2020-2021

Benefits Guide

Your Benefits, Your Choice

WELCOME

To Your 2021 Benefits!

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

Open Enrollment is your chance to elect benefits or change your elections for the coming year. The choices you make now will remain with you for all of 2021 and no changes are allowed - unless you experience a qualifying life event as detailed on page 5. **Please review this guide, share it with your family, and make your benefit decisions before your Open Enrollment deadline!**



Annual Open Enrollment is happening from November 1st to November 14th, 2020.

Employee Self-Service Website Enrollment: unum.benselect.com/cghMedical

Step 1: Connect to the website through your web browser at unum.benselect.com/cghMedical.

Step 2: At the "Employee Login" screen, enter your Social Security Number and your personal identification number (PIN). Your PIN is a combination of the last 4 digits of your Social Security Number and the 2-digit year of your birth. For example, if the last 4 digits of your SSN are 3214 and you were born on September 21, 1968, your PIN would be "321468". **All PINs have been reset.** Be sure to make note of the new secure PIN for future use.

If you are having trouble logging on the system, contact your HR department.

Step 3: When the CGH Medical Center Welcome Page appears on your screen that means you are in! Follow the onscreen instructions to enroll in your benefits, find answers to your questions, download forms and more.

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

Sincerely,
CGH Medical Center

All benefits EXCEPT retirement options will be available on the CGH Benefits portal.
Please see page 29 for instructions to login to cghretirement.org
where you will make your retirement elections.

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BE PREPARED

What you need to know before you enroll in benefits.

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

IMPORTANT CHANGES FOR 2020

Unum Life

The new Unum plans match the current Symetra rates and benefits. **If you are currently enrolled, you will be automatically rolled over to the new plan.**

Unum Accident

The new Unum Accident plan features enhanced benefits at slightly lower rates than the Aflac plan offered. Highlights are included in this guide. **If you are currently enrolled in the Aflac Accident plan, you will be automatically rolled over to the new plan in the same tier.** If already enrolled, you do not need to take action unless you want to add dependents, drop or make changes to your coverage elections.

Unum Hospital Indemnity

The new Unum Hospital Indemnity plan features similar benefits at slightly lower rates than the Aflac plan offered. Highlights are included in this guide. **If you are currently enrolled in the Aflac Hospital Indemnity plan, you will be automatically rolled over to the new plan in the same tier.** If already enrolled, you do not need to take action unless you want to add dependents, drop or make changes to your coverage elections.

Unum Critical Illness

The new Unum Critical Illness plan features more covered conditions than the Aflac plan. Highlights are included in this guide. **If you are currently enrolled in the Unum Critical Illness plan, you will be automatically rolled over to the new plan.** If already enrolled, you do not need to take any action unless you want to add dependents, drop or make changes to your coverage elections.

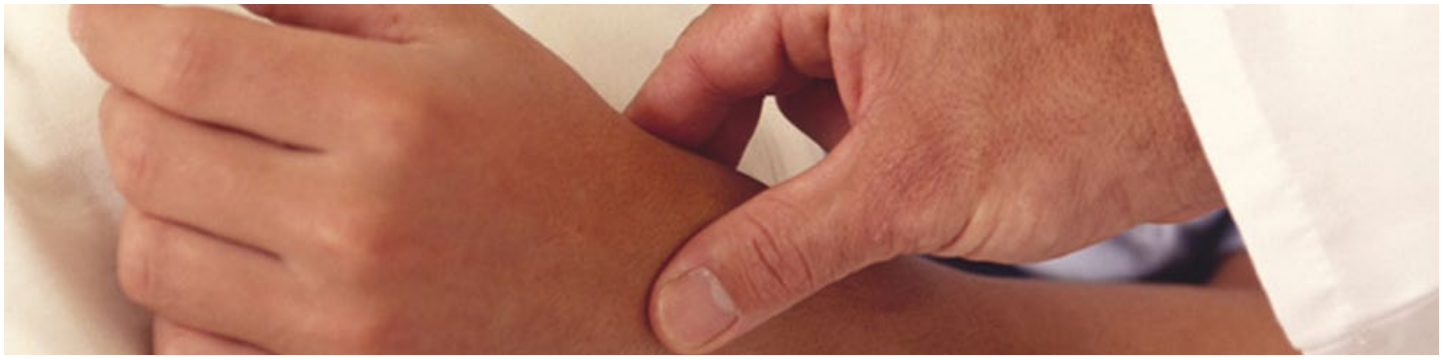
IMPORTANT:

- **New Attained Age/Uni-Tobacco Rate**s – The Unum Critical Illness rates are based on your attained age, similar to the Voluntary Supplemental Life Insurance plan. This is a change from the Aflac plan, which was based on your age as of the original effective date when you elected the coverage. This change will save most employees money, while also allowing CGH Medical Center to streamline processes in the future. Additionally, your tobacco use will no longer be a factor in your premium.
- **New Increments** – Previously, employees could select Critical Illness coverage in $5,000 increments for both employees and spouses. The new Unum plan offers 3 choices for employees ($10,000, $20,000 or $30,000). Spouses and children will be covered at 50% of the employees amount. Children are covered at no additional cost. You will be enrolled at your current volume or rounded up to the next closest increment (Example – An employee with $15,000 of coverage will be automatically enrolled in $20,000).

If you'd like to keep your Aflac benefits for 2021 and beyond,
you may do so on a direct bill basis meaning you'll pay for it outside of CGH.

Call the Aflac service center at 800-992-3522 between January 18th and February 1st, 2021,
Monday to Friday 7:00 am to 7:00 pm CST.

ELIGIBILITY, ENROLLMENT & CHANGES



Eligibility for Benefits

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

Your Eligible Dependents

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

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

Children up to age 26 as defined below.

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

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

Benefit Election Changes During the Year May Be Made for the Following Reasons:

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

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

Pretax Elections

Some employee premiums will be deductible on a pre-tax basis through payroll deduction. Due to IRS rules, elections cannot be revoked or changed during the plan year, unless you experience a qualifying event or "Status Change" as described.

BENEFIT CONTACT INFORMATION

Coverage	Carrier	Contact
Medical Insurance	Self-Funded Administered by UMR	800-826-9781 www.umr.com
Locate In-Network Providers	UMR	
Dental Insurance	UMR	
Flexible Spending Accounts	Employee Benefits Corporation	800-346-2126 (Option 1) www.ebcflex.com
Employee Assistance Program	Moeller, Myers & Associates, PC	815-626-8760
Defined Contribution Plan	OneAmerica & UBS-The Klaas Group	OneAmerica: 800-858-3829 UBS- The Klaas Group: 847-277-2165 www.cghretirement.org
IMRF Defined Benefit Plan	Illinois Municipal Retirement Fund (IMRF)	800-275-4673 www.imrf.org
Additional Company Benefits	See CGH Medical Center Human Resources	
Additional Voluntary Benefits		

CGH Medical Center Human Resources

Tracey McCaslin
Benefits Administrator

PHONE	ADDRESS
815.625.0400 x5664 815.625.6175 (FAX)	100 E. Le Fevre Rd. Sterling, IL 61081

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HOW MY MEDICAL PLAN WORKS

Participating Provider Option (PPO) Plan

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

In-Network Benefits	Out-of-Network Benefits
When you visit a provider that is within the PPO network, you will maximize the benefits of your medical plan. You do not have to select a Primary Care Physician, nor do you need a referral to see a specialist. Simply visit any doctor you choose within the PPO network for your medical need. Even within the PPO Network, you are responsible for the annual deductible before your plan begins paying coinsurance for most benefits. After your deductible is met, you are only responsible for your portion up to your annual out-of-pocket maximum. ***All services under the PPO Plan must be provided by participating providers to be covered at the In-Network benefit level. Services received elsewhere will be paid at the Out-of-Network level of benefits.***	Your plan allows you to visit any provider you want, even if they are not within the PPO network. However, you will pay more for the services of any provider who is out-of-network, and you will have to satisfy your out-of-network deductible before the plan's coinsurance kicks in. When you visit an out-of-network provider, the plan bases its payments on what it considers the usual & customary rate (U&C) for each service provided. If the charge incurred is more than the U&C limit set forth by the plan, you are responsible for paying the full difference between the charge and what the plan pays. When you receive out-of-network care, you are responsible for filing claim forms for reimbursement. As with in-network providers, you will still need to contact UMR to pre-certify hospital stays and certain outpatient procedures.

Locate a participating provider at **www.umr.com** or call UMR at **800-826-9781**.

Pre-Certification Process

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

What Treatment Requires Pre-certification?
Inpatient Hospitalization, including:

- Inpatient maternity stays over 48 hours for normal delivery and 96 hours for C-section
- Inpatient behavioral health
- Transplant and related services
- Skilled nursing facility (extended care)
- Residential treatment

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

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

How do I pre-certify?
Call 866-494-4502 BEFORE you/your family member has a procedure done. Have your insurance card and ID number available.

MEDICAL "BASE" PLAN SUMMARY & RATES

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

Deductible	In-Network	Out-of-Network
Individual	$750	$3,000
Family	$1,500	$6,000
Coinsurance (You Pay)	You Pay 20%	You Pay 50%
Out-Of-Pocket Maximum	**In-Network**	**Out-of-Network**
Individual	$2,500	$7,000
Family	$5,000	$14,000
Overview of Benefits Paid by Plan	**In-Network**	**Out-of-Network**
Preventative Care	No Charge	Not Covered
Office Visits *PCP: Primary Care Provider* *SPC: Specialty Care Provider*	CGH (PCP & SPC) $25 Copay (PCP) $35 Copay (SPC) $50 Copay	(PCP) You Pay 50% (SPC) You Pay 50%
Emergency Room Services (MUST be a true emergency)	You Pay 20% *Deductible Waived if Admitted*	You Pay 20% *Deductible Waived if Admitted*
Emergency Transportation	You Pay 20% *Deductible Waived*	You Pay 20%
Hospitalization	CGH (Facility) You Pay 0% (Facility) You Pay 20% (Physician) You Pay 20%	(Facility) You Pay 50% (Physician) You Pay 50%
Urgent Care	You Pay 20%	You Pay 50%

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

Prescription Drug Benefits (Out-of-Network is Not Covered)	CGH Pharmacy Price per 31 day supply	Rx Benefits Network Pharmacy Price per 31 day supply
	Pharmacy Annual Out-of-Pocket Max.: $4,350 (single) / $8,700 (family)	Pharmacy Annual Out-of-Pocket Max.: $2,350 (single) / $4,700 (family)
Generic	$4 Copay	$35 Copay
Preferred Brand, Formulary	$15 Copay	$50 Copay
Non-Preferred Brand, Non Formulary	You Pay 50%	You Pay 50%
Specialty Drugs *Must be reviewed and approved by PBM before purchase! Must be obtained through CGH Pharmacy for benefits to apply. Refer to SBC for details.*	You Pay 20%	You Pay 20%

Per-Paycheck Employee Premiums	FT No Tobacco	FT Tobacco	PT No Tobacco	PT Tobacco
Single	$31.26	$78.16	$87.54	$125.06
Single + Child(ren)	$60.48	$193.24	$186.57	$287.86
Family	$88.36	$217.50	$206.62	$309.93

MEDICAL "VALUE" PLAN SUMMARY & RATES

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

Deductible	In-Network	Out-of-Network
Individual	$1,500	Not Covered
Family	$3,000	
Coinsurance (You Pay)	You Pay 30%	
Out-Of-Pocket Maximum	**In-Network**	**Out-of-Network**
Individual	$3,500	Not Covered
Family	$6,000	
Overview of Benefits Paid by Plan	**In-Network**	**Out-of-Network**
Preventative Care	No Charge	Not Covered
Office Visits *PCP: Primary Care Provider* *SPC: Specialty Care Provider*	CGH (PCP & SPC) $35 copay (PCP) $100 Copay (SPC) $125 Copay	Not Covered
Emergency Room Services (MUST be a true emergency)	You Pay 30% *Deductible Waived if Admitted*	You Pay 30% *Deductible Waived if Admitted*
Emergency Transportation	You Pay 30% *Deductible Waived*	You Pay 30%
Hospitalization	CGH (Facility) You Pay 0% (Facility) You Pay 30% (Physician) You Pay 30%	Not Covered
Urgent Care	You Pay 30%	Not Covered

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by using **www.umr.com** or **800-826-9781**

Prescription Drug Benefits (Out-of-Network is Not Covered)	CGH Pharmacy Price per 31 day supply	Rx Benefits Network Pharmacy Price per 31 day supply
	Pharmacy Annual Out-of-Pocket Max.: $3,350 (single) / $7,700 (family)	Pharmacy Annual Out-of-Pocket Max.: $850 (single) / $1,700 (family)
Generic	$10 Copay	$50 Copay
Preferred Brand, Formulary	$30 Copay	$75 Copay
Non-Preferred Brand, Non Formulary	You Pay 50%	You Pay 50%
Specialty Drugs *Must be reviewed and approved by PBM before purchase! Must be obtained through CGH Pharmacy for benefits to apply. Refer to SBC for details.*	You Pay 20%	You Pay 20%

Per-Paycheck Employee Premiums	FT No Tobacco	FT Tobacco	PT No Tobacco	PT Tobacco
Single	$14.69	$36.70	$41.10	$58.72
Single + Child(ren)	$30.24	$89.36	$86.27	$133.11
Family	$40.86	$100.57	$95.54	$143.31

FLEXIBLE SPENDING ACCOUNTS

CGH Medical Center offers you two different FSA options: a Medical Reimbursement Account and a Dependent Care Reimbursement Account. By using these accounts, you can save money and bring home more of your income by paying for medical care and dependent care expenses using PRE-TAX dollars from your payroll.

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

IMPORTANT TO NOTE:

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

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

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

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

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

For a complete list of eligible medical expenses see IRS publication 502: http://www.irs.gov/publications/p502/
For a complete list of eligible dependent care expenses see IRS publication 503: http://www.irs.gov/publications/p503/

Flexible Spending Account FAQs

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

When Do I Make My Election?
You need to make your election during Open Enrollment at your employer. This usually occurs once per year prior to the start of the new plan year. The start of the plan year may vary.

Can I Change My Benefit Election Mid-Year?
Medical reimbursement accounts can be changed with a qualifying event (i.e. marriage, divorce, death or a spouse or child, birth or adoption of a child, termination of employment of your spouse, or a change in work schedule). You may change your reimbursement election if you were enrolled in the plan prior to the qualifying event and you wish to change your election.

Changes must be made within 30 days of the event.

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

What Happens If My Reimbursement Request Exceeds The Balance In My Account?
Your medical reimbursement account claims will be paid in full, up to the annual amount you have elected to have withheld for that plan year.

What Happens To The Money In My Account If I Should Terminate Employment?
You would be entitled to reimbursement for expenses which were incurred within the same plan year and before your termination date. Your plan allows you to submit claims up to 180 days after termination in the plan.

What Happens To Any Money Left Over At The Close Of The Plan Year?
Your plan allows a "Grace Period" of 2.5 months so you may use any remaining money between January 1st and March 15th following the close of the plan-year (December 31st).

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

When Can I Incur Claims?
Your plan year allows you to incur claims from January 1st - December 31st, each year. There is an additional "Grace Period" allowing you to incur claims through March 15th, of the next plan year.

For example: *You may incur claims January 1st, 2021 - December 31st, 2021. Using the "grace period" you may continue to incur claims up until March 15th, 2022.*

What Is The Filing Deadline For Claims Submission?
You may file claims up through March 31st of the year following the end of the plan-year.

For example: *If you incur claims January 1st, 2021 - December 31st, 2021, you will have until March 31st, 2022 to submit claims.*

DENTAL PLAN SUMMARY & RATES

CGH Medical Center offers you the option to buy affordable Dental Insurance through UMR.

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

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

Dental Benefit Summary	
Annual Maximum Benefit for Class I, II, III services combined	$1,800
Orthodontia Maximum Lifetime Benefit	$1,500 (Covered dependent children under age 19)
Type of Service	
Class I: Diagnostic & Preventative Care Like cleanings, exams, x-rays	Covered 100% - No deductible
Class II: Basic Restorative Services Like cavity fillings	Covered 80% - No deductible
Class III: Major Restorative Services Like root canals, crowns, implants	Covered 50% - No deductible
Class IV: Orthodontic Services For covered dependent children only	Covered 50% - No deductible

Per-Paycheck Employee Premiums	
Single	$3.70
Family	$11.86

BE SMILEY!

It's important to see a dentist twice a year, and not just for your teeth!
Did you know that gum disease has been linked to heart disease, strokes, osteoporosis, diabetes, and Alzheimer's?
Taking care of your mouth is taking care of your body.

COMPANY-PAID TERM LIFE & AD&D INSURANCE

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is offering you this coverage at no cost to you. Unum is the leading provider of employee benefits, with more than 165 years of experience.[1] We'll be there to back our benefits and provide you with the support you need.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 20 hours per week, you can receive coverage for:

You:	You can receive 1 times your earnings up to a maximum of $200,000. You can get up to $200,000 with no health questions.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	You can get 1 times your earnings of AD&D coverage up to a maximum of $200,000.

No questions or health exams required for AD&D coverage.

1 Unum internal data, 2017

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths that are caused by suicide occurring within 24 months after the effective date of coverage or the date that increases to existing coverage becomes effective. This exclusion standardly applies to all medically written amounts and contributory amounts that are funded by the employee including shared funding plans.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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VOLUNTARY TERM LIFE INSURANCE

Term Life Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

Why is this coverage so valuable?

If you buy a minimum of $10,000 of coverage now, you can increase your coverage in the future up to $150,000 to meet your growing needs. You won't have to answer any health questions or take a health exam.

Who can get Term Life coverage?

If you are actively at work at least 20 hours per week, you may apply for coverage for:

You:	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. You can get up to $150,000 with no health questions. This is your guaranteed issue amount.
Your spouse:	Get up to $100,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to $50,000 with no health questions, if eligible (see delayed effective date). This is their guaranteed issue amount.
Your children:	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children from live birth to 14 days is $0. The maximum benefit for children 14 days to 6 months is $1,000.

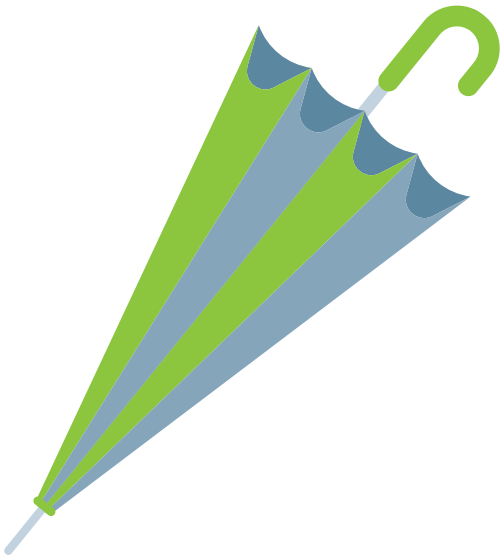
What else is included?

A 'Living' Benefit
If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit. These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlement, and may be taxable. Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium
Your cost may be waived if you are totally disabled for a period of time.

Portability
You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.



How much coverage can I get?

Calculate your costs

1. **Enter the coverage amount you want.**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the rate table (at right) to find the rate based on age.**
   (Choose the age you will be when your coverage becomes effective on 01/01/2021. To determine your spouse rate, choose the age the spouse will be when coverage becomes effective on 01/01/2021.)
4. **Enter your cost.**

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____
			Total cost	

Employee monthly rate	
Age	Per $10,000 of coverage
	Cost
15-24	$0.400
25-29	$0.400
30-34	$0.500
35-39	$0.700
40-44	$1.000
45-49	$1.400
50-54	$2.300
55-59	$3.600
60-64	$5.500
65-69	$10.500
70-74	$20.000
75+	$20.600

Spouse monthly rate	
Per $5,000 of coverage	
Cost	
$0.200	
$0.200	
$0.250	
$0.350	
$0.500	
$0.700	
$1.150	
$1.800	
$2.750	
$5.250	
$10.000	
$10.300	

Child monthly rate
$0.380 per $2,000 of coverage

Billed amount may vary slightly.
If you apply for coverage above the guaranteed issue amount, you will be asked health-related questions which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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DISABILITY PLAN SUMMARIES

The following Disability Insurance options are for non-IMRF participating employees only.
If you participate in IMRF, your disability benefit will be through IMRF and you are not eligible for these coverages.

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

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

Company-Paid Long-Term Disability	
Monthly Benefit Amount	50% of your earnings. See Human Resources for your coverage amount.
Benefit Duration	See Human Resources for your benefit duration.
Pre-Existing Condition Exclusion	The pre-existing condition exclusion applies if the insured received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to his or her effective date of coverage; and the disability begins in the first 12 months after his or her effective date of coverage.
Elimination Period	180 days

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

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

Voluntary Short-Term Disability	
Weekly Benefit Amount	60% weekly earnings to $1,000
Benefit Duration	24 weeks
Pre-Existing Condition Limitations	The pre-existing condition exclusion applies if the insured received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to his or her effective date of coverage; and the disability begins in the first 12 months after his or her effective date of coverage.
Elimination Period	14 days injury / 14 days sickness
Employee Cost	Login to unum.benselect.com/cghMedical to learn your personalized rate.

ACCIDENT INSURANCE

Accident Insurance

can pay you money for covered accidental injuries and their treatment.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status. Child coverage is available until the child's 30th birthday if the dependent child is actively enrolled in the military.

How much does it cost?

Your monthly premium	Plan 1
You	$10.55
You and your spouse	$18.75
You and your children	$27.18
Family	$35.38

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 90 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf

Accident Insurance – Schedule of Benefits

Accidental Death and Dismemberment

AD&D	
Employee	$100,000
Spouse	$50,000
Children	$25,000
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	$100,000
Spouse	$50,000
Children	$25,000
Dismemberment	
Both Feet	$100,000
Both Hands	$100,000
One Foot	$50,000
One Hand	$50,000
Thumb and Index Finger of the same Hand	$25,000
Coma	
Coma	$20,000
Loss of Use	
Hearing	$50,000
Sight of one Eye	$50,000
Sight of both Eyes	$100,000
Speech	$50,000
Paralysis	
Uniplegia	$25,000
Hemi/Paraplegia	$50,000
Triplegia	$75,000
Quadriplegia	$100,000

Hospitalization

Admission	$1,000
Admission – Hospital ICU	$300
Daily Stay (amount)	$200
Daily Stay – Hospital ICU (amount)	$400
Short Stay	N/A

Injury

Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$500
2nd Degree Burns - 20% or greater of skin surface	$1,000
3rd Degree Burns - Less than 5% of skin surface	$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$5,000
3rd Degree Burns - 20% or greater of skin surface	$10,000

Injury

Concussion	
Concussion	$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Knee joint (other than patella)	$1,650
Ankle bone or bones of the foot (other than toes)	$1,650
Hip joint	$3,375
Collarbone (sternoclavicular)	$825
Elbow joint	$500
Hand (other than Fingers)	$500
Lower Jaw	$500
Shoulder	$500
Wrist joint	$500
Collarbone (acromioclavicular and separation)	$325
Finger or Toe (Digit)	$150
Kneecap (patella)	$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Skull (except bones of Face or Nose), Depressed	$4,500
Hip or Thigh (femur)	$3,375
Skull (except bones of Face or Nose), Non-depressed	$2,250
Vertebrae, body of (other than Vertebral Processes)	$1,350
Leg (mid to upper tibia or fibula)	$1,350
Pelvis	$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$675
Upper Arm between Elbow and Shoulder (humerus)	$675
Upper Jaw, Maxilla (other than alveolar process)	$675
Ankle (lower tibia or fibula)	$450
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$450
Foot or Heel (other than Toes)	$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$450
Kneecap (patella)	$450

Injury

Lower Jaw, Mandible (other than alveolar process)	$450
Vertebral Processes	$450
Rib	$450
Tailbone (coccyx) , Sacrum	$450
Finger or Toe (Digit)	$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$50
Repair Less than 2 inches	$150
Repair At least 2 inches but less than 6 inches	$300
Repair 6 inches or greater	$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$750
One Digit (a Thumb or Big Toe)	$1,125
Two or more Digits	$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$150
Ruptured or Herniated Disc	
One Disc	$150
Two or more Discs	$250

Recovery

At-Home Care	$75
Physician Follow-Up Visits	$50
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$50
Therapy Services (chiro, speech, PT, occ)	$15
Therapy Services Maximum Days	15 Days

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$60
General Anesthesia	$150

Surgery

Connective Tissue	
Exploratory without Repair	$75
Repair for One Connective Tissue	$600
Repair for Two or more Connective Tissues	$900
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$200
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,000
Incidence per covered accident	1 Per Insured
Exploratory	$100
Hernia Surgery	
Hernia Surgery	$100
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$100
Knee Cartilage (Meniscus) with Repair	$500
Outpatient Surgical Facility	
Outpatient Surgical Facility	$200
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$100
One Disc	$525
Two or more Discs	$800

Treatment

Ambulance	
Air	$1,000
Ground	$200
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$35
Tier 2 (bedside commode, cold therapy system, crutches)	$75
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$150
Emergency Dental Repair	
Dental Crown	$300
Dental Extraction	$100
Filling or Chip Repair	$75
Imaging	
Tier 1: X-rays or Ultrasound	$50

Treatment

Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$200
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$100
Prosthetic Device	
One Device or Limb	$500
Two or more Devices or Limbs	$1,000
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$125
Not Burns - 20% or greater of skin surface	$250
Treatment	
Emergency Room Treatment	$50
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$100
Transfusions	$300
Transportation (per trip)	$75
Treatment in a Physician's Office or Urgent Care Facility (initial)	$75

Accident Insurance

See Schedule of Benefits for a complete listing of what is covered.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as the result of any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- an occupational injury;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug,alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Termination of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:

- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.
  However, as long as premium is paid as required, coverage will continue
- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.
  We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

Accident Insurance

THIS IS A LIMITED BENEFITS POLICY

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GAP16-1 et al. or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

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CRITICAL ILLNESS INSURANCE

Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical illnesses	
• Heart attack • Stroke • Major organ failure • End-stage kidney failure	• Coronary artery disease **Major (50%):** Coronary artery bypass graft or valve replacement **Minor (10%):** Balloon angioplasty or stent placement

Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive	• Non-invasive cancer (25%) • Skin cancer — $500

Progressive diseases	Supplemental conditions
• Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease All conditions are paid at 25%	• Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D • Infectious Diseases (25%)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- If you apply during your initial enrollment, you can get coverage without a health exam or medical questions.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit	
Every year, each family member who has Critical Illness coverage can also receive a payment for getting a covered Be Well Benefit screening test, such as:	
• Annual exams by a physician include sports physicals, well-child visits, dental and vision exams • Screenings for cancer, including pap smear, colonoscopy • Cardiovascular function screenings	• Screenings for cholesterol and diabetes • Imaging studies, including chest X-ray, mammography • Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical questions if you apply during this enrollment.
Your spouse:	Spouses can get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 90 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Critical Illness Insurance benefit and cost

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$3.64	$2.74
25 - 29	$4.54	$3.19
30 - 34	$5.64	$3.74
35 - 39	$7.44	$4.64
40 - 44	$9.64	$5.74
45 - 49	$12.54	$7.19
50 - 54	$15.64	$8.74
55 - 59	$21.04	$11.44
60 - 64	$29.14	$15.49
65 - 69	$41.84	$21.84
70 - 74	$64.84	$33.34
75 - 79	$95.34	$48.59
80 - 84	$138.74	$70.29
85+	$223.14	$112.49

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $75	
	Employee	Spouse
under 25	$7.28	$5.48
25 - 29	$9.08	$6.38
30 - 34	$11.28	$7.48
35 - 39	$14.88	$9.28
40 - 44	$19.28	$11.48
45 - 49	$25.08	$14.38
50 - 54	$31.28	$17.48
55 - 59	$42.08	$22.88
60 - 64	$58.28	$30.98
65 - 69	$83.68	$43.68
70 - 74	$129.68	$66.68
75 - 79	$190.68	$97.18
80 - 84	$277.48	$140.58
85+	$446.28	$224.98

Monthly costs		
Age	Employee coverage: $30,000 Spouse coverage: $15,000 Be Well benefit: $100	
	Employee	Spouse
under 25	$10.92	$8.22
25 - 29	$13.62	$9.57
30 - 34	$16.92	$11.22
35 - 39	$22.32	$13.92
40 - 44	$28.92	$17.22
45 - 49	$37.62	$21.57
50 - 54	$46.92	$26.22
55 - 59	$63.12	$34.32
60 - 64	$87.42	$46.47
65 - 69	$125.52	$65.52
70 - 74	$194.52	$100.02
75 - 79	$286.02	$145.77
80 - 84	$416.22	$210.87
85+	$669.42	$337.47

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Date of diagnosis must be after the coverage effective date.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, or occurs as a result of any of the following:

committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or Injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, intoxicant, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; being Intoxicated; and a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution;

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS. This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete definitions of coverage and availability, please refer to Certificate Form GCIC16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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HOSPITAL INDEMNITY INSURANCE

Hospital Insurance

can pay benefits that help you with the costs of a covered hospital visit.

How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth.

Why is this coverage so valuable?

- The money is paid directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get affordable rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.
- The plan provides enhanced Hospital benefits of none% when you use hospitals owned, operated, or controlled by your employer. This enhanced benefit applies to Hospital Admission, Hospital Daily Stay, and ICU Daily Stay.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive $50 for getting a covered Be Well screening test, such as:

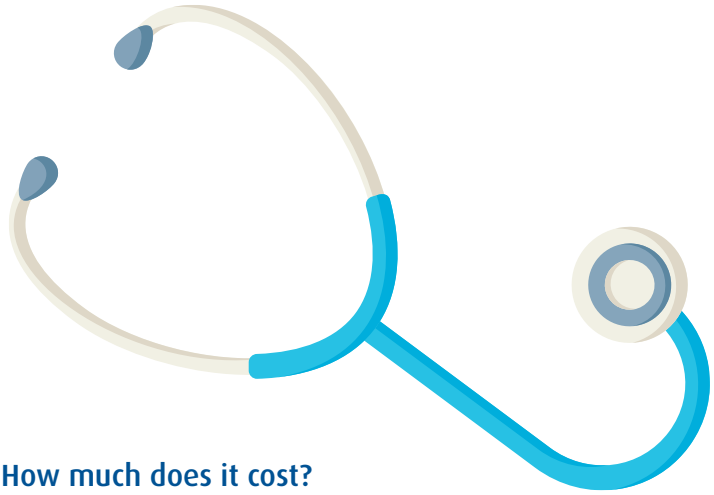
- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

This plan has a childbirth limitation. See disclosures for more information.

Who can get coverage?

You:	If you're actively at work
Your spouse:	Ages 17 and up
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.



How much does it cost?

Your monthly premium	Option 1
You	$24.04
You and your spouse	$46.60
You and your children	$33.88
Family	$56.44

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf.

Hospital		
Option 1 benefits		
Hospital Admission	Payable for a maximum of 1 day per year	$1,000
Hospital Daily Stay	Payable per day up to 365 days	$150
ICU Daily Stay	Payable per day up to 15 days	$150

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours per week each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 90 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date.

Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate.

If you have not returned to Active Employment before any Insured's covered loss, any benefits payable will be limited to what would have been paid by the prior carrier.

Childbirth Limitation

We will not pay benefits due to Childbirth for any Insured within the first nine months after the Insured's Coverage Effective Date.

Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- Committing or attempting to commit a felony;
- Being engaged in an illegal occupation;
- Injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- Active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- Participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- Being Intoxicated as defined and determined by the laws of the state of occurrence;
- A Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- Elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- Any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- Voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- Stroke, Alzheimer's disease, trauma, viral infection; or
- Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage as defined in federal law. Some states may require individuals to have comprehensive medical coverage before purchasing hospital insurance.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete definitions of coverage and availability, please refer to Certificate Form GHIP16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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ADDITIONAL COMPANY BENEFITS

CGH Medical Center is proud to offer our employees the following additional benefits at no cost to you! All benefits are paid by the company and you will be automatically enrolled when eligible.

PAID TIME OFF (PTO) (Based on actual hours worked up to 40 hours per week)

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10-14	Year 15-20	Year 21+
21 Days	22 Days	23 Days	24 Days	25 Days	26 Days	27 Days	28 Days	29 Days	30 Days	32 Days	35 Days

PTO covered vacation, sick days, holidays, and bereavement days.	In July of each year, all accrued PTO balances are reduced to 480 hours. The balance over 480 is reviewed and will be paid to the employee to a maximum of 80 hours less any PTO cash-in the employee has taken during the year. Shift premium is excluded from the calculation.	If you have 200 or more hours of PTO, you can cash in 20 hours per pay period (80 hours per year is the max cash in allowance.)	You also may "donate" PTO to other employee in time of need as long as you have over 200 hours in your PTO Bank and they are on approved leave.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

What is an EAP?	Includes:
CGH Medical Center provides you with professional assistance to identify and resolve personal problems that may interfere with your well-being and job performance. EAP counselors are available to offer you confidential assistance or referral information. Two free visits per year are included in this benefit and your insurance will continue covering mental health after that.	▪ Family and marital issues ▪ Emotional strains and stress ▪ Chemical dependency ▪ Alcohol dependency ▪ Financial concerns

RETIREMENT PLAN OPTIONS

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

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

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

Please note: you may participate in both plans at the same time, however if you do so, you will only receive contributions from CGH to the IMRF plan. Your one America plan would receive no CGH contributions.

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

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

Retirement Plan Options Continued

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

Logging into your OneAmerica account

Go to: www.cghretirement.org

Verify your identity with your plans by providing:

- **Social Security Number**
- **Date of Birth**
- **Zip Code**

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

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

For investment related questions, contact:
The Klaas Group/UBS (877) 846-9827
Karoline.oconnor@ubs.com
303 E. Main St., 3rd Floor Barrington, IL 60010

REQUIRED NOTICES

CGH Medical Center
Health Law Notices

Michelle's Law Notice
If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave
Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

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

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

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

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2020. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

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

ALASKA-Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Website:
https://www.healthfirstcolorado.com/
Phone: 1-800-221-3943
CHP+ Website:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Phone: 1-800-359-1991
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
Phone: 1-855-692-6442

FLORIDA-Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA-Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA-Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY-Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Medicaid Website: https://chfs.ky.gov

LOUISIANA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740

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

MINNESOTA-Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

NEBRASKA-Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

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

NEW HAMPSHIRE-Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP
Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

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

NORTH DAKOTA-Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

OREGON-Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA-Medicaid
Website:https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND-Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

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

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

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

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

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

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

WASHINGTON-Medicaid
Website: http://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA-Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN-Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING-Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Important Disclosures

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

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

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

Maternity Coverage Length of Hospital Stay
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders
A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning

of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

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

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

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

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

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

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices Effective Date: March 1, 2013

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

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

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

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

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

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

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

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

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

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

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

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

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

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

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

Notice in Case of Breach
CGH Medical Center is required maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

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

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and

procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

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

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400 to make this request.

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

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at CGH Medical Center, 100 E. LeFevre Road, Sterling, IL 61081, 815-625-0400. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CGH Medical Center and about your options under Medicare's

prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current CGH Medical Center coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current CGH Medical Center coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with CGH Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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 CGH 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: 09-15-2020
Name of Entity/Sender: CGH Medical Center
Contact--Position/Office: Human Resources
Address: 100 E. LeFevre Road, Sterling, IL 61081
Phone Number: 815-625-0400