BENEFIT ENROLLMENT GUIDE

2018
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Benefits designed for you and your family
CAMC Health System Inc. is pleased to provide our employees with one of the most comprehensive benefit packages available today. We recognize the importance of providing comprehensive benefits and consider them to be a major part of your total compensation package. Our program includes medical, vision, dental, employee, spouse, and child term life, accidental death and dismemberment, short-term disability, long-term disability, retirement planning, health care spending account dependent care spending account and health savings account.

The Benefit Enrollment Guide is an overview of the summary of benefits for each benefit option in which you may enroll. It serves as a handy reference for you and your family, enabling you to receive the most from your benefit plans throughout the year. Whenever you have questions about your benefits, this packet is a good place to start.

If there is any difference between this booklet and the official plan documents, the latter will govern.

Lawson Self Service (LSS) employee portal
LSS is an employee portal to our human resources system that allows individuals to access various personal information. You can view and print your own paycheck information. You can make tax-withholding changes, add emergency contacts, change direct deposit set up, and view and change employee benefits during annual enrollment. All new employees will be shown how to access the system during new employee orientation. LSS is not available from your home. You can only access LSS from a CAMC computer.
Am I eligible for benefits?
Eligibility for benefits is determined by employment status as outlined in chart:

<table>
<thead>
<tr>
<th>Status</th>
<th>Hours per pay</th>
<th>Benefit Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time 01, 21, 31, 61</td>
<td>80</td>
<td>Eligible for all benefits</td>
</tr>
<tr>
<td>Prorata 09, 39</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Prorata 08, 38</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Prorata 07, 37</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Prorata 06, 36</td>
<td>48</td>
<td>Not eligible for medical insurance</td>
</tr>
<tr>
<td>Prorata 05, 35</td>
<td>40</td>
<td>but eligible for all other benefits</td>
</tr>
<tr>
<td>Special Part Time 10</td>
<td>Less than 20</td>
<td>Only eligible for retirement 401K Plan</td>
</tr>
<tr>
<td>Regular Casual 12</td>
<td>Less than 20</td>
<td></td>
</tr>
<tr>
<td>Per Diem 11</td>
<td>Contract employee</td>
<td>Not eligible for any benefits</td>
</tr>
</tbody>
</table>

Who can I put on my benefits?
For family members eligible dependents include*:

1. Your lawful spouse
2. Your child until the end of the month he/she attains age 26 and is either:
   - A blood descendant of the first degree
   - Legally adopted child or a child who is living with the eligible employee as an adopting parent during any period of probation
   - A step child
   - An individual for whom the eligible employee has been appointed legal guardian
3. Your unmarried child who is mentally or physically incapable of self-support and is claimed as a dependent by the eligible employee for Federal Income Tax purposes and was covered in the component plan in question immediately prior to aging out as an eligible dependent.

For additional information on eligibility requirements, please refer to the Summary Plan Description or call the human resources department.

Dependent eligibility verification
CAMC requires proof of dependent eligibility prior to entry of dependent information into Lawson as an active dependent. You will need to provide the following documents at new hire orientation or to Human Resources within 30 days of hire or becoming benefit eligible.

Spouse:
Marriage Certificate
Most recent tax return (if married prior to current year)
Spouse Health Coverage Verification Form (if electing medical coverage on spouse)

Child(ren):
Birth Certificate
You may purchase certified records of West Virginia marriages and births through the West Virginia Vital Registration Office, Health Statistics Center, at 350 Capitol St., Charleston, WV 25301. You may also purchase records online at wvdhhr.org/bph/hsc. Call the Health Statistics Center directly at (304) 558-2931.

Please contact the human resources office for dependent eligibility verification options if you are unable to provide the documents listed above.

Please note: you will not be permitted to enroll dependents in your benefits until their eligibility is confirmed.

*CAMC and its medical service providers reserve the right to audit dependent eligibility. If you provide false information or documents that do not provide credible support as verification of dependent eligibility, then your dependents’ benefit claims may be denied, coverage will be terminated retroactively, and premiums will not be refunded. In addition, if you provide false information when enrolling or verifying your dependents, you may also be subject to disciplinary action – up to and including termination.
Important dates

Enrollment period
The initial enrollment period for a newly benefit eligible employee is 30 days from your date of hire or notification for current employees becoming benefit eligible. If you do not make your elections during this time period, you will have to wait for the annual enrollment period, unless you experience a change in family circumstance.

Enrollment deadline
You must elect your benefits through Lawson self-service by: ______________________

If you do not elect your benefits by this date, you will only be enrolled in the employee group term life plan and the retirement savings plan. After this date, benefits can only be changed at annual enrollment in October with changes effective January 1 of the next year or mid-year due to a change in family circumstance with proper documentation and timely notification.

Benefit effective date
Most benefits go into effect the first of the month following 60 days of employment with benefit premiums starting the first pay of that month.

If elected, these benefits will go into effect _____________

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Initial enrollment effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Employee Supplemental Life</td>
</tr>
<tr>
<td>Vision</td>
<td>Spouse Term Life</td>
</tr>
<tr>
<td>Dental</td>
<td>Child Term Life</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>Long Term Disability</td>
</tr>
<tr>
<td>Health Savings Account</td>
<td></td>
</tr>
<tr>
<td>Retirement Savings 401K Plan</td>
<td>Automatic enrollment at 4% effective first pay</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>Only available to elect at annual enrollment in October with benefit starting next plan year</td>
</tr>
<tr>
<td>Purchased Paid Time Off</td>
<td></td>
</tr>
</tbody>
</table>
Special enrollment mid year

You may change your elections for pre-tax benefits during the annual enrollment period, for the upcoming plan year. Generally, you cannot change your election to participate in the pre-tax premium payment option or vary the pre-tax premium you have selected during the plan year.

The IRS does allow certain exceptions to this rule. These exceptions are commonly referred to as a change in family circumstance or qualifying event. If you experience a qualifying event during the plan year, you may be entitled to a special enrollment period.

**Under HIPAA Special Enrollment and IRS Section 125 rules, employees and/or dependents may make benefit changes due to the following qualifying events:**

- Marriage, divorce or legal separation
- Birth or adoption of a child
- A child reaching an age or situation that removes the dependent status
- Death of an eligible dependent
- Loss or gain of eligibility for benefits of participant, spouse or child.
- When employer contributions toward employee’s or dependent’s coverage terminates
- An employee or dependent becoming entitled to coverage or losing coverage under Part A or Part B Medicare or Medicaid
- Loss or gain of eligibility for a state Children’s Health Insurance Program (CHIP) or Medicaid

**Below are a few examples of changes that you may make as a result of a qualifying event:**

- Adding or dropping a benefit
- Changing coverage levels (i.e. from single coverage to family coverage)
- Adding or removing a dependent (regardless of whether it results in a change in coverage level)

**Notification requirements**

In order to qualify for special enrollment, you must notify the HR office and complete the appropriate forms within 60 days of the qualifying event. In addition, you will be required to present proper documentation of the qualifying event and documentation to verify eligibility of any dependents added to your coverage. If notification is not made within the 60-day timeframe, you will not be permitted to make changes to your benefits until the annual enrollment period or until you experience another qualifying event.

**Special enrollment effective date**

Benefit changes due to qualifying events will become effective the first of the month following completion of change form. Birth/adoption will be effective the date of birth/adoption.

**Important COBRA information**

If your covered spouse or dependent child ceases to be eligible for coverage under a CAMC group health plan as a result of a divorce or the dependent child ceasing to be a dependent child, either you, your former spouse, or the child must notify HR of the event. Failure to do so in a timely manner (60 days from the later of the date of the COBRA qualifying event or the date the beneficiary would otherwise lose coverage) will result in forfeiture of their COBRA rights.
Medical plan

The company offers two comprehensive medical plans for eligible employees. The plans include coverage for a wide range of medically necessary services and offers medical benefits through a three tier network (preferred network, Highmark network, and out of network).

Spouse eligibility
Spouses who are offered employer-sponsored health insurance must be enrolled in their employer’s plan as primary coverage in order to be eligible to enroll in a CAMC medical plan as secondary coverage. Eligibility will be determined by completion of the spouse health coverage verification form.

Medical plan benefits
Your medical plan options reduce health care hassles by providing you with:

- Savings by using the companies’ facilities
- Access to a comprehensive provider network
- Emergency care is covered at the higher reimbursed network level, regardless of where the care is received
- Highmark BCBS recognition across the United States
- 100% coverage for preventive services received in the preferred network

High Deductible Health Plan (HDHP)

- The HDHP is available with lower bi-weekly premiums and a higher deductible. The deductible amount is determined by federal guidelines based on election of a single plan or an employee plus child/spouse or family plan.
- IMPORTANT: Other than specific preventive services, the plan deductible must be met before the insurance covers anything including office visits, prescriptions, lab, X-rays, etc.
- If you elect the HDHP you will be given the opportunity to elect a Health Savings Account (HSA) which you can use to pay for medical expenses (see the health saving account page in this guide for more information).

PPO Plan

- The PPO plan has higher bi-weekly premiums and a lower deductible.
- Coverage begins day 1 with co-pay cost share for office visits and prescriptions.

Review the medical plan highlights on the next page. We encourage you to compare these plans and select the one that best fits the needs of you and your eligible family members.

Highmark self service portal
The Highmark Blue Cross Blue Shield self-service portal is an easy-to-use online resource for managing your medical benefits such as:

- Request replacement ID cards
- Find a provider
- View and print Explanation of Benefits (EOB)
- Check claim status
- Print claim forms
- Print discount coupons

Follow the instructions below to register. You will need your member ID number located on your Highmark identification card

- Go to mybenefitshome.com
- Click on Member tab in the upper right hand corner
- Click on Register now in the box on the right

Tobacco surcharge
As part of the enrollment process in Lawson self service, employees who enroll in the medical plan will be asked to indicate whether or not they use tobacco. It is not required that you disclose whether you use tobacco or not to enroll in CAMC’s medical plan.

- Non-tobacco users will not pay the tobacco surcharge.
- Tobacco users will pay an additional $40 surcharge per pay period and will be offered the opportunity to complete a tobacco cessation education program in order to avoid the $40 per pay surcharge. CAMC will offer free nicotine cessation education programs. Upon successful completion of a program, any surcharges paid will be refunded in full and the surcharge will be removed on the first of the month following HR’s receipt of the required documents for program completion.
- Employees who choose not to disclose and enroll in one of CAMC’s medical plans will pay an additional $40 per pay surcharge.

Have questions? Call Highmark Member Services 1-877-770-6991
### Medical Plan Overview

#### Benefit Period (used for Deductible and Coinsurance limits)

<table>
<thead>
<tr>
<th>CAMC Preferred Network</th>
<th>High Risk Network Facilities and Physician/Professional Providers</th>
<th>Non-Network</th>
<th>CAMC Preferred Network</th>
<th>High Risk Network Facilities and Physician/Professional Providers</th>
<th>Non-Network</th>
<th>CAMC Preferred Network</th>
<th>High Risk Network Facilities and Physician/Professional Providers</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,650</td>
<td>$14,700</td>
<td>Individual</td>
<td>$6,650</td>
<td>$14,700</td>
<td>Individual</td>
<td>$6,650</td>
<td>$14,700</td>
</tr>
<tr>
<td>Family (may be met collectively)</td>
<td>$13,300</td>
<td>$27,400</td>
<td>Family (may be met collectively)</td>
<td>$13,300</td>
<td>$27,400</td>
<td>Family (may be met collectively)</td>
<td>$13,300</td>
<td>$27,400</td>
</tr>
<tr>
<td><strong>Coinsurance Limits</strong></td>
<td></td>
<td></td>
<td><strong>Coinsurance Limits</strong></td>
<td></td>
<td></td>
<td><strong>Coinsurance Limits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$800</td>
<td>$200</td>
<td>Individual</td>
<td>$800</td>
<td>$200</td>
<td>Individual</td>
<td>$800</td>
<td>$200</td>
</tr>
<tr>
<td>Family (may be met collectively)</td>
<td>$5,800</td>
<td>$11,100</td>
<td>Family (may be met collectively)</td>
<td>$5,800</td>
<td>$11,100</td>
<td>Family (may be met collectively)</td>
<td>$5,800</td>
<td>$11,100</td>
</tr>
<tr>
<td><strong>Total Maximum Out of Pocket</strong></td>
<td>(includes deductible, copays and coinsurance per calendar year, Non-Network)**</td>
<td></td>
<td><strong>Total Maximum Out of Pocket</strong></td>
<td>(includes deductible, copays and coinsurance per calendar year, Non-Network)**</td>
<td></td>
<td><strong>Total Maximum Out of Pocket</strong></td>
<td>(includes deductible, copays and coinsurance per calendar year, Non-Network)**</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$7,950</td>
<td>$14,700</td>
<td>Individual</td>
<td>$7,950</td>
<td>$14,700</td>
<td>Individual</td>
<td>$7,950</td>
<td>$14,700</td>
</tr>
</tbody>
</table>

#### Life Time Maximum Benefit

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Value</th>
<th>Single Beneficiary</th>
<th>Family Beneficiary</th>
<th>Unlimited</th>
<th>Non-Preferred</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Office Visit/Outpatient Consultation</strong></td>
<td>$15 Copay per Office Visit</td>
<td>$15 Copay per Office Visit</td>
<td>$15 Copay per Office Visit</td>
<td>Unlimited</td>
<td>$200 Copay per Office Visit</td>
<td>$200 Copay per Office Visit</td>
<td>$200 Copay per Office Visit</td>
<td>Unlimited</td>
<td>$200 Copay per Office Visit</td>
<td>$200 Copay per Office Visit</td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>$5 Copay per Urgent Care Visit</td>
<td>$5 Copay per Urgent Care Visit</td>
<td>$5 Copay per Urgent Care Visit</td>
<td>Unlimited</td>
<td>$120 Copay per Urgent Care Visit</td>
<td>$120 Copay per Urgent Care Visit</td>
<td>$120 Copay per Urgent Care Visit</td>
<td>Unlimited</td>
<td>$120 Copay per Urgent Care Visit</td>
<td>$120 Copay per Urgent Care Visit</td>
</tr>
<tr>
<td><strong>Specialized Office Visit/Outpatient Consultation</strong></td>
<td>$40 Copay per Office Visit</td>
<td>$40 Copay per Office Visit</td>
<td>$40 Copay per Office Visit</td>
<td>Unlimited</td>
<td>$120 Copay per Office Visit</td>
<td>$120 Copay per Office Visit</td>
<td>$120 Copay per Office Visit</td>
<td>Unlimited</td>
<td>$120 Copay per Office Visit</td>
<td>$120 Copay per Office Visit</td>
</tr>
<tr>
<td><strong>Emergency Accident Care/ Emergency Medical Care in the ER (if admitted to any hospital directly from the ER due to an emergency, CAMC Preferred Network Copay, Deducible, and Coinsurance will apply, regardless of facility used.)</strong></td>
<td>Facility Copay of $175</td>
<td>Facility Copay of $175</td>
<td>Facility Copay of $175</td>
<td>Unlimited</td>
<td>Facility Copay of $175</td>
<td>Facility Copay of $175</td>
<td>Facility Copay of $175</td>
<td>Unlimited</td>
<td>Facility Copay of $175</td>
<td>Facility Copay of $175</td>
</tr>
</tbody>
</table>

#### Note

- **Occupational and Physical Therapy** (message therapy is not covered service) - Physical Outpatient Network Services Network - Pay toward the Total Maximum Out-of-Pocket. - If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowance, in addition to your Coinsurance, unless the physician writes "Brand necessary" (DMV) on the prescription, or if no generic equivalents exist.

#### Prescription Deductible

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Value</th>
<th>Single Beneficiary</th>
<th>Family Beneficiary</th>
<th>Unlimited</th>
<th>Non-Preferred</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAMC Internal Pharmacy</strong> - Maximum 90 day supply</td>
<td>No Deductible</td>
<td>No Deductible</td>
<td>No Deductible</td>
<td>Unlimited</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
<td>Unlimited</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
</tr>
</tbody>
</table>

#### Prescription Drugs

- Prescription Drugs are provided through the Pharmacy Network. If you choose a non-CAMC Preferred Network brand, you will pay the difference between the generic and specialty drugs.

#### Non-Preferred Brand

- Member pays 10% up to a maximum of $150 30 days only.

#### Maintenance Drugs

- Maintenance drugs limited to two refills per script through a local pharmacy, thereafter refills must be filled through the CAMC pharmacy if available.

#### CAMC PHARMACY

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Value</th>
<th>Single Beneficiary</th>
<th>Family Beneficiary</th>
<th>Unlimited</th>
<th>Non-Preferred</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Preferred</th>
<th>Non-Network</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>30/90 Day Supply</strong></td>
<td>No Deductible</td>
<td>No Deductible</td>
<td>No Deductible</td>
<td>Unlimited</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
<td>Unlimited</td>
<td>$100 Deductible</td>
<td>$100 Deductible</td>
</tr>
</tbody>
</table>

#### **Total Maximum Out of Pocket**:

- Value includes deductible, copays and coinsurance per calendar year, Non-Network.
CAMC pharmacies

CAMC Pharmacy
As a participant in the medical plan you will pay the lowest costs for your medications when you fill your prescriptions at a CAMC Pharmacy.

90 day fills – Prescriptions written as 90 day fills will lower the number of times you go to the pharmacy for refills and save you a few dollars on your co-pay maximum at CAMC pharmacies. You can request that your physician write your prescriptions for 90 day fills.

There are two CAMC pharmacies you can use to fill prescription drugs.

CAMC Pharmacy at Memorial Hospital
Open seven days a week
Hours 7 a.m. to 7 p.m.
Monday through Friday
9 a.m. to 5:30 p.m.
Saturday and Sunday
(304) 388-9547

CAMC Cancer Center Pharmacy
Hours 8 a.m. to 6 p.m.
Monday through Friday
(304) 388-9700

Delivery options:
Phone prescription refills into the Memorial Pharmacy
(304) 388-9547
Choose the delivery option
Most prescriptions can be delivered to other Charleston area campuses.

How do I transfer prescriptions from a retail pharmacy to a CAMC Pharmacy?
Call the pharmacy you want the prescription moved to and provide them with the following information (can move prescriptions among the CAMC pharmacies without doing this):

- Your name, date of birth, address and phone numbers
- Your prescription plan ID number and person code
- Your current pharmacy’s name, location and phone number
- A list of all the medications you want transferred
How to enroll
If you elect the high deductible health plan you will be given the option to elect the health savings account. If elected, MyCafeteria Plan will send you information to set up your Health Savings bank account. You will have 90 days to activate your bank account. If your account is not activated within 90 days your deductions will be stopped and refunded.

What is an HSA?
An HSA is a special bank account owned by an individual where contributions to the account are used to pay for current and future medical expenses or specifically, to offset the deductible of High Deductible Health plans. Your contributions are made on a pre-tax basis, the funds are portable and the balance rolls over from year to year.

In order to be eligible to participate in CAMC’s HSA:
1. You MUST BE ENROLLED IN CAMC’S High Deductible Health Plan
2. You cannot be enrolled in any medical plan other than a HDHP
3. You cannot be enrolled in Medicare
4. You cannot be claimed as a dependent on anyone’s taxes
5. You are at least 20 years old and not a full time student
6. You cannot be enrolled in a flexible spending account with an HSA. However, you can be enrolled in a limited flexible spending account.

CAMC will annually deposit $200 in your HSA if you have an Employee Only medical plan; or $400 if you have either Employee + Child, Employee + Spouse, or Family coverage. In order to receive CAMC’s annual contribution you must be actively contributing to your HSA account and be actively working.

How does the HSA work?
Your HSA works like a regular savings account at a bank. You can deposit money into your HSA through direct deposit, pre-tax deductions, or family and friends can make post-tax contributions on your behalf. If you are on the employee only HDHP, you can deposit $3,450 per year and if you’re on the Employee + Spouse, Child(ren), or Family HDHP, you can deposit up to $6,900 per year. Maximum contributions include CAMC’s deposit.

How can I spend it?
Eligible expenses include medical, dental and vision expenses with a date of service after your HSA is active. You can pay for any medical expenses for your spouse or your tax dependent children (up to age 24) even if they are not enrolled in your plan and/or have other insurance coverage. Usage is limited to available funds.

What if my spouse has an HSA?
Your combined annual contributions cannot exceed $6,900. Additionally, you must have separate accounts if your spouse has an HSA and you would like to contribute to an HSA as well. The maximum amount you can contribute is based on health insurance coverage levels.

Are there any fees associated with the HSA?
There is an administrative fee of $2.50 per month per account. This monthly fee will be deducted from participants’ accounts.

For more information regarding the HSA, you can visit myCafeteriaPlan.com

Limited Flexible Spending Account
• Can only be elected during annual enrollment with benefit effective January 1, of the next year.
• If an employee elects an HSA and wants to put additional pre-tax dollars away to cover dental vision or medical expenses, they can elect the limited FSA
• The limited FSA can only be used for dental and vision expenses. However, once a participant has met the deductible on the medical plan, it can then be used for any additional medical expenses for the remainder of the year.
• The maximum contribution allowed is $2,600 with the same use it or lose it and roll over rules as the regular flexible spending account.
• For more information regarding the limited flexible spending account, you can visit myCafeteriaPlan.com.
Flexible spending accounts

Can only be elected during annual enrollment with benefit effective January first of next plan year.

Important things to consider before enrolling in flexible spending accounts:
The flexible spending account cannot be your only source of medical coverage. Therefore, you must be covered on a medical plan in order to elect this benefit.

Use it or lose it rule:
• Any amount over $500 follows the use-it-or-lose-it rule.
• Up to $500 of unused funds from your current plan will be allowed to rollover into your new plan year.
• This rollover does NOT count toward your plan’s maximum annual election.
• You must re-elect this benefit each year. Once you authorize deposits to either account for the year, you will not be allowed to change your elections until the next annual enrollment.
• Keep all receipts. According to the IRS, documentation must be provided when additional claim verification is needed.
• You will have until March 31 to submit receipts incurred in the previous calendar year.
• If you do not provide proper receipt documentation when requested to myCafeteriaPlan by March 31, the amount will be added to your pay as taxable wages.
• If you terminate employment or change to a non-benefit eligible status, participation in the plan will cease on the effective date of your termination or status change. However, claims for expenses incurred up to the termination date may be submitted up to 60 days following the termination date.

Health care spending account
Health care spending account dollars can be used to pay for out-of-pocket medical expenses for yourself and your dependents (children up to age 26). Examples of eligible expenses are co-pays, deductibles, prescription drugs, dental, orthodontia, eyeglasses and contact lenses. A complete list of eligible expenses can be found at mycafeteriaplan.com. As part of the Health Care Reform legislation, non-prescription, over-the-counter medications are not considered eligible expenses. Non-medicine over-the-counter items, such as bandages and saline solution, are eligible expenses. The maximum contribution allowed by the IRS is $2,550.

Mobile app. Now you can use your smartphone, iPod, iPad, or android to check your health care and dependent care spending account balances and submit receipts anywhere, anytime. Simply download the free mobile app by searching for myCafeteriaPlan on-the-go through your app store.

Dependent day care spending account
The dependent day care spending account can be used for out-of-pocket expenses related to child care or elder care services for your dependents. The maximum contribution allowed by the IRS is $5,000 ($2,500 for employees who are married but file separately).

A participant is only eligible to have a dependent day care account if he or she pays dependent day care expenses in order to be able to work. If married, the participant’s spouse must also work, go to school full time, or be incapable of self-care.

The IRS does require that you meet certain criteria to be eligible to participate in the dependent care spending account. For this reason, if you are contributing to the account and experience any of the following qualifying events and notify human resources within 30 days of the event, you may stop your contribution.
• A change in the participant’s legal married status.
• A change in the participant’s number of dependents.
• A change in the work schedule of the participant or the participant’s spouse.
• Termination or commencement of employment of the participant’s spouse.
• An unpaid leave of absence taken by either the participant or the participant’s spouse.
• A change in dependent day care provider.

Important things to consider before enrolling in flexible spending accounts:
The flexible spending account cannot be your only source of medical coverage. Therefore, you must be covered on a medical plan in order to elect this benefit.

Use it or lose it rule:
• Any amount over $500 follows the use-it-or-lose-it rule.
• Up to $500 of unused funds from your current plan will be allowed to rollover into your new plan year.
• This rollover does NOT count toward your plan’s maximum annual election.
• You must re-elect this benefit each year. Once you authorize deposits to either account for the year, you will not be allowed to change your elections until the next annual enrollment.
• Keep all receipts. According to the IRS, documentation must be provided when additional claim verification is needed.
• You will have until March 31 to submit receipts incurred in the previous calendar year.
• If you do not provide proper receipt documentation when requested to myCafeteriaPlan by March 31, the amount will be added to your pay as taxable wages.
• If you terminate employment or change to a non-benefit eligible status, participation in the plan will cease on the effective date of your termination or status change. However, claims for expenses incurred up to the termination date may be submitted up to 60 days following the termination date.

Health care spending account
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• A change in the participant’s number of dependents.
• A change in the work schedule of the participant or the participant’s spouse.
• Termination or commencement of employment of the participant’s spouse.
• An unpaid leave of absence taken by either the participant or the participant’s spouse.
• A change in dependent day care provider.
Vision plan

Charleston Area Medical Center

SUMMARY OF BENEFITS

**Vision Care Services**

<table>
<thead>
<tr>
<th>Exam With Dilation as Necessary</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinal Imaging</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td>Frames</td>
<td>$0 Co-pay, $130 Allowance, 20% off balance over $130</td>
<td>Up to $90</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td>Up to $25 Co-pay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Single Vision</td>
<td>Up to $25 Co-pay</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Up to $25 Co-pay</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Triphaconate</td>
<td>Up to $25 Co-pay</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$90 Co-pay</td>
<td>Up to $73</td>
</tr>
<tr>
<td>Premium Progressive Lens</td>
<td>$90 Co-pay, 80% of charge less $120 Allowance</td>
<td>Up to $70</td>
</tr>
</tbody>
</table>

**Lens Options**

| UV Treatment                    | $15                   | N/A |
| Tint (Solid and Gradient)       | $15                   | N/A |
| Standard Plastic Scratch Coating| $0 Co-pay             | Up to $12 |
| Standard Polycarbonate          | $40                   | N/A |
| Standard Polycarbonate-Kids under 19 | $0 Co-pay | Up to $32 |
| Standard Anti-Reflective Coating| $45                   | N/A |
| Polarized                       | 20% off retail price  | N/A |
| Other Add-Ins and Services      | 20% off retail price  | N/A |

**Contact Lens Fit and Follow-Up** (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)

| Standard Contact Lens Fit & Follow-Up | Up to $55 |
| Premium Contact Lens Fit & Follow-Up | 10% off retail price |

**Contact Lenses** (Contact lens allowance includes materials only)

| Conventional                    | $0 Co-pay, $130 Allowance, 15% off balance over $130 | Up to $105 |
| Disposable                      | $0 Co-pay, $130 Allowance, plus balance over $130 | Up to $105 |
| Medically Necessary             | $0 Co-pay, paid-in-full | Up to $250 |

**Laser Vision Correction**

LASIK or PRK from U.S. Laser Network

15% off the retail price or 5% off the promotional price

**Hearing Care**

Hearing Health Care from Amplifon Hearing Network

40% off hearing exams and a low price guarantee on discounted hearing aids

**Frequency**

| Examination                      | Once every calendar year |
| Lenses or Contact Lenses         | Once every calendar year |
| Frame                            | Once every two calendar years |

**Additional discounts**

- **40% OFF** Complete pair of prescription eyeglasses
- **20% OFF** Non-prescription sunglasses
- **20% OFF** Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

**Take a sneak peek before enrolling**

- You’re on the ACCESS Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.723.0596.
- For LASIK providers, call 1.877.SLASER6.

Benefits are not provided from services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing, Anisolekric lenses, medical and/or surgical treatment of the eye, eyes or supporting structures, Any vision examination, any corrective eyewear required by a Preadjustor as condition of employment, safety eyewear, Services provided as a result of any workers' compensation law, of similar legislation, or required by any governmental agency or program, whether federal, state or subdivisions thereof, Premature lenses, non-prescription lenses, Non-prescription sunglasses, Two pair of glasses in lieu of bifocals, Services or materials provided by any other group benefit plan providing vision care, Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage expired are delivered, and the services rendered to the insured Person are within 30 days from the date of such order, Lost or broken lenses, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would have become available, Benefits may not be combined with any discount, promotional offering, or other group benefit plans, Standard/Progressive lens not covered – fund as a Bifocal lens, Standard Progressive lens covered – fund Premium Progressive as a Standard, Benefit allowance provides no remaining balance for future use with the same benefits year, Fees charged for a non-insured benefit must be paid in full to the Provider, Such fees or materials are not covered, Underwritten by Combined Insurance Company of America, 5010 Broadway, Chicago, IL 60640, available in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Premium progressive and premium anti-reflective designations are subject to annual review by Eyemed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of branded at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.
Benefit Highlights
Delta Dental PPO

> ELIGIBILITY: WHO MAY RECEIVE BENEFITS?
• Primary enrollee and spouse
• Eligible dependent children to:
  end of month dependent turns age 26

> WAITING PERIODS
Basic Services: none
Major Services: none
Orthodontics: 10 months

> DEDUCTIBLES
$25 / $75 each plan year (PPO network)
$50 / $150 each plan year (outside PPO network)

> MAXIMUMS per person
$1,500 each plan year (PPO network)
$1,000 each plan year (outside PPO network)

** BENEFITS AND COVERED SERVICES**

<table>
<thead>
<tr>
<th>Diagnostic &amp; Preventive Services (D&amp;P)</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams, cleanings, x-rays and sealants</td>
<td>100%</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic Services</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings</td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endodontics (Basic)</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root canals</td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Periodontics (Basic)</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gum treatment</td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral Surgery (Basic)</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Services</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns, inlays, onlays and cast restorations</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthodontics (Major)</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridges, dentures and implant abutments</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontics</th>
<th>PPO dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>For dependent children to age 19</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime per person</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDITIONAL BENEFITS AND COVERED SERVICES*</th>
<th>Facial Surgery Center I &amp; II</th>
<th>Delta Dental PPO and Delta Dental Premier dentists**</th>
<th>Non-PPO dentists**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant Benefits**</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Implant Maximum</td>
<td>$1,000 per person per contract year</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Impactions and Extraction of Wisdom teeth</td>
<td>80%</td>
<td>60%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist’s submitted fees.
** Reimbursement is based on PPO contracted fees for PPO, Premier and non-Delta Dental dentists.
*** Implant body is covered solely at the CAMC’s Facial Surgery Center I & II; however, abutment and restorative Piece (crown) can be obtained by a general dentist under the Major Benefits section.

This benefit information is not intended to replace or serve as the plan’s Evidence of Coverage, Summary Plan Description or Group Dental Service Contract. If you have specific questions regarding the benefits eligibility, limitations or exclusions of your plan, please consult your company’s benefits representative.

Date created: 8/02/16
Check the site

1. Enter deltadentalins.com/enrollees on your computer’s browser.
2. Browse the features listed below. If you haven’t already done so, register for Online Services. Already got an account? Log in!

Features:
A. **Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card
B. **Find a dentist**
C. **Dental Plan Support Guide**
D. **SmileWay® Wellness site**

Go mobile

1. Enter deltadentalins.com on your smartphone’s browser.
2. Click the Visit Mobile Site button.

Features:
A. **Find a dentist**
B. **View your electronic ID card**
C. **Check deductibles and maximums**
D. **See your benefits and eligibility**
E. **Check claims**

Get the app

1. Open the App Store or Google Play.
2. Search for “Delta Dental.”
3. Download the free app titled Delta Dental by Delta Dental Plans Association.

Features:
A. **Get a cost estimate**
B. **Find a dentist**
C. **Check claims**
D. **See your benefits, eligibility, deductibles and maximums**
E. **Use a musical timer to brush for 2 minutes**

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1 Available to Delta Dental PPOSM and Delta Dental Premier® enrollees only.
2 Some features available to PPO and Premier enrollees only.
Short-term disability

Coverage
Short-term disability (STD) insurance is designed to pay a benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need. STD is fully insured and administered by Lincoln Financial Group.

You must be actively working on the effective date of coverage, otherwise your benefit will be effective when you return to work.

Pre-existing
All short term disability claims filed within the first six months of coverage will be subject to pre-existing determination.

Benefit amount
60% of your base earnings. Available to all eligible employees

Benefit waiting period
Payments will begin after an elimination period of seven (7) consecutive days. During the wait period, you must use 40 hours PTO. PPTO days may be used only if available and requested by the employee.

Benefit period
Benefits may continue during disability up to 90 days. Your weekly benefit is based on your employment status, i.e. full-time and pro-rata 5 through 9. The plan maximum weekly benefit is $2,350.

Continuation of benefits
You will be responsible for maintaining your benefits premiums by paying benefits by check or money order to the benefits department. All other benefits: credit union loans, Unum critical illness, Unum cancer insurance and Boston Mutual whole life insurance must also be maintained by contacting the vendors directly to discuss payment options.

Supplement STD with PTO
You will have the option to use paid time off (PTO) to supplement your STD income. The short term disability income and supplement cannot exceed 100% of your weekly pay. You will only be able to supplement if the entire week is coded as short term disability. All supplement hours will be added to and processed through regular payroll with tax withholding and regular payroll deductions. The chart below shows the number of PTO hours that will be used each week based on your status and short term disability plan:

<table>
<thead>
<tr>
<th>Status</th>
<th>Status Hours Per Week</th>
<th>PTO Supplement Hours Per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro Rata .5</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Pro Rata .6</td>
<td>24</td>
<td>9.6</td>
</tr>
<tr>
<td>Pro Rata .7</td>
<td>28</td>
<td>11.2</td>
</tr>
<tr>
<td>Pro Rata .8</td>
<td>32</td>
<td>12.8</td>
</tr>
<tr>
<td>Pro Rata .9</td>
<td>36</td>
<td>14.4</td>
</tr>
<tr>
<td>Full Time</td>
<td>40</td>
<td>16</td>
</tr>
</tbody>
</table>

Filing a claim
To file a claim, contact Lincoln Financial Group’s claim intake service center 1-866-783-2255 between 8 a.m. and 8 p.m. EST Monday through Thursday and 8 a.m. to 6 p.m. EST on Fridays. You will be asked to provide the following information (in addition to other questions about your absence):

- Employer Name and/or Group Number: CAMC group # 000010179739
- Name, Social Security number and date of birth
- Address and phone number
- Doctor’s name, address, phone number and fax number
- Your occupation and the last day you worked
- Your condition or diagnosis

Important Information
- Disability pay will be based on your hourly rate in effect on your last day at work. Any changes in your rate while on disability will not affect your disability earnings.
- Lincoln Financial Group does not automatically withhold income taxes. If you want income taxes withheld, you must complete a W-4 withholding form. You can find forms on CAMnet or request them from Lincoln Financial Group.
Long-term disability

Coverage
Long-term disability is fully insured and administered by Lincoln Financial Group.

As a newly benefit-eligible employee, you may enroll in this benefit with guaranteed issue. If you waive the plan now and elect later as part of annual enrollment or as the result of a qualifying event, you will have to complete an Evidence of Insurability form (EOI) and be approved for coverage by Lincoln Financial Group.

You must be actively working on the effective date of coverage, otherwise your benefit will be effective when you return to work.

Pre-existing
All long term disability claims filed within the first 12 months of coverage will be subject to pre-existing determination.

Benefit Amount
60% of your base earnings. The plan maximum monthly benefit is $10,000.

Elimination period
90 consecutive calendar days of total disability.

Benefit period
LTD benefits continue as long as you remain totally disabled from any occupation up to age 65 or older if certain guidelines are met. It is the employee’s responsibility to provide Lincoln Financial Group with all required information in order to receive LTD benefits.

Coordination of coverage
LTD income is coordinated with other income including Social Security disability.

Continuation of benefits
If you are approved for LTD, you may continue your benefits for up to 12 months, provided you continue to make the required monthly contributions. At the end of 12 months, employment will be terminated and COBRA coverage for benefits will be offered. COBRA benefits include health, vision, dental and flexible spending accounts.
Life insurance options

Life insurance gives you the opportunity to protect your family's dreams, ambitions and finances should an unexpected death occur. The employee and dependent life insurance plans are fully insured and administered by Lincoln Financial Group.

**Basic Employee Term Life:** The company provides employees with term life insurance equal to one times their annual salary (not to exceed $50,000) at no cost to the employee. Coverage amount is rounded up to the next $1,000.

**Supplemental Employee Term Life:** Employees may purchase an additional one, two, three, or four times their annual salary (maximum $600,000) in supplemental term life insurance. As a new employee, you can elect supplemental term life insurance up to the guaranteed issue amount of four times your annual salary (maximum of $450,000) without providing evidence of insurability.

**Must be enrolled in employee supplemental term life in order to elect Spouse or Child term life.**

**Spouse Term Life:** If enrolled in employee supplemental term life, employees may purchase term life insurance on their spouse. Coverage amounts are $10,000, $20,000, $30,000, or $50,000. The $50,000 coverage automatically requires evidence of insurability. As a new employee, you can elect spouse term life insurance up to the guaranteed issue amount of $30,000 without providing evidence of insurability.

**Child Term Life:** If enrolled in employee supplemental term life, employees may purchase term life insurance on their unmarried child(ren). Coverage amounts are $3,000, $5,000, $10,000, $15,000 or $20,000. Evidence of insurability is not required.

**Accidental Death And Dismemberment Insurance Benefit:** This is a form of insurance covering death or specific types of injury as a result of an accident. In the event of death or accident, this insurance will pay benefits, if elected, in addition to any life insurance coverage also elected. This benefit is available for the employee and/or their family in $10,000 increments up to a maximum of 10 times the employee's annual salary (maximum $500,000). When the family plan is chosen, the employee is covered at 100 percent, spouse is covered at 60 percent, and each child is covered at 20 percent.

**Spouse is benefit eligible through CAMC Health System:**
- You cannot have “double coverage” and, therefore, cannot elect Spouse Term Life
- The AD&D plan will pay for spouse as the policy holder or as a dependent, but it will not pay out as both
- Children can be covered under two AD&D family plans and/or two Child Life plans. However, if your child is a benefit eligible employee of CAMC, you cannot carry child life on that dependent.

**Evidence of Insurability (EOI)**
If you elect more than $450,000 employee supplemental life or $50,000 spouse life, you must complete an EOI form online at lincoln4benefits.com.

You will need the following information to complete the EOI:
Group Policy Name: Charleston Area Medical Center
ID: CAMC
Group Policy #: 000010179739
Don’t fool yourself into thinking you can’t save for your future. Your workplace savings plan helps make it easy, convenient and affordable to accumulate the money you need for retirement. Your benefit at retirement depends on how much you contribute, your employer’s matching contributions, and the results from the investments you select.

Take these easy steps to ensure your future today:

Enroll
The 401(k) Plan allows you to contribute pretax contributions through payroll deductions. If you are not enrolled in the CAMC Plan, enroll today at www.netbenefits.com/camc and select Enroll Now or call 1-800-343-0860.

If you take no action within two weeks of your hire date, you will be automatically enrolled in the CAMC plan at 4% of your eligible pay. The plan lets you invest your account in a number of investment funds. If you do not actively choose an investment option(s), your contribution will be defaulted to a JPMorgan SmartRetirement Institutional Class Shares Fund that has a target retirement date closest to the year you might retire based on your current age and assuming a retirement age of 65. However, we encourage you to take an active role in the Plan and choose investment options that are appropriate for you. To learn more about the investment options available, go to plan and investment options at netbenefits.com/camc. Through payroll deduction, you may contribute up to 100% of your eligible pay on a pretax basis, up to the IRS dollar limits.

Employer contributions
CAMC will contribute to your retirement account after 1 year of service provided you are contributing.

<table>
<thead>
<tr>
<th>Employee contributes</th>
<th>CAMC contributes</th>
<th>Total contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>3%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>4%</td>
<td>3.50%</td>
<td>7.50%</td>
</tr>
<tr>
<td>5%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>6% or more</td>
<td>4%</td>
<td>10% or more</td>
</tr>
</tbody>
</table>

Increase your contribution
Most experts recommend a contribution rate of 10 to 15% annually to reach retirement goals. Increase your contribution percentage at any time by logging onto www.netbenefits.com/camc, under quick links drop down, choose Contribution Amount. Having trouble remembering to increase your percentage? Sign up for the Annual Increase Program to automatically increase your contribution each year. Click Annual Increase Program to choose the increase percent and the date of the increase!

Catch-up contributions
If you have reached age 50 or will reach 50 during the calendar year and are making the maximum IRS pretax contribution ($18,000 for 2017) you may make an additional “catch-up” contribution ($6,000 for 2016). The IRS annual limits are subject to cost of living adjustments. Contact the Benefits Department at (304) 388-7555 if you are electing the “catch-up” contribution for the first time.

Beneficiaries
Your beneficiary or beneficiaries will inherit your account in the event of your death. Designate your beneficiary when you enroll, and update the information if you experience a life-changing event such as marriage, divorce, death, etc. Fidelity’s Online Beneficiaries Service, available through NetBenefits offers a quick and convenient process. Simply click on “Menu” then “Profile” then “Beneficiaries.” You may also download the form from the Benefits webpage on CAMNet under 401(k), complete and send to Fidelity Investments.

Stay on track
Manage your account by using the tools on NetBenefits. Fidelity Workplace Planning & Guidance Consultants provide free one-on-one guidance for participants. Schedule an in-person or phone consultation at fidelity.com/atwork/reservations. Visit the Benefits web page on CAMNet for the on-site consultation schedule.
Saving for retirement under our 401(k) plan is easy as each newly hired eligible employee is automatically enrolled.

The automatic enrollment feature won’t change your contribution level if you already turned in a deferral election through Fidelity Investments electing the level of your contributions to the Plan or electing not to contribute. Your election will continue to be followed. You can change your contribution level by contacting Fidelity Investments at any time.

If you have not made a contribution election through Fidelity Investments, you will be automatically enrolled in the Plan starting with your first paycheck after you are employed or move into a benefit eligible position. This means that amounts will be taken from your pay and contributed to the Plan. The automatic contributions will be 4% of your eligible pay each pay period. But, you can choose a different amount. You can choose to contribute more, less, or even nothing.

Keep in mind that once you have completed a Year of Service, the Company will match one dollar for each dollar you contribute, up to 3% of your eligible pay. The Company will also match 50 cents for each dollar you contribute on the next 2% of your eligible pay. To get the most of the Employer’s match of 4%, you will need to increase your salary deferral contribution from the 4% automatic contribution rate to at least 5%.

This notice gives you important information about some Plan rules, including the Plan’s automatic enrollment feature, Company matching contributions and the Plan’s default investments. The notice covers these points:

- Whether the Plan’s automatic enrollment feature applies to you;
- What amounts will be automatically taken from your pay and contributed to the Plan;
- How you will know the contribution is being deducted and sent to your account with Fidelity Investments;
- What other amounts the Company will contribute to your Plan account;
- How your Plan account will be invested;
- When your Plan account will be vested (that is, not lost when you leave your job), and when you can get your Plan account; and
- How you can change your contributions.
You can find out more about the Plan in another document, the Plan’s Summary Plan Description ( SPD). The Summary Plan Description is available on the Employee Benefits page on CAMNet or by contacting your HR Department.

1. **Does the Plan’s automatic enrollment feature apply to me?**

   The Plan’s automatic enrollment feature will not apply to you if you already elected (by making a salary reduction election through Fidelity Investments) to make contributions to the Plan or to not contribute. If you made an election, your contribution level will not automatically change. But, you can always change your contribution level by making a new election through Fidelity Investments.

   If you have not elected a contribution level, you will be enrolled in the Plan starting with your first paycheck after you become employed or change from a non-benefit eligible to benefit eligible position. This means money will be automatically taken from your pay and contributed to your Plan account. If you do not want to be enrolled, you need to make this election through Fidelity Investments. If you are not sure how to do this, either review the SPD or contact CAMC’s benefits department.

2. **If I do nothing, how much will be taken from my pay and contributed to the Plan?**

   If you do not complete an electronic contribution form, 4% of your eligible pay for each pay period will be taken from your pay and contributed to the Plan. This will start with your first paycheck and continue until you elect otherwise, terminate or cease to be in a benefit eligible position. To learn more about the Plan’s definition of eligible pay, you can review Article 2 of the SPD.

   Your contributions to the Plan are taken out of your pay and are not subject to federal income tax at that time. Instead, they are contributed to your Plan account and can grow over time with earnings. Your account will be subject to federal income tax only when withdrawn. This helpful tax rule is a reason to save for retirement through Plan contributions.

   Contributions will be taken out of your pay if you do nothing. But you are in charge of the amount that you contribute. You may decide to do nothing and become automatically enrolled, or you may choose to contribute an amount that better meets your needs. For example, after you complete 1 Year of Service, you may want to increase your salary deferral to at least 5% to take full advantage of the Company’s matching contribution. You can change your salary deferral contributions at any time through Fidelity Investments (see Article 4 of the SPD).

3. **How will I know the contribution is being deducted and sent to my account with Fidelity Investments?**

   Review your check stub each pay period to ensure your retirement contribution is being deducted. Your check stub will show the deduction “RET %” and the current pay period and year to date amounts. If you did not contact Fidelity to elect zero percent and you do not see the deduction “RET %”, call the Benefits Department at 388-6262.
Each quarter you will receive a statement from Fidelity Investments showing the activity on your account. You may obtain a statement and view transactions on your account at any time by logging into your account at www.netbenefits.com/camc. If you have questions regarding the statement, please call Fidelity at 1-800-343-0860 or contact your Benefits Department.

4. In addition to the contributions taken out of my pay, what amounts will the Company contribute to my Plan account?

Besides contributing the amounts taken from your pay, the Company will make other contributions to your Plan account after you have completed a Year of Service. The Company will match, on a dollar-for-dollar basis, the first 3% of eligible pay you contribute each pay period. The company will match 50¢-per-dollar on the next 2% of eligible pay you contribute. These matching contributions will be made if you are automatically enrolled or if you choose your own contribution level.

The Company’s matching contributions depend on the amount you contribute out of your pay each pay period.

For example, after you have completed 1 Year of Service:

If you earn $1,000 in eligible pay during a pay period and you elect to contribute 3% of your pay, the Company will deduct $30 from your pay for the pay period (that is, 3% x $1,000). The $30 will be put in your Plan account. The Company will also make matching contributions to your Plan account of $30 for the pay period. In other words, the Company will make a dollar-for-dollar matching contribution on your contributions up to 3% of eligible pay (100% of 3% x $1,000, or $30). Or, if you contribute 4% of your eligible pay for the pay period, the Company will take $40 from your pay and put it in your Plan account, and will also make $35 in matching contributions for the pay period. Or, if you contribute 5% of your eligible pay for the pay period, the Company will take $50 out of your pay and put it in you Plan account, and will also make $40 in matching contributions for the pay period. Or, if you choose not to contribute to the Plan for a pay period, you will get no matching contributions for the pay period.

Remember, you can always change the amount you contribute to the Plan by making a new election through Fidelity Investments.

5. When will my Plan account be vested and available to me?

You will always be fully vested in your contributions to the Plan. You will also be fully vested in matching contributions. To be fully vested in Plan contributions means that the contributions (together with any investment gain or loss) will always belong to you, and you will not lose them when you leave your job.
Even if you are vested in your Plan account, there are limits on when you may withdraw your funds. These limits may be important to you in deciding how much, if any, to contribute to the Plan. Generally, you may only withdraw vested money after you leave your job or become disabled. Also, there is generally an extra 10% tax on distributions before age 59-1/2. Your beneficiary can get any vested amount remaining in your account when you die.

You also can borrow certain amounts from your vested Plan account, and may be able to take out certain vested money if you have a hardship. Hardship distributions are limited to the dollar amount of your contributions. They may not be taken from earnings or matching contributions. Hardship distributions must be for a specified reason – for qualifying medical expenses, costs of purchasing your principal residence (or preventing eviction from or foreclosure on your principal residence, or repairing qualifying damages to your principal residence), qualifying post-secondary education expenses, or qualifying burial or funeral expenses. Before you can take a hardship distribution, you must have taken other permitted withdrawals and loans from qualifying Company plans. If you take a hardship distribution, you may not contribute to the Plan or other qualifying Company plans for 6 months.

You can learn more about the Plan’s loan provisions and hardship withdrawal under Article 8 and Article 10 of the Plan’s SPD as well as the Plan’s loan procedures. You can also learn more about the extra 10% tax in IRS Publication 575, Pension and Annuity Income.

6. Can I change the amount of my contributions?

You can always change the amount you contribute to the Plan. If you know now that you do not want to contribute to the Plan (and you haven’t already elected not to contribute), you will want to make an election through Fidelity Investments electing zero contributions. That way, you avoid any automatic contributions.

But, if you do not make an election in time to prevent automatic contributions, you can withdraw the automatic contributions for a short time, despite the general limits on Plan withdrawals. During the 90 days after automatic contributions are first taken from your pay, you can withdraw the prior automatic contributions by notifying the Plan Administrator. The amount you withdraw will be adjusted for any gain or loss. Also, your withdrawal will be subject to federal income tax (but not the extra 10% tax that normally applies to early distributions). If you take out automatic contributions, the Company will treat you as having chosen to make no further contributions. However, you can always choose to continue or restart your contributions by turning in an electronic contribution form at www.netbenefits.com/camc or by calling 1-800-343-0860.

7. How will my Plan Account be invested?

You have the right under the Plan to direct the investment of your contributions to any of the Plan’s available investment options. Any contributions for which you do not provide investment direction will be invested in the Plan’s designated default option (the “Plan Designated Fund”).

{C1389034.1}
The JP Morgan SmartRetirement Institutional Class Shares® are currently the Plan Designated Fund and are described in more detail below. Upon participation in the Plan, you have the right under the Plan to direct the investment of your account, including the right to transfer out of the Plan Designated Fund to any of the Plan’s available investment options. If you have not already made an investment election decision, we encourage you to review the investment options available to you. However, if no elections are made, CAMC Health System Inc. has directed Fidelity to invest your future contributions in the JPMorgan SmartRetirement® Institutional Class Shares based on your current age and assuming a retirement age of 65.

JPMorgan SmartRetirement® Institutional Class Shares are designed for investors expecting to retire around the year indicated in each fund’s name. The funds are managed to gradually become more conservative over time as it approaches the target date. The investment risk of each JPMorgan SmartRetirement® Institutional Class Shares Fund changes over time as its asset allocation changes. The funds are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after the target dates.

<table>
<thead>
<tr>
<th>Fund Name</th>
<th>Description*</th>
<th>Date of Birth Range</th>
<th>Gross Expense Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPMorgan SmartRetirement® Income Fund Institutional Class Shares</td>
<td>Fund Code: JSIIX Objective: The investment seeks current income and some capital appreciation. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors who are retired or about to retire soon. It is designed to provide exposure to a variety of asset classes through investments in underlying funds, with an emphasis on fixed income funds over equity funds and other funds. Risk: The fund is subject to the volatility of the financial markets, including that of equity and fixed income investments. Fixed income investments carry issuer default and credit risk, inflation risk, and interest rate risk. (As interest rates rise, bond prices usually fall, and vice versa. This effect is usually more pronounced for longer-term securities.) Principal invested is not guaranteed at any time, including at or after retirement. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>Before 12/31/1953</td>
<td>0.55%</td>
</tr>
<tr>
<td>JPMorgan SmartRetirement® 2020 Fund Institutional Class Shares</td>
<td>Fund Code: JTTIX Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2020 (target retirement</td>
<td>1/1/1954–12/31/1958</td>
<td>0.57%</td>
</tr>
<tr>
<td>JPMorgan SmartRetirement® 2025 Fund Institutional Class Shares</td>
<td>Fund Code: JNSIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2025 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1959–12/31/1963</td>
</tr>
<tr>
<td>JPMorgan SmartRetirement® 2030 Fund Institutional Class Shares</td>
<td>Fund Code: JSMIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2030 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1964–12/31/1968</td>
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<tr>
<td>JPMorgan SmartRetirement® 2035 Fund Institutional Class Shares</td>
<td>Fund Code: JRJIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2035 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1969–12/31/1973</td>
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<tr>
<td>JPMorgan SmartRetirement® 2040 Fund Institutional Class Shares</td>
<td>Fund Code: SMTIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2040 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1974–12/31/1978</td>
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<tr>
<td>JPMorgan SmartRetirement® 2045 Fund Institutional Class Shares</td>
<td>Fund Code: JSAIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2045 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1979–12/31/1983</td>
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<tr>
<td>JPMorgan SmartRetirement® 2050 Fund Institutional Class Shares</td>
<td>Fund Code: JTSIX</td>
<td>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date. Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2050 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change. Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
<td>1/1/1984–12/31/1988</td>
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approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.

<table>
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<tr>
<th>JPMorgan SmartRetirement® 2055 Fund Institutional Class Shares</th>
<th>Fund Code: JFFIX</th>
<th>Objective: The investment seeks high total return with a shift to current income and some capital appreciation over time as the fund approaches and passes the target retirement date.</th>
<th>1/1/1989 and after</th>
<th>Expense ratio information as of November 13, 2017 0.64%</th>
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<tbody>
<tr>
<td>Strategy: The fund is a &quot;fund of funds&quot; that invests in other J.P. Morgan Funds (underlying funds), and is generally intended for investors expecting to retire around the year 2055 (target retirement date). It is designed to provide exposure to a variety of asset classes through investments in underlying funds, and over time the fund's asset allocation strategy will change.</td>
<td>Risk: The target date funds are designed for investors expecting to retire around the year indicated in each fund's name. The funds are managed to gradually become more conservative over time as they approach their target date. The investment risk of each target date fund changes over time as its asset allocation changes. They are subject to the volatility of the financial markets, including that of equity and fixed income investments in the U.S. and abroad, and may be subject to risks associated with investing in high-yield, small-cap, and foreign securities. Principal invested is not guaranteed at any time, including at or after their target dates. Additional risk information for this product may be found in the prospectus or other product materials, if available.</td>
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</table>

* A mutual fund registered under JPMorgan Trust I, and managed by J.P. Morgan Investment Management Inc. This description is only intended to provide a brief overview of the fund. Read the fund's prospectus for more detailed information about the fund.

For a mutual fund, the expense ratio is the total annual fund or class operating expenses (before waivers or reimbursements) paid by the fund and stated as a percentage of the fund's total net assets. Expense ratios change periodically and are drawn from the fund’s prospectus. For more detailed fee information, see the fund prospectus or annual or semiannual reports.

To obtain information about other plan investment options, please log onto NetBenefits® at www.netbenefits.com/camc or call your plan’s toll free number 1-800-343-0860 to speak to a representative. You may also make changes to your investment elections for future contributions and/or exchange all or a portion of your existing balance into other options.
available under the Plan via NetBenefits or by phone. We encourage you to review your investment mix and deferral percentage and update as appropriate.

To learn more about the Plan’s investment funds and procedures for changing how your Plan account is invested you can review Article 9 of the Plan’s SPD. Also, you can contact the Plan Administrator using the contact information at the end of this notice.

If you have any questions about how the Plan works or your rights and obligations under the Plan, or if you would like a copy of the Plan’s SPD or other Plan documents, please contact the Plan Administrator at:

CAMC Health System, Inc.  
419 Brooks Street  
Charleston, West Virginia  25301  
(304) 388-6262
If you are an eligible Participant in the CAMC Health System Basic Retirement Plan (the “Plan”), you may make contributions (called “Salary Deferrals”) directly from your paycheck into the Plan. The ability to make Salary Deferrals provides you with an easy method to save for retirement on a tax-deferred basis. If you make Salary Deferrals to the Plan, you generally will not be taxed on those deferrals or on any earnings on those contributions until you withdraw those amounts from the Plan.

If you have any questions regarding your eligibility to make Salary Deferrals under the Plan or any other questions regarding the Plan that are not addressed in this Notice, please review your Summary Plan Description. For example, Article 5 of the Summary Plan Description contains a discussion of the eligibility conditions applicable to Salary Deferrals and the safe harbor contributions. In addition, from time to time we may make changes to the Plan and/or Summary Plan Description, which are described in a Summary of Material Modifications supplementing the Summary Plan Description. Any reference to the Summary Plan Description in this Notice includes any Summary of Material Modifications we may have issued with respect to the Plan. If you do not have a copy of the Summary Plan Description or any Summary of Material Modifications, if applicable, please contact the Plan Administrator named below.

Safe Harbor Matching Contribution

For the Plan Year beginning January 1, 2018, if you make Salary Deferrals into the Plan, you will receive a special safe harbor matching contribution (“safe harbor contribution”) under the Plan, provided you satisfy any eligibility conditions for such contribution. This Notice provides important information about the safe harbor contribution as well as other information regarding:

- your right to make Salary Deferrals under the Plan;
- when you can change your Salary Deferral election;
- how your Plan account will be invested;
- the eligibility conditions for receiving the special safe harbor contribution;
- whether there are any other contributions available under the Plan; and
- other valuable information about your retirement benefits under the Plan.

Notwithstanding any language in this Notice to the contrary, we reserve the right to amend the Plan at any time during the Plan Year to reduce or suspend the safe harbor contribution. If we decide to reduce or suspend the safe harbor contribution, we will provide you with a supplemental notice at least 30 days prior to the effective date of such reduction or suspension describing the consequences of the amendment. Any amendment to reduce or suspend safe harbor contributions will not affect any contributions earned prior to the effective date of such amendment.

For a full discussion of your benefits under the Plan, please review your Summary Plan Description.

 Procedures for making Salary Deferrals under the Plan – Automatic Deferral Feature for Newly Eligible Participants. The Plan has an automatic deferral feature. Under this automatic deferral feature, an employee who becomes eligible to participate in the Plan during 2018 will be automatically enrolled in the Plan. If you become eligible to participate in the Plan during 2018 and if you do not make an affirmative election specifying the percentage (including a 0% election) of your pay that you want withheld from your paycheck and contributed to the Plan, we will automatically withhold 4% of your pay from your paycheck each pay period and deposit that amount into the Plan in your name as a Salary Deferral. This is called your automatic contribution rate. If you wish to
defer a greater or lesser amount (including no deferral), you must affirmatively elect to defer a different amount. If you have any questions about how to change your automatic contribution rate, you should contact the Plan Administrator.

Application of automatic deferral feature. The current automatic deferral feature under the Plan applies to all employees who become eligible to participate in the Plan during 2018. In addition, a Participant who was previously automatically enrolled at the 4% automatic contribution rate and who has not made an affirmative Salary Deferral election since being automatically enrolled will continue to have automatic contributions equal to 4% of pay withheld from his paycheck and contributed to the Plan until the Participant makes an affirmative election of a different contribution amount (including an election not to defer).

Special withdrawal rule. If amounts are automatically withheld from your paycheck, you may withdraw those amounts within 90 days after the first amounts are withheld from your pay, regardless of any other withdrawal restrictions under the Plan. If you withdraw automatic deferrals under this special withdrawal rule, you will lose any matching contributions associated with those deferrals. Such withdrawal also will not be subject to the 10% penalty for early withdrawal. If you withdraw the automatic deferrals, no additional deferrals will be withheld from your paycheck unless you enter into a subsequent election to defer into the Plan.

Taxation of Salary Deferrals. The amount that you defer into the Plan reduces your taxable income, meaning you do not pay income taxes on those amounts until you withdraw your deferrals from the Plan. Any gains or earnings made from the investment of these contributions within the Plan are also not subject to income tax until they are withdrawn from the Plan.

Change in deferral amount. You may increase or decrease the amount of your current Salary Deferrals or stop making Salary Deferrals altogether, as of any designated election date. For this purpose, the designated election date(s) for changing or modifying your Salary Deferrals will be set forth in the Salary Deferral election or other written procedures describing the time period for changing Salary Deferral elections. However, regardless of the Plan’s normal deferral procedures, you will have a reasonable time after receipt of this notice and before the first amount is withheld from your paycheck under the automatic deferral feature to modify the automatic contribution rate. In addition, unless provided otherwise under the Plan, you may revoke an existing deferral election at any time. Any change you make to your Salary Deferrals will become effective as of the next designated election date, and will remain in effect until modified or canceled during a subsequent election period.

Amount of safe harbor matching contribution. The safe harbor matching contribution will be a 100% (dollar-for-dollar) matching contribution on your Salary Deferrals up to 3% of compensation plus a 50% matching contribution on any additional Salary Deferrals that exceed 3% of compensation but do not exceed 5% of compensation. The safe harbor matching contribution is calculated on a Plan Year basis, taking into account Salary Deferrals you make during the Plan Year and your eligible compensation for the Plan Year.

Example. You earn $30,000 of compensation and you defer $1,800 (6% of compensation) into the Plan. If you satisfy the conditions for receiving the safe harbor matching contribution, you will receive a safe harbor matching contribution equal to $1,200. This is calculated based on a 100% match on the first $900 (3% of compensation) deferred into the plan plus a 50% match on $600 of deferrals (the deferrals above 3% up to 5% of compensation) for an additional match of $300, giving a total matching contribution of $1,200.

Eligibility for safe harbor contribution. You are eligible to receive a safe harbor contribution under the Plan if you satisfy the following requirements:

- **Eligible Employee.** The same eligibility requirements that apply for Salary Deferrals also apply for safe harbor contributions. See the Summary Plan Description for a description of the Eligible Employees who may make Salary Deferrals under the Plan.

- **Minimum service requirement.** To be eligible to receive a safe harbor contribution, you must satisfy the following minimum service requirements: One Year of Service using Anniversary Year Eligibility Computation Period.

- **Minimum age requirement.** No minimum age conditions apply for purposes of determining eligibility for safe harbor contributions.
• **Entry Date.** Upon satisfaction of the minimum age and service conditions, you will be eligible to enter the Plan on the first Entry Date following your satisfaction of the minimum age and service conditions. For this purpose, the Entry Date is immediate upon satisfaction of the eligibility conditions.

**Compensation.** In determining the amount of the safe harbor contribution, your compensation must be considered. The Plan defines the types of compensation and the period for which compensation is taken into account for this purpose. Under the Plan, no compensation may be taken into account to the extent such compensation exceeds the compensation limit described under the Internal Revenue Code. See the Summary Plan Description for an explanation of the types of compensation that will be included for purposes of calculating the safe harbor contribution, including the maximum amount of compensation that may be taken into account in determining the contributions under the Plan.

**Other contributions.** The safe harbor contribution is in addition to any Salary Deferrals you make to the Plan.

**Vesting of contributions.** You are always 100% vested in the safe harbor contribution and any Salary Deferrals you make to the Plan. This means that you have an immediate ownership right to such contributions and you will not lose that right if you should terminate from employment. However, see below for restrictions on your ability to withdraw these amounts from the Plan.

**Withdrawal restrictions.** Generally, you may withdraw amounts held on your behalf under the Plan upon death, disability or termination of employment. In addition, the following withdrawal options apply while you are still employed.

- **All contributions.** You may withdraw all or any portion of your accounts under the Plan in which you are 100% vested after you have reached age 59½.

- **Salary Deferrals.** You may withdraw amounts attributable to Salary Deferrals from the Plan while you are still employed under the following circumstances:
  - You suffer a hardship (as defined in the Plan). See the Summary Plan Description for a list of permissible hardship events.

- **Safe harbor contributions.** Safe harbor contributions are generally eligible for distribution at the same time as Salary Deferrals. However, you may not take a withdrawal of your safe harbor contributions on account of a hardship.

**Plan investments.** The amounts contributed to the Plan on your behalf will be invested in accordance with the Plan’s investment procedures. Any earnings on the investment of your contributions under the Plan will be allocated to your Plan account.

The Plan allows you to direct the investment of your Plan account within the available investment options under the Plan. If you do not elect to invest your Plan account, such amounts will automatically be invested in the Plan’s default investment fund. Even if your Plan account is invested in the Plan’s default investment fund, you have the continuing right to change your default investment and elect to have your Plan account invested in any other available investment options under the Plan. For more information regarding the Plan’s default investment fund, see the Qualified Default Investment Notice which will be provided to you by the Plan Administrator.

To learn more about the available investments under the Plan, you may contact the Plan Administrator.

**Additional information.** Please refer to the Summary Plan Description for additional information regarding Plan contributions, withdrawal restrictions, and other Plan features. You also may contact the Plan Administrator for more information. The following is the name, address and phone number of the Plan Administrator.

CAMC Health System, Inc.
P.O. Box 1547
Charleston, West Virginia 25326
(304) 388-6262
Paid time off

Your PTO plan is designed to recognize the diverse needs of employees in regards to time off from work. PTO is inclusive of hours for sick days, vacation time, holidays, bereavement (beyond bereavement policy), doctor appointments and other personal time off from work.

PTO is computed based on your base hourly rate in effect at the time the paid time off is taken. PTO is automatically provided to eligible employees, which includes regular full-time, and pro-rata status employees. The amount of PTO provided is based on your years of service and status. Employees will accrue PTO 26 pay periods per year. The maximum amount of PTO that may be carried over each year is 62 days (496 hours) for regular full-time, pro-rata 9, and pro-rata 8 employees. The maximum amount of PTO that may be carried over each year is 30 days (240 hours) for pro-rata 7, pro-rata 6, and pro-rata 5 employees.

- Your department manager sets the amount of advance notice required for scheduling PTO.
- You can access your time accrual balances on Lawson Self Service.
- Paid time off may be taken in hourly increments with a minimum of one hour.
- All transfers between units, departments, and/or hospitals will be treated as continuation of accumulated PTO.
- If you terminate employment within first year of hire, accumulated PTO will be forfeited.

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Days accrued per year</th>
<th>Hrs. per pay (26)</th>
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<td>0-10</td>
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<td>11+</td>
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<th>Years of Service</th>
<th>Days accrued per year</th>
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<tr>
<td>20+</td>
<td>27</td>
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<th>Years of Service</th>
<th>Days accrued per year</th>
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<tr>
<td>20+</td>
<td>35</td>
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</table>
Purchased paid time off (PPTO)

Can only be elected during annual enrollment to be used the next plan year.

Each year during annual enrollment, eligible employees have the option to purchase additional time off through the Purchased Paid Time Off plan. Below are a few key points employees should keep in mind when electing to purchase additional days off:

- PPTO is a no-risk plan in which the employee pays 100% of the premium. This means that every dollar paid in will be paid out either when you use PPTO or when remaining balances are paid out to you at the end of the year.

- The premium is calculated on the number of hours elected and at 104% of your base rate. The premium is withheld over the first 24 pay periods of the year.

- If you terminate employment or change to a non-PPTO eligible status prior to the 24th pay period of the year and you have used more hours than you have paid into the plan, you will owe the difference between what you have paid into the plan and the total you elected for the year.

### Annual purchased days of PTO available based on an eight-hour work day

<table>
<thead>
<tr>
<th>Employee status</th>
<th>0-8 years of service</th>
<th>9-18 years of service</th>
<th>19+ years of service</th>
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<tr>
<td>Regular full-time</td>
<td>5 days per year</td>
<td>10 days per year</td>
<td>15 days per year</td>
</tr>
<tr>
<td>Pro-rata 9 (72-79 hours)</td>
<td>5 days per year</td>
<td>9 days per year</td>
<td>14 days per year</td>
</tr>
<tr>
<td>Pro-rata 8 (64-71 hours)</td>
<td>4 days per year</td>
<td>8 days per year</td>
<td>12 days per year</td>
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<tr>
<td>Pro-rata 7 (56-63 hours)</td>
<td>4 days per year</td>
<td>7 days per year</td>
<td>11 days per year</td>
</tr>
<tr>
<td>Pro-rata 6 (48-55 hours)</td>
<td>3 days per year</td>
<td>6 days per year</td>
<td>9 days per year</td>
</tr>
<tr>
<td>Pro-rata 5 (40-47 hours)</td>
<td>3 days per year</td>
<td>5 days per year</td>
<td>8 days per year</td>
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</table>
**Benefit enrollment instructions**

Once you have been activated as a new employee in the system, you can enroll for benefits through Lawson Self Service (LSS). LSS is available from any hospital system computer that is tied to CAMnet. You cannot access this program from home.

Before accessing Lawson Self Service you must log onto a computer and change your password.

You will be required to make an election for every benefit even if you are declining coverage. If you are declining coverage, you will select to waive coverage for that plan. If you are selecting family coverage, you will be prompted to select which dependents you want covered by each benefit.

Just follow these easy steps to enroll:

- From CAMnet, click on “Lawson” on the left.
- Click on “login now” on the left, then click “run” at the bottom, then click “continue” to sign in.
- To sign in, use your network user ID and password (icamcuserid).
- On left, click on “bookmark,” then “Employee Self-Service,” then “New Hire,” then “Benefits” then “New Hire Enrollment.”
- Read the Welcome Screen for important enrollment information then click “Continue.”
- Carefully review each benefit and make a selection for each one.
- For dependent benefits, be sure to check the box next to the dependents you want to cover.
- On the final benefit summary page, select “Continue.”
- On the Lawson Self Service web dialog box, select “Print” to print these benefits.

Once you make your initial elections and exit the system, it will not allow you to go back in and make additional changes. If you need to make corrections and are still within 30 days of your date of hire, you can come to human resources to make those changes.

If you do not have access to a computer in your department, you may come to any HR office to make your elections.

Please consult your HR associate if you have any questions.
To make benefit elections, you must enroll through Lawson Self Service within 30 days of hire or benefit eligible status change. Costs are per pay.

Annual salary calculation: _________ X _________ = _________
hourly rate       status hours       annual salary

Status hours: full-time = 2080; pro-rata 9 = 1872; pro rata 8 = 1664; pro rata 7 = 1456; pro-rata 6 = 1248 pro rata 5 and part-time regular = 1040

PPO Plan (Medical and Prescription Drug)     HDHP (Medical and Prescription Drug)
$ 66.00    PPO plan employee            $ 31.00    HDHP plan employee
$141.00    PPO plan employee + child(ren)  $ 66.50    HDHP plan employee + child(ren)
$197.50    PPO plan employee + spouse    $ 92.00    HDHP plan employee + spouse
$222.00    PPO plan family             $103.00    HDHP plan family

Premiums do not include $40 tobacco surcharge if applicable.

Employee Vision Plan (includes exam and materials)
$1.40    Employee only
$3.00    Employee + child(ren)
$2.85    Employee + spouse
$4.75    Family

Dental Plan
$9.75    Employee
$19.25    Employee + child(ren)

Purchased Paid Time Off (PPTO)
1.04 x hourly rate x number of hours purchased ÷ 24

Short-Term Disability
60% Plan - Annual salary x .0053 = _________ ÷ 24 pay periods

Long-Term Disability
Annual salary x .003 = _________ ÷ 24 pay periods

Health Care Flexible Spending Account (FSA)
Annual Contribution ÷ 24 pay periods

Dependent Day Care Spending Account
Annual Contribution ÷ 24 pay periods

Employee Term Life Insurance
You may purchase additional life insurance in the amount of 1, 2, 3 or 4 times your annual salary.
Annual Salary x _________ = _________ round up _________ ÷ 1,000 x _________ = _________
(1, 2, 3 or 4)                                (next $1,000)     (age bracket cost)

Cost by Age Bracket
29 under .02    50 – 54 .140
30 – 34 .025   55 – 59 .215
35 – 39 .035   60 – 64 .265
40 – 44 .055   65 – 69 .365
45 – 49 .085   70 + .735 1/2 coverage

Spouse Term Life Insurance
(must have employee term life) $1.30 ($10,000) $2.60 ($20,000) $3.90 ($30,000)

Child Term Life Insurance
(must have employee term life) $0.29 ($3,000) $0.50 ($5,000) $1.00 ($10,000)

Accidental Death & Dismemberment
$0.13 per $10,000 – Employee only Desired coverage ÷ 10,000 x .13 =
$0.20 per $10,000 – Family Desired coverage ÷ 10,000 x .20 =

The following benefits can be added, changed or dropped throughout the year: Health Savings Account (HSA) by contacting myCafeteria Plan at 1-800-865-4485, or Fidelity Retirement Contributions by contacting Fidelity at 1-800-343-0860
### Important Contact Information

<table>
<thead>
<tr>
<th>PLAN</th>
<th>ADMINISTRATOR</th>
<th>PHONE NUMBER</th>
<th>WEB ADDRESS</th>
<th>APP</th>
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</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>Highmark Blue Cross Blue Shield</td>
<td>Customer service 1-877-770-6991 24-hr. Nurse Line 1-888-258-3428</td>
<td>mybenefitshome.com</td>
<td></td>
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<tr>
<td>Dental</td>
<td>Delta Dental (Group 1022)</td>
<td>1-800-932-0783</td>
<td>deltadentalins.com</td>
<td>yes</td>
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<tr>
<td>Short-Term Disability</td>
<td>Lincoln Financial Group</td>
<td>1-866-783-2255 (8 a.m. to 8 p.m. Monday through Thursday 8 a.m. to 6 p.m. Friday)</td>
<td>lincoln4benefits.com</td>
<td></td>
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<tr>
<td>and Long-Term Disability</td>
<td>Lincoln Financial Group</td>
<td>1-888-628-4824</td>
<td>eapadvantage.com</td>
<td></td>
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<tr>
<td>Employee Assistance Program</td>
<td>Lincoln Financial Group</td>
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<td></td>
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<tr>
<td>Term Life Insurance</td>
<td>Lincoln Financial Group</td>
<td>1-866-783-2255 (8 a.m. to 8 p.m. Monday through Thursday 8 a.m. to 6 p.m. Friday) Life Insurance Claims 1-800-487-1485 Life Keys: 1-855-891-3684 Travel Connect: 1-800-527-0218</td>
<td>lincoln4benefits.com <a href="http://www.lfg.com">www.lfg.com</a></td>
<td></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>myCafeteriaPlan</td>
<td>1-800-865-6543</td>
<td>mycafeteriaplan.com</td>
<td>yes</td>
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<tr>
<td>401K/Retirement</td>
<td>Fidelity</td>
<td>1-800-343-0860</td>
<td>netbenefits.com/camc</td>
<td>yes</td>
</tr>
<tr>
<td>COBRA</td>
<td>Business Plans, Inc.</td>
<td>1-800-865-4485</td>
<td>mycobraplan.com</td>
<td></td>
</tr>
<tr>
<td>CAMC Financial Counselor</td>
<td>CAMC Benefits Department</td>
<td>(304) 388-7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Benefits</td>
<td>Lincoln</td>
<td></td>
<td></td>
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<tr>
<td>Critical Illness Whole Life</td>
<td>1-800-423-2765</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Old Critical Illness</td>
<td>Unum</td>
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<td>Old Cancer Insurance</td>
<td>New Accidental Insurance</td>
<td>1-800-635-5597</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Whole Life</td>
<td>Boston Mutual</td>
<td>1-800-669-2668</td>
<td></td>
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</tr>
</tbody>
</table>

For all other benefit related questions, please contact your human resources associate or the benefits department directly.

Benefits Department................................................................. (304) 388-7555
Human Resources - General Hospital........................................ (304) 388-7638
Human Resources - Memorial Hospital...................................... (304) 388-5400
Human Resources - Women and Children’s Hospital ............... (304) 388-2287
Human Resources - Teays Valley Hospital............................. (304) 757-1891

This booklet is a summary of the benefit plans effective Jan. 1, 2018 and does not cover all provisions, limitations and exclusions. Your summary plan descriptions (SPDs), summaries of material modifications (SMMs) and summary of benefits insert (SOBI) for each plan can be found on the benefits website. In addition, you can access forms, links to providers, and other important details related to your benefit portfolio. From CAMnet, click on the benefits link.
CAMC encourages staff to go green!
Here’s how it works:
Rather than receive paper copies of the notices and documents described below, you will receive an email through your CAMC work email with a link to these documents. That way you can download them or access them at your convenience. You may also access these documents on CAMnet through the Benefits link.

What’s included? We will email to you a link to access all ERISA Title I Disclosures and other related benefit information pertaining to the Master Health and Welfare Plan and the Basic Retirement Plan, including, but not limited to the items listed below.

- Summary Plan Description ( SPD)
- Summary of Annual Reports (SARs)
- Summary of Material Modifications (SMM)
- Summary of Benefits and Coverage (SBC)
- Claims procedure notices
- COBRA notices
- Qualified Medical Child Support Order (QMCSO) notices
- Any documents required to be furnished under ERISA, 104(b) (4) or ERISA 104(b) (2)

You may request a paper version of any document. To request a paper copy, you must notify the Benefits Department in writing, or send an email to benefits@camc.org. Our mailing address is 419 Brooks St., Charleston, WV 25301.
MyHealth

CAMC has made a commitment to build a nationally recognized wellness program designed to help our employees live well. The MyHealth program has five main focus areas: Weight Management, Stress Management, Physical Activity, Nutrition and Tobacco Cessation. MyHealth is here to help you take charge by giving you access to programs and resources that take a comprehensive approach to health and well being, and allow you to earn rewards for taking a positive step to living a healthier life. Taking advantage of this program could be your first step to becoming a healthier, happier you.

Are you ready for the challenge?
We want our employees to take the next step with us. If you are currently using tobacco, we are encouraging you to kick the habit…for good. We believe it is important to invest in the health of our employees, so CAMC will pay for the full cost of the cessation program.
If you have questions about our cessation programs, please call the benefits department at (304) 388-7593.
CAMC is recognized as a leader in employee wellness!

MyHealth offers you a choice of rewards. The reward choices will be posted on the MyHealth web site.

Get started earning your rewards! Complete the following steps.

Step 1: Complete the Wellness Profile
Take the easy and confidential wellness profile for a snapshot of your current health risks and status. Your personalized report can help you set goals for improving and managing your health.

Step 2: Health screening
Biometric screenings provide overall key indicators of your health. You will earn points toward your incentive when you receive your annual screenings and log them.

Step 3: Preventive care
Preventive care is crucial to helping you get and stay healthy. That includes a physical exam and other age- or gender-appropriate preventive care exams. Log those that you complete.

Step 4: Healthy living
MyHealth will give you points toward incentive for participation in fun, evidence-based programs that focuses on topics such as physical activity, stress management and nutrition.
Quickcharge
Quickcharge is a voluntary debit system through payroll deduction that allows you to use your ID badge to make cash-free purchases at the employee pharmacy, cafeterias, coffee shop, human resources and auxiliary sales. Quickcharge automates the payroll deduction process, by scanning your ID badge for your purchases.

There is a deduction limit based upon personal information and The West Virginia Wage Payment & Collection Act. This amount cannot be more than 25 percent of your wages, less taxes. It is calculated based on your hourly rate and status hours, less your average taxes for a pay period. This amount is multiplied by 25 percent to equal your allowable charge amount.

Employees who have a wage assignment amount less than $50 are not eligible. Newly-hired employees, or employees that have had a change in hire date, must have received at least three paychecks prior to being eligible to participate. To sign up for Quickcharge as a new hire, you will need to go to one of the human resources offices or the payroll office at General Hospital.

Free Parking – Parking facilities are provided on company property for the convenience of all employees.

CAMC Federal Credit Union – Credit Union membership offers employees access to a full range of financial products and services.

Pride Card - CAMC has established relationships with external local and national vendors to give our employees discounts on many products and services.

Employee Health Services – The company provides all employees access to employee health services which include employment physicals, immunizations, and treatment of illness or injury at no cost to the employee.

Employee Emergency Fund
A few cents is all it takes to help each other. Together, through the CAMC Employee Emergency Fund, we have the power to make a difference for fellow employees when the unexpected happens. Since the program’s inception in 2001, the CAMC Foundation has awarded more than $1,000,000 to 1,542 employees who experienced financial hardship during personal emergencies such as:

You don’t know when the unexpected might happen, and this fund is there to help! For more information, call (304) 388-9860 or email camcfoundation@camc.org.

CAMC PatientLink - Your information on your time.
CAMC PatientLink is a secure patient portal that allows you 24/7 access to information about your care at CAMC. It’s a convenient way to manage your health information on your own time.

You’ll be able to see test results and other documents related to your health care more quickly, instead of waiting on a call from your doctor’s office. Many test results will be available within 36 hours of testing. If you’ve been an inpatient, your visit summary and discharge information will also be available.

Available results include:

- Lab tests
- Imaging reports
- Continuity of care/discharge summary documents (inpatient)
- Patient Plan (select CAMC Physicians Group practices)

Learn more and sign up at camc.org/patientlink.
Required annual notices

Required Notices

Important Notice from CAMC Health System, Inc. About Your Prescription Drug Coverage and Medicare under the CAMC Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CAMC Health System, Inc. 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. CAMC Health System, Inc. has determined that the prescription drug coverage offered by the CAMC plan(s) 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through 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 CAMC Health System, Inc. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current CAMC Health System, Inc. coverage, be aware that you and your dependents will not 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 CAMC Health System, Inc. 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 at the end of these notices 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 CAMC Health System, Inc. 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 Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2018
Name of Entity/Sender: CAMC Health System, Inc.
Contact—Position/Office: Human Resources
Address: PO Box 1547
Charleston, WV 25326
Phone Number: 304-388-7555
Women’s Health and Cancer Rights Act
The Women’s Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

» Reconstruction of the breast on which a mastectomy has been performed
» Surgery and reconstruction of the other breast to produce a symmetrical appearance
» Prostheses
» Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 304-388-7555.

HIPAA Privacy and Security
The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 304-388-7555.

HIPAA Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage).

Loss of eligibility includes but is not limited to:

» Loss of eligibility for coverage as a result of ceasing to meet the plan’s eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
» Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
» Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
» Failing to return from an FMLA leave of absence; and
» Loss of coverage under Medicaid or the Children’s Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent(s)’ other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Human Resources at 304-388-7555.
Required annual notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

**ALABAMA – Medicaid**  
**WEBSITE** [http://myahipp.com/](http://myahipp.com/)  
**PHONE** 1-855-692-5447

**ALASKA – Medicaid**  
**PHONE** 1-866-251-4861  
**EMAIL** CustomerService@MyAKHIPP.com  
**MEDICAID ELIGIBILITY** [http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx)

**ARKANSAS – Medicaid**  
**WEBSITE** [http://myarahipp.com/](http://myarahipp.com/)  
**PHONE** 1-855-MyARHIPP (855-692-7447)

**COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)**  
**WEBSITE** Health First Colorado [https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/)  
Health First Colorado Member Contact Center 1-800-221-3943 / State Relay 711  
**PHONE** [https://colorado.gov/hcpf/child-health-plan-plus](https://colorado.gov/hcpf/child-health-plan-plus)  
**WEBSITE** [http://www.ACCESSNebraska.ne.gov](http://www.ACCESSNebraska.ne.gov)  
**PHONE** 855-632-7633  
Lincoln: 402-473-7000  
Omaha: 402-965-1178

**FLORIDA – Medicaid**  
**WEBSITE** [http://flmedicaidtplrecovery.com/hipp/](http://flmedicaidtplrecovery.com/hipp/)  
**PHONE** 1-877-357-3268

**GEORGIA – Medicaid**  
**WEBSITE** [http://dch.georgia.gov/medicaid](http://dch.georgia.gov/medicaid)  
**PHONE** 404-656-4507

**INDIANA – Medicaid**  
**WEBSITE** [http://www.indianamedicaid.com](http://www.indianamedicaid.com)  
**PHONE** 1-800-403-0864

**IOWA – Medicaid**  
**WEBSITE** [http://dhha.state.ia.us/dhhs/members/medicaid-a-to-z/hipp](http://dhha.state.ia.us/dhhs/members/medicaid-a-to-z/hipp)  
**PHONE** 1-888-346-9562

**KANSAS – Medicaid**  
**WEBSITE** 1-877-438-4479  
**PHONE** [http://www.kdhks.gov/hcf/](http://www.kdhks.gov/hcf/)

**KENTUCKY – Medicaid**  
**WEBSITE** [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
**PHONE** 1-888-695-2447

**LOUISIANA – Medicaid**  
**WEBSITE** [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
**PHONE** 1-888-695-2447

**MAINE – Medicaid**  
**PHONE** 1-800-442-6003  
TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**  
**PHONE** 1-800-862-4840

**MINNESOTA – Medicaid**  
**WEBSITE** [http://www.dhs.state.mn.us/minnesotahealthprograms/medical-assistance.jsp](http://www.dhs.state.mn.us/minnesotahealthprograms/medical-assistance.jsp)  
**PHONE** 1-800-657-3739

**MISSOURI – Medicaid**  
**WEBSITE** [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
**PHONE** 573-751-2005

**MONTANA – Medicaid**  
**WEBSITE** [http://dphhs.mt.gov/MontanaHealthcarePrograms/hipp](http://dphhs.mt.gov/MontanaHealthcarePrograms/hipp)  
**PHONE** 1-800-694-3084

**NEVADA – Medicaid**  
**WEBSITE** [http://dwws.nv.gov/](http://dwws.nv.gov/)  
**PHONE** 1-800-992-0900
NEW HAMPSHIRE – Medicaid
PHONE: 603-271-5218

NEW JERSEY – Medicaid and CHIP
MEDICAID
WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/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
www.oregonhealthcare.gov/index-es.html
PHONE: 1-800-699-9075

PENNSYLVANIA – Medicaid
WEBSITE: http://www.dhs.pa.gov/provider/medicalassistance/
healthinsurancepremiumpaymenthippprogram/index.htm
PHONE: 1-800-692-7462

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

SOUTH CAROLINA – Medicaid
WEBSITE: https://www.scdhhs.gov
PHONE: 1-888-362-3002

SOUTH DAKOTA – Medicaid
WEBSITE: http://dss.sd.gov

TEXAS – Medicaid
WEBSITE: http://gethipptexas.com/
PHONE: 1-800-440-0493

UTAH – Medicaid and CHIP
MEDICAID
WEBSITE: https://medicaid.utah.gov/
PHONE: 1-800-362-3002
CHIP WEBSITE: http://health.utah.gov/hip
PHONE: 1-877-543-7669

VERMONT – Medicaid
WEBSITE: http://www.greenmountaincare.org/
PHONE: 1-800-250-8427

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

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

WEST VIRGINIA – Medicaid
WEBSITE: http://www.wvhealth.gov/
PHONE: Toll-free: 1-888-549-0820

WISCONSIN – Medicaid and CHIP
PHONE: 1-800-362-3002

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)