2021
Employee Benefits Guide

Resources to take care of your present and prepare for your future

Capital Region®
MEDICAL CENTER
An Affiliate of Health Care
Better. Every day.

Employee Benefits Enrollment & Eligibility

Capital Region Medical Center offers an excellent selection of benefits for eligible employees.

This Employee Benefits Enrollment Guide is designed to familiarize you with the benefits that are available to you. Benefits are a significant part of your total compensation package. It is important to be aware of the benefits and the value they represent.

Eligibility

Benefit eligible employees (full time, weekend program employees, and part-time benefit eligible employees) and their eligible dependents may participate in the Capital Region Medical Center Benefits Program following their waiting period.

Generally, for the Capital Region Medical Center Benefits Program, dependents are defined as:

- Legal Spouse
- Dependent "child" up to age 26
- (Child means the employee's natural child or adopted child and any other child as defined in the certificate of coverage)
- Your disabled children of any age

If you and your spouse are both employees of the company, dependent children can only be covered under either your coverage or your spouse's coverage, but not under both.

What is Open Enrollment?

Open Enrollment is a once-a-year opportunity to make changes to your current benefits and to review which dependents you will be covering during the new plan year. All changes you request will take effect January 1, 2020.

Open Enrollment Dates:
Thursday, October 22, 2020-
Wednesday, November 10, 2020

Making Election Changes during the year?

In most cases, your benefit elections remain in effect until the next annual open enrollment period. You will not be able to make any plan changes unless you experience a life status change.

For questions regarding your benefits or enrollment options, please contact:

Human Resources

573-632-5046

Life Status Change Events

Events described in IRS regulations allow you to make a change to your benefit coverage if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment / ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

You have 31 days from the date of the event to report and update your benefits with the Human Resources department.

What's new this year?

- No rate increase for the High Deductible Health Plan
- Capital Region Medical Center will contribute $25 per pay period to employee's HSA.
- Rates for the Traditional PPO plan will see a 10% increase in premiums
- Changing from First Health Network to HealthLink Open Access III as our Tier II Network of Providers
- Spousal Surcharge will increase from $50 per pay period to $75 per pay period.

Not making any changes?

All Employees **MUST** re-enroll in the plan even if not making changes from the previous year. You must go online to make these confirmations.

Enrolling for the first time or making changes?

Please go to the Personal section of the Timekeeping system and select Benefit>Benefit Plans to begin your online open enrollment process for the Health, Vision and Dental plans.

Frequently Asked Questions

What is a Deductible?

A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for health care services rendered. For example, if you have a $1,500 deductible, you would be required to pay the first $1,500, in total, of any claims during a plan year. The deductible excludes copayments where applicable.

What is Coinsurance?

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible.

When do I pay a Copayment?

Expect to pay a copayment for doctor's visits, emergency room visits and urgent care center visits.

How do I know when to go to an Urgent Care Center vs. the Emergency Room?

If you need medical care when your regular doctor is not available, think about going to an urgent care center. The urgent care center should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out -of-town. The copayment is less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for true emergencies such as broken bones, vigorous bleeding or severe pain.

The next time you are faced with deciding where to go, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay.

What is Out-Of-Pocket Maximum?

The maximum amount (deductible and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

What is an Explanation of Benefits?

An EOB is a description the insurance company sends to you explaining the health care charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.

What is Preventive Care?

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early.

Remember all preventive care benefits are covered 100% under the two medical plan options.

What is the difference between generic and brand name drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

What is the provider network for 2021?

Tier I Network remains Missouri Custom. Tier II will be moving from First Health to HealthLink Open Access III.

What should I ask my doctor?

Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.

Medical Benefits

Not everyone needs the same automobile or number of bedrooms in their home or apartment. In the same regard, not everyone needs the same type of health insurance plan or drug coverage. Our lives and our needs are diverse. Some are young; some are old. Some of us have families to consider, others don't. Some have major ongoing health issues; others see a doctor once a year just for a physical. These variables and many more influence the decisions we make as individuals.

Capital Region Medical Center offers 2 medical plans administered by Trustmark, Inc. The Medical Plans feature a deductible, office visit copayment, prescription drug coverage and coinsurance for certain services.

Through these plans, you have access to thousands of network physicians and hospitals. You, the employee, and your dependents are responsible for ensuring the providers that you utilize are In Network.

Network Providers for 2021: The Tier 1 network for 2021 will continue to be the **Missouri Custom Network**.
Tier II will move to HealthLink Open Access III. This collaboration will provide enhanced care manage services for our health plan participants. Find in-network providers here: www.missouricustom.com and www.healthlink.com

Compare the plans below.

Base Plan (HDHP)			
Medical Benefit	**Missouri Custom (Tier I)**	**HealthLink (Tier II)**	**Out of Network**
Deductible (You Pay)	$2,800 per person $5,600 max per family	$3,500 per person $7,000 max per family	$5,000 per person $10,000 max per family
Coinsurance (Insurance Pays)	90% of medical charges after you meet deductible	80% of medical charges after you meet deductible	50% of medical charges after you meet deductible
Out of Pocket Maximum (You Pay)	$5,500 per person $11,000 max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.	$6,650 per person $13,300 max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.	Unlimited per person Unlimited max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.
Physician Office Visit (You Pay)	10% AD primary care visit 10% AD specialist visit	20% AD primary care visit 20% AD specialist visit	50% AD primary care visit 50% AD specialist visit
Preventive Care	Covered in full	Covered in full	Not Covered
Emergency Room (You Pay)	10% AD	20% AD	20% AD
Urgent Care (You Pay)	10% AD	20% AD	50% AD
Inpatient Hospital Services (You Pay)	10% AD	20% AD	50% AD
Outpatient Surgery/Services (You Pay)	10% AD	20% AD	50% AD
Lab/X-Ray (You Pay)	10% AD	20% AD	50% AD
Complex Radiology (You Pay)	10% AD	20% AD	50% AD
Pharmacy Benefits	CRMC	In Network	**Out of Network**
Retail Drugs 30-day script (You Pay)	10% AD	10% AD	50% AD
Mail Order Drugs 90-day script (You Pay)	10% AD	10% AD	50% AD

*AD = After Deductible
Refer to the benefit summary or certificate of coverage for more information.

Health Savings Account

New for 2021: Capital Region Medical Center will begin funding employee's Health Savings Accounts (HSAs) at a rate of $25 per pay period. The HSA will be housed at Central Bank. Employees will be issued an HSA Debit Card to be used for qualifying medical expenses.

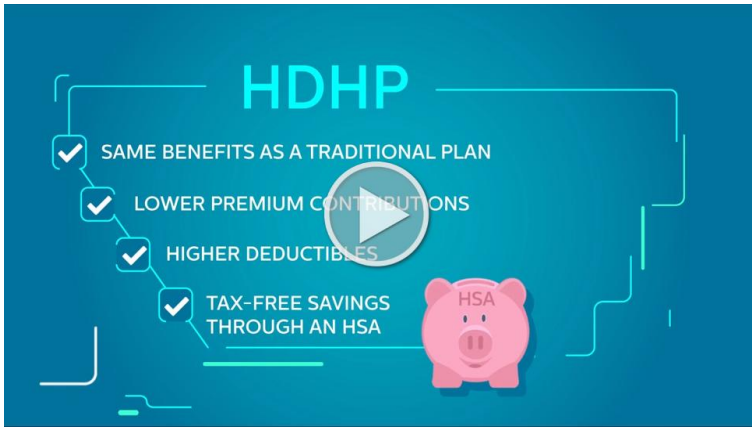
What is a Health Savings Account: A Health Savings Account (HSA) is a tax-exempt account in which funds accumulate to pay for medical expenses. HSAs create tax deductions and, as a result, lower your health care costs.

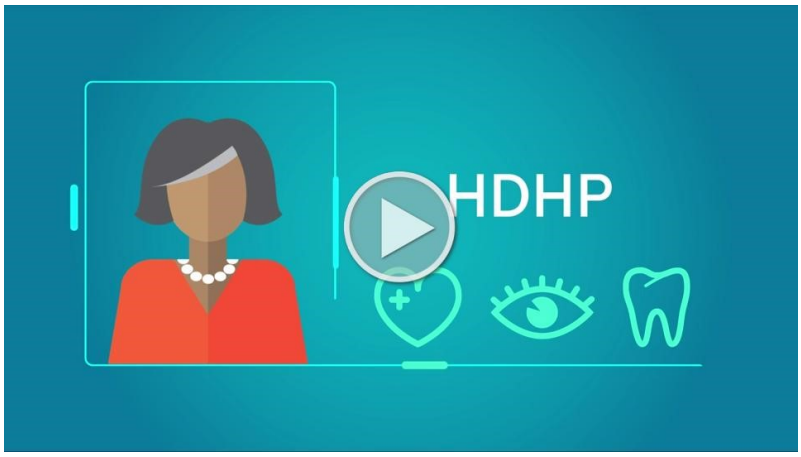
Who is eligible for an HSA? You must have a high deductible health plan (HDHP) that covers yourself or your family; you are not enrolled in Medicare; you cannot be claimed as a dependent on someone else's tax return.

What it the Maximum I Can Contribute to an HSA? Capital Region Medical Center will contribute $25 per pay period ($650 annually) on your behalf into an HSA with Central Bank. The annual contribution limits for 2021 are $3,600 for an individual, and $7,200 for a family. The maximum amount an employee can contribute for 2021 will be $2,950 for an individual, and $6,550 for a family. Catch-up contributions for those 55 and older are $1,000.

What are the Benefits of an HSA?

- Contributions (if made outside of payroll deduction) are 100% tax-deductible.
- You choose if and how you want to invest your contributions
- Contributions to your HSA made by your employer are excluded from your gross income
- Funds rollover from year to year
- The interest or other earnings on the assets in the account are tax-deferred
- Funds can be used t any time for qualified expenses, tax-free





Buy-Up Plan (PPO)			
Medical Benefit	**Missouri Custom (Tier I)**	**HealthLink (Tier II)**	**Out of Network**
Deductible (You Pay)	$1,500 per person $2,500 max per family	$2,000 per person $3,500 max per family	$2,500 per person $4,500 max per family
Coinsurance (Insurance Pays)	80% of medical charges after you meet deductible	70% of medical charges after you meet deductible	50% of medical charges after you meet deductible
Out of Pocket Maximum (You Pay)	$3,500 per person $6,000 max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.	$5,000 per person $9,000 max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.	Unlimited per person Unlimited max per family The deductible is included in the out of pocket max. Copays do not count towards out of pocket max.
Physician Office Visit (You Pay)	$25 copay primary care visit $40 copay specialist visit	30% AD primary care visit 30% AD specialist visit	50% AD primary care visit 50% AD specialist visit
Preventive Care	Covered in full	Covered in full	Not Covered
Emergency Room (You Pay)	$300 copay	$300 copay, then 30% AD	$300 copay, then 30% AD
Urgent Care (You Pay)	$50 copay	30% AD	50% AD
Inpatient Hospital Services (You Pay)	20% AD	$200/day up to $600, then 30% AD	$200/day up to $600, then 50% AD
Outpatient Surgery/Services (You Pay)	20% AD	30% AD	
Lab/X-Ray (You Pay)	20% AD	20% AD	50% AD
Complex Radiology (You Pay)	20% AD	30% AD	50% AD

Pharmacy Benefits		CRMC Pharmacy	**Out of Network**
Out-of-Pocket Prescription Maximum (separate from medical)			
Rx Out of Pocket Max Single/Family		$2,500/$5,000	
Retail Drugs 30- day script (You Pay)	Generic Brand Non-Preferred Brand	$10 Co-pay $35 Co-pay $60 Co-Pay	$20 Co-pay $45 Co-pay $70 Co-pay
CRMC Pharmacy / Mail Order Drugs 90-day script (You Pay)	Generic Brand Non-Preferred	$25 Co-pay $75 Co-pay $115 Co-pay	
Specialty Drugs		10% up to $200 per fill	

*AD = After Deductible
Refer to the benefit summary or certificate of coverage for more information.

2021 Premium Rates* (based on 26 pay periods)

Coverage Level	Medical HSA Base Plan HDHP	Medical PPO Buy-Up plan
Employee Only	$36.25	$96.62
Employee & Spouse	$129.23	$262.01
Employee & Child(ren)	$78.46	$187.42
Employee & Spouse & Child(ren)	$170.77	$328.12

***A $75 per pay period spousal surcharge will apply for those spouses enrolled in the CRMC Health Plan who are eligible for insurance through their employer. A spousal form must be turned in to Human Resources.**

Flexible Spending Accounts with **ASI**

Employees interested in starting or continuing the Flexible Spending Account Benefit for Health Care Flexible Spending Account – FSA (Unreimbursed Medical) and/or the Dependent Care Flexible Spending Account for 2021 **MUST re-enroll**. Enrollment for the Flexible Spending Accounts will be online at https://enroll.asiflex.com
The Employer-Provided Code Word for enrolling with ASI is **CRMC.**

(Detailed enrollment instructions are available on THE REGION.)

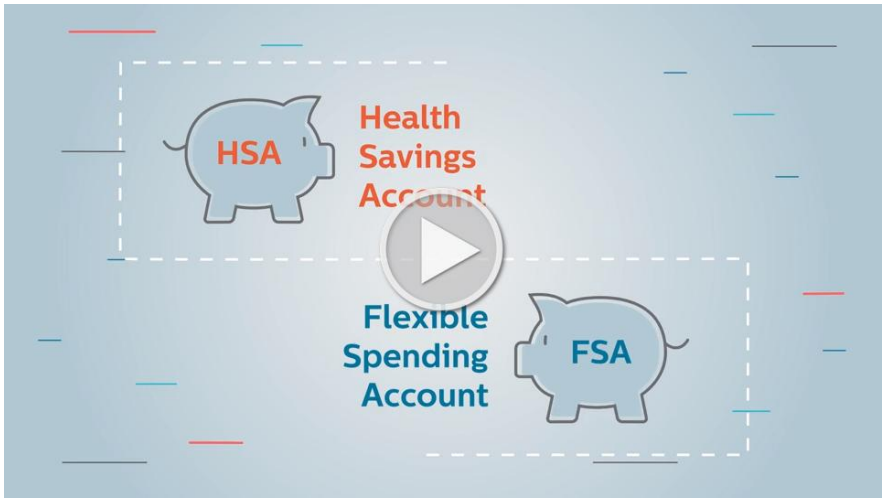
The ASI online enrollment will be available to you from October 22 through November 4, 2020. Online enrollment after November 4 for 2021 plan year will **not** be accepted.

The annual maximum allowable for 2021 is $2,750 for the Unreimbursed Medical and $5,000 for the Dependent Care Account. These deductions will be taken from 26 pay periods for 2021.

If you have a problem accessing the ASI web site, please contact ASI support at 1-800-659-3035, or Human Resources at 632-5046.

Flex Health, Dental and/or Vision Insurance Premiums

As in the past, if you are enrolled in the Health, Dental and/or Vision Insurance benefits, your premiums **are** automatically processed through payroll **pre-tax**.



Dental Benefits

For 2021 the CRMC Dental Plan will once again be insured through Sun Life's Dental Plan, Sun Life Financial. (You will receive a separate card for your Dental benefit from Sun Life). Also, to receive your maximum dental benefit, you will need to access your care through a Sun Life Dental Network provider. The network of dentists can be found by accessing the following site: www.sunlife.com/findadentist .

Calendar Year Maximum	**In-Network**	***Out-of-Network**
Types II and III (Basic and Major) Services	$1,250 per person	$1,250 per person
Type IV Ortho Services	$1,000 lifetime child and adult	$1,000 lifetime child and adult
Calendar Year Deductible Procedure Type	**In-Network**	***Out-of-Network**
Type I Preventive Services Type II, III (Basic and Major Services) Type IV Ortho Services	N/A $50 individual/$150 family N/A	N/A $50 individual/$150 family N/A
Procedure Type	**In-Network**	***Out-of-Network**
Type I Preventive Services Type II Basic Services Type III Major Services Type IV Ortho Services	100% 75% 75% 50%	100% 75% 75% 50%

**Please note that by using an In-Network Provider, you will maximize your annual total benefit and lower your potential out-of-pocket charges.*

Refer to the benefit summary or certificate of coverage for more information.

2021 Premium Rates (based on 26 pay periods)

Coverage Level	Dental Premiums
Employee Only	$15.77
Employee & Spouse	$31.56
Employee & Child(ren)	$38.34
Employee & Spouse & Child(ren)	$44.81

Vision Insurance

CRMC's vision plan is administered through Anthem Blue View. You may choose from many private practice doctors, local optical stores and many national retail stores including LensCrafters, Target Optical, JCPenney Optical, etc. Find participating providers by visiting www.anthem.com. In-Network benefits include a $10 copay for your annual vision exam. A $20 materials copay will provide frames every two years, or lenses (contacts or glass lenses) every year. Please refer to the full benefit summary found on The Region for details on allowances, exclusions and limits.

2021 Premium Rates (based on 12 Months):

Coverage Level	Vision
Employee Only	$6.49
Employee & Spouse	$11.35
Employee & Child(ren)	$12.32
Employee & Spouse & Child(ren)	$18.82

Voluntary Long-Term Disability Insurance

Currently Enrolled employees – If you are currently enrolled for the Voluntary Disability insurance, you may now increase your benefit amount without proof of good health, however, the amount of your increase will be subject to a new pre-existing condition limitation period. *Also, please remember that your premium is "aged rated" and you may have a premium increase based on your age as of 1/1/2021.*

Late Entrants – If you were eligible for, but did not enroll for Voluntary Long-Term Disability Insurance, you may be able to enroll now without proof of good health for amounts up to the Guarantee Issue amount. Amounts elected are subject to the usual pre-existing conditions limitation.
A summary of this benefit and enrollment information is available on THE REGION – 2021 Employee Benefits.

Voluntary Short-Term Disability Insurance

If you are interested in the Short-Term Disability Insurance program or would like to make a change to your current benefit through Colonial Life Insurance Company, please call Human Resources at 632-5046 or you may also contact the Colonial Representative, Gaye Holloman at 417-889-1546

Basic Life Insurance

Capital Region Medical Center provides a Basic Group Term Life Insurance through The Harford for all benefit eligible employees at no cost to the employee. For all Full-Time and Weekend Program employees, the policy is equal to 1x's the employee's annual salary. For all Part-Time Benefit Eligible employees, Capital Region Medical Center provides a $15,000 policy. Benefit Summaries and Beneficiary forms can be found on The Region.

Supplemental Term Life Insurance

There is no change in the term life insurance program with **The Hartford** for 2021**.** Your current premiums will remain unchanged. Supplemental Term Life Insurance has always been available to employees to purchase for themselves (to supplement the one times base annual salary that CRMC provides at no cost to full time, weekend program and part-time benefit eligible employees) or for their dependents. Employees wishing to purchase additional coverage for themselves or family members (subject to plan limitations) may talk with a representative during the designated open enrollment times or you may contact Human Resources at 632-5046. During open enrollment, anyemployees who are currently enrolled in supplemental life coverage may increase coverage by two levels up to the Guarantee Issue amount without proof of good health.

Boston Mutual Supplemental Plans

Boston Mutual provides employees with the opportunity to enroll in Accident, Critical Illness with Cancer, and Whole Life plans, to supplement the other benefits offered to CRMC employees.

Accident
- 24-hour coverage (on- and off-the-job)
- Benefits covered (but not limited to) - Emergency Room Visit, Fractures, Dislocations, and Lacerations caused byan accident

Critical Illness
- Family Coverage
- Wellness Benefit included
- Benefits covered (but not limited to) - Cancer, Heart Attack, Stroke, Coma, Paralysis, Server Burns and Alzheimer's disease

Life Insurance
- Coverage until age 95.
- Affordable, Flexible protection
- Constant Coverage
- Wellness Benefit included
- Coverage options include employee, spouse, children and grandchildren.

Capital Region Medical Center
Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 17 for more details.

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

Important Legal Notices Affecting Your Health Plan Coverage

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce your Rights

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

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

Assistance with your Questions

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

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Human Resources
1125 Madison St
Jefferson City, Missouri 65101
573-632-5046

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

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

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

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

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

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

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

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

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

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

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

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

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

Important Notice from Capital Region Medical Center About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2021
Name of Entity/Sender:	Capital Region Medical Center
Contact--Position/Office:	Human Resources
Address:	1125 Madison Street, Jefferson City, MO 65101
Phone Number:	573-632-5046

Important Notice From Capital Region Medical Center About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Capital Region Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. **Capital Region Medical Center has determined that the prescription drug coverage offered by the HDHP HSA Plan through Coresource is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Health Savings Account plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. **You can keep your current HDHP HSA Plan through Coresource. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – It explains your options.**

When Can You Join A Medicare Drug Plan?

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

Since you are losing creditable prescription drug coverage under the HDHP HSA Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the coverage under HDHP HSA Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium

may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Capital Region Medical Center changes. You also may request a copy of this notice at any time.

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

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

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	January 1, 2021
Name of Entity/Sender:	Capital Region Medical Center
Contact--Position/Office:	Human Resources
Address:	1125 Madison Street, Jefferson City, MO 65101
Phone Number:	573-632-5046

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

contact.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Capital Region Medical Center	4. Employer Identification Number (EIN) 44-0556366	
5. Employer address 1125 Madison Street	6. Employer phone number 573-632-5046	
7. City Jefferson City	8. State MO	9. ZIP code 65101
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) 573-632-5046	12. Email address Lburks@crmc.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full time, part- time benefit eligible, weekend program employees

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal Spouse
Dependent "child" up to age 26
(Child means the employee's natural child or adopted child and any other child as defined in the certificate of coverage)
Your disabled children of any age

☐

We do not offer coverage.

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

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

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

• An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)