefits for the next plan year. Please note, various eligibility rules may apply.

Balance Billing
A medical bill from a healthcare provider billing the patient for the difference between the total cost of services being charged and the amount insurance pays.

Coinsurance
Agreement between the insured and the insurance company where a payment is shared for claims above the deductible covered by the policy. For example, under an **80/20** plan, the insurance company pays 80% and the insured pays 20% after the deductible is met.

Deductible
Amount the covered insured must pay upfront before an insurer will pay any expenses.

Copayment
A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care. Copayments are a common feature of medical plans. Copayment size may vary depending on the service, generally with lower copayments required for visits to a regular medical provider and higher payments for services received in a hospital setting. Not available on all plan options.

Annual Out-of-Pocket Maximum
The maximum amount an insured is required to pay on a calendar year basis under a plan or insurance contract.

Guaranteed Issue Amount
The amount of coverage a newly eligible associate may obtain regardless of health conditions.

Pre-existing Condition
A condition or diagnosis which existed (or for which treatment was received) before coverage began under a current plan or contract and for which benefits are not available or are limited.

Term Life Insurance
Provides a stated benefit upon the death of the insured. Typically the term life insurance contract runs for a stated period/term of time and does not provide any cash value and/or dividend or returns beyond the stated death benefit.

Health Care Flexible Spending Account (FSA)
Health Care FSA allows you to set aside pre-tax money via payroll deduction to pay for certain out-of-pocket health care expenses not covered by your insurance plan(s). Some examples of expenses you can pay with your Health Care FSA include copayments, deductibles, orthodontia, hearing aids, chiropractic treatment, laboratory fees, mental health counseling, etc. Not eligible if participating in an HSA.

Dependent Care Flexible Spending Account (FSA)
A dependent care FSA allows you to set aside pre-tax money via payroll deduction to pay for eligible dependent care expenses for a qualifying dependent. A qualifying dependent includes a tax dependent of yours who is under age 13, any other tax dependent of yours, such as an elderly parent or spouse who is physically or mentally incapable of self-care and has the same principle residence as you.

Health Savings Account (HSA)
A tax-advantaged medical savings account available to associates enrolled in a Qualified High Deductible Health Plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit and unused funds roll over and accumulate year to year if not spent.

My Notes

2022 Benefits Provider Directory

HEALTH & WELFARE			
Benefit	**Vendor**	**Phone Number**	**Website**
Medical Insurance	BAS	800.843.3831	BAShealth.com
Healthcare Navigation	Health Pathway	877.371.0735	N/A
Prescription Drug Coverage	MAXORplus	800.687.0707	maxorplus.com
Internal Member Pharmacy	Health Pathway Pharmacy	877.371.0735	N/A
Dental Insurance	Delta Dental Plan ID 18169	800.521.2651	deltadentalins.com
Vision Insurance	VSP Plan ID 30062826	800.877.7195	vsp.com
Health Savings Account	Optum Bank	866.234.8913	optumbank.com
Flexible Spending Accounts	BAS & HealthEquity	866.346.5800	my.healthequity.com
401(k) Retirement Plan	Principal - Plan #613011	800.547.7754	principal.com
Organization Paid Basic Life Insurance/AD&D	Reliance Standard Life	See your Benefits Representative	
Voluntary Term Life Insurance	Reliance Standard Life	See your Benefits Representative	
Voluntary Critical Illness Insurance	Reliance Standard Life	See your Benefits Representative	
Short-term/Long-term Disability	Reliance Standard Life Matrix Absence Management	866.533.3437	matrixabsence.com
Employee Assistance Program (EAP)	SupportLinc	888.881.5462	supportlinc.com **Username:** CHS
Whole Life Insurance	Boston Mutual	800.669.2668	Boston Mutual is a frozen benefit. New enrollment and policy changes are not allowed.

TBC
The Benefit Company

Updated: January 14, 2022 12:40 PM