CareSTL Health
2023 Open Enrollment

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This brochure summarizes the benefit plans that are available to CareSTL Health eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

A Message From CareSTL Health

Benefits Open Enrollment is Here!

Welcome to your 2023 employee benefits guide. In these pages, you'll learn about the CareSTL Health benefits program, which is designed to help you stay healthy, secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information in this guide carefully, and for full details about our plans, refer to each plan's summary plan description

2023 Benefit Plan Highlights

- We are pleased to announce that for the 2023 plan year, contributions will remain the same.
- There have been some Medical benefit changes, including deductible and out-of-pocket maximum increases. Please see the Medical section for specifics.
- All employees and dependents are eligible to elect the Critical Illness plan each year at open enrollment with NO Evidence of Isurability, up to Guarantee Issue limits – even if you have previously waived coverage or are currently enrolled in a lesser amount.

Who is Eligible?

Full-time employees working at least 30 hours/week and eligible dependents may participate in the benefit program. You are eligible for benefits on the first of the month after your date of hire.

Generally, for the CareSTL Health benefits program, dependents are defined as:

- Your spouse or domestic partner
- Dependent child(ren) up to age 26.

When and How Can I Enroll?

Open enrollment is December 5th – 14th, 2022

All eligible employees are required to complete the enrollment process, even if you do not want to make changes to your benefits.

When is Coverage Effective?

The effective date for your benefits is January 1, 2023.

Changing Coverage During the Year

You can change coverage during the year only when you experience a qualifying life event, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

For questions about your benefits or enrollment options, contact Michael Jenkins at 314-367-5820 x 3164.

Medical Insurance

CareSTL Health will continue to offer medical coverage. The below chart is a brief outline of the plan. Please refer to the summary plan description for complete plan details. Go to www.anthem.com/login to search for In-Network providers, find Preferred Provider Pharmacies, view your claims and access many other Anthem resources.

	Anthem Insurance Companies Inc HSA $1500 Deductible		Anthem Insurance Companies Inc PPO $1000 Deductible	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$3,000	$9,000	$1,500	$4,500
Family	$6,000	$18,000	$3,000	$9,000
Coinsurance	100%	70%	100%	50%
Maximum Out-of-Pocket				
Individual	$4,000	$12,000	$4,000	$12,000
Family	$8,000	$24,000	$8,000	$24,000
Physician Office Visit				
Primary Care	100% after deductible	70% after deductible	$30 copay	70% after deductible
Specialty Care	100% after deductible	70% after deductible	$70 copay	70% after deductible
Preventive Care				
Adult Periodic Exams	100%	70% after deductible	100%	70% after deductible
Well-Child Care	100%	70% after deductible	100%	70% after deductible
Diagnostic Services				
X-ray and Lab Tests	100% after deductible	70% after deductible	100%	70% after deductible
Complex Radiology	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Urgent Care Facility	100% after deductible	70% after deductible	$50 copay	70% after deductible
Emergency Room	100% after deductible	100% after deductible	$300 copay/visit after deductible; waived if admitted	Covered as In-Network
Inpatient Facility Charges	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Outpatient Facility Charges	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Mental Health & Substance Abuse				
Inpatient	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible	100% after deductible	70% after deductible
Retail Pharmacy (30 Day Supply)				
Generic (Tier 1)	$10 copay after deductible*	70% after deductible	$10 copay*	50% after deductible
Preferred (Tier 2)	$35 copay after deductible*	70% after deductible	$35 copay*	50% after deductible
Non-Preferred (Tier 3)	$75 copay after deductible*	70% after deductible	$75 copay*	50% after deductible
Preferred Specialty (Tier 4)	25% up to $350 after deductible*	70% after deductible	25% up to $350*	50% after deductible
Mail Order Pharmacy (90 Day Supply)				
Generic (Tier 1)	$25 copay after deductible**	Not covered	$25 copay**	Not covered
Preferred (Tier 2)	$105 copay after deductible**	Not covered	$105 copay**	Not covered
Non-Preferred (Tier 3)	$225 copay after deductible**	Not covered	$225 copay**	Not covered
Preferred Specialty (Tier 4)	25% up to $350 after deductible**	Not covered	25% up to $350*	Not covered

**You may pay a higher copay if you see an In-Network pharmacy as opposed to a Preferred Network Pharmacy*
***Mail Order only covered with Preferred Network Pharmacies*

Medical Contributions

Employee Contributions (Bi Weekly 26 per yr)	
$1500 Deductible HSA	
Employee	$69.79
Employee & Spouse	$156.93
Employee & Child(ren)	$137.33
Employee & Spouse & Child(ren) (Family)	$215.79
$1000 Deductible PPO	
Employee	$104.78
Employee & Spouse	$170.82
Employee & Child(ren)	$149.67
Employee & Spouse & Child(ren) (Family)	$235.18

Sydney Health

Connect with us 24/7

Text, chat or ask Alexa to find answers and support whenever is best for you

When you have questions about your Anthem health plan, you can find answers in real time, in the way that suits you best. Anthem's digital tools ensure that help is available whenever you need it. Whether you prefer interactive chat, hands-free voice commands, or live chat, you now have solutions that make it easier for you to focus on your unique needs and priorities.

The SydneySM Health mobile app provides quick access to your health plan information — all in one place. The app's interactive chat feature helps you navigate your benefits with greater ease. Simply type your questions in the app to find answers quickly. Sydney Health can also suggest resources to help you understand your benefits, improve your health, and save money.

How to use Sydney Health's Interactive chat:

Download the app

- Download the Sydney Health app from the App Store® or Google Play™.
- Register or log in to your account using your Anthem username and password.
- Look for the interactive chat feature icon, then type in your questions.

Use the Sydney Interactive chat feature to:

- Search for doctors, hospitals, labs, and other health care providers in your plan.
- Check costs for care before you see a doctor.
- Pull up your digital member ID card.
- See what your plan covers.
- Find your deductible, copay, and share of costs.
- Access your spending account balance.

How to Use Live Chat

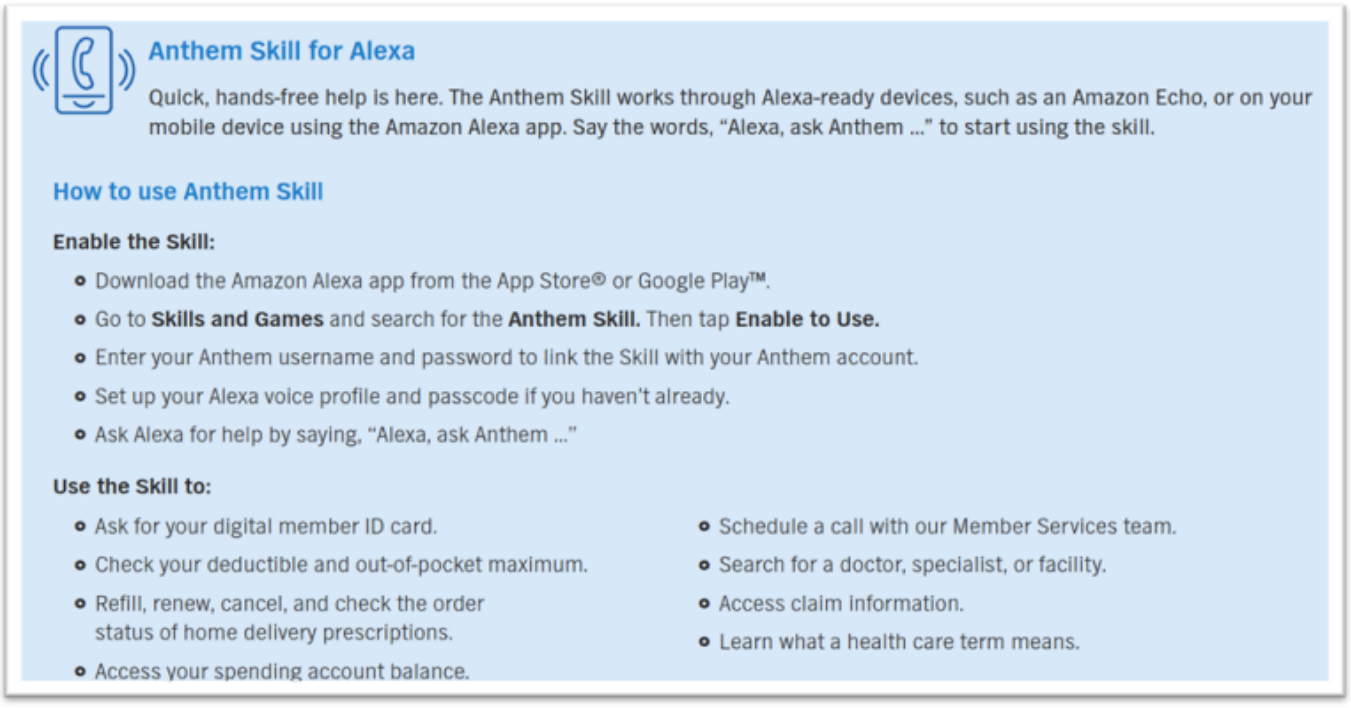
Log in using Sydney Health or anthem.com:

1. For Sydney Health, go to the Menu tab and under Get Support, select Start a live chat.
2. For anthem.com, choose Live Chat under the Support tab.

Choose your chat topic:

Once you start a chat, select a topic or program to connect with a representative who can best help you. Topics include:

- 24/7 NurseLine
- Behavioral Health
- Benefits, coverage and claims
- Maternity and baby benefits
- Pharmacy



Anthem Skill for Alexa

Quick, hands-free help is here. The Anthem Skill works through Alexa-ready devices, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app. Say the words, "Alexa, ask Anthem ..." to start using the skill.

How to use Anthem Skill

Enable the Skill:

- Download the Amazon Alexa app from the App Store® or Google Play™.
- Go to **Skills and Games** and search for the **Anthem Skill.** Then tap **Enable to Use.**
- Enter your Anthem username and password to link the Skill with your Anthem account.
- Set up your Alexa voice profile and passcode if you haven't already.
- Ask Alexa for help by saying, "Alexa, ask Anthem ..."

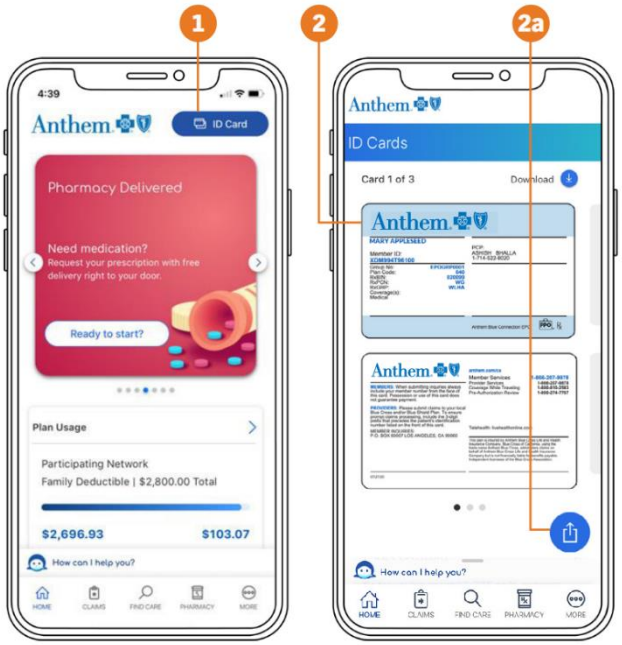
Use the Skill to:

- Ask for your digital member ID card.
- Check your deductible and out-of-pocket maximum.
- Refill, renew, cancel, and check the order status of home delivery prescriptions.
- Access your spending account balance.
- Schedule a call with our Member Services team.
- Search for a doctor, specialist, or facility.
- Access claim information.
- Learn what a health care term means.

Anthem Digital ID Cards

An easy, step-by-step guide

With a digital ID card, you'll never have to search for your member ID card because it's always available on your mobile device or computer. Share it with your doctor over email, fax, or download. It's convenient, and you can be confident that your health plan information and details are always up-to-date.



Access your digital ID card on the Sydney Health app:

1. Select the ID card button at the upper right corner
2. View your ID card(s) or switch to dependent view, as appropriate
3. Print, email, fax, or download your ID card(s)

When you download your card on the Sydney Health app you can securely access it 24/7, online or offline.

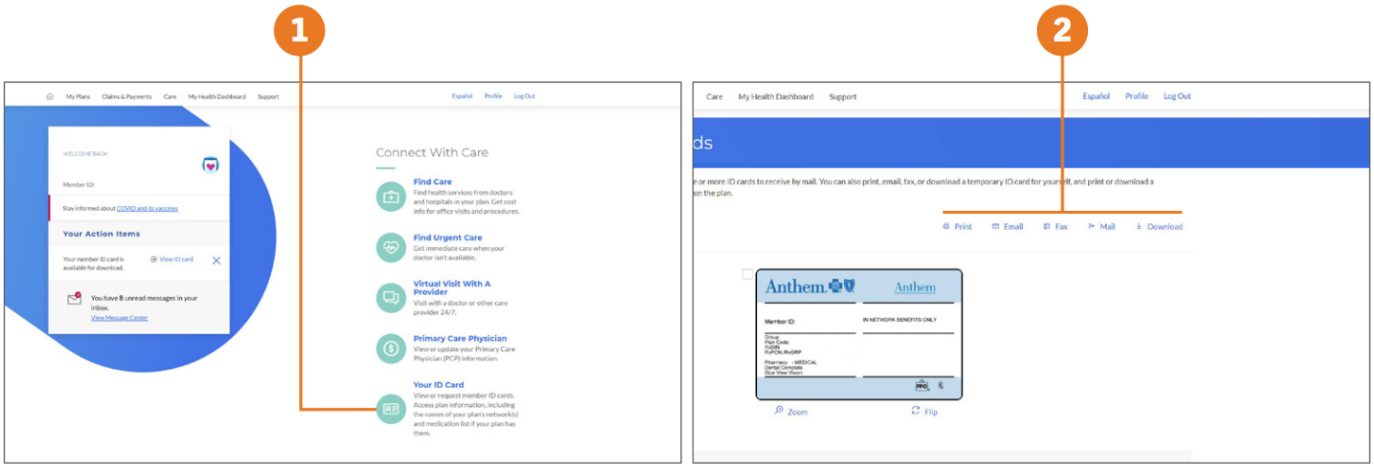
Download the Sydney Health app today in the Google Play or Apple App Store

Available on the App Store

GET IT ON Google Play

Access your digital ID card on anthem.com

1. Select the ID card icon in the bottom right corner
2. Print, email, fax, mail, or download your ID card(s)



If you have questions, go to Live Chat

You can find all the information you need about your healthcare benefits by chatting with an Anthem representative in real-time. Use the Sydney Health app or log in to anthem.com to start a Live Chat.

Dental Insurance

CareSTL Health will continue to offer dental insurance through Anthem Insurance Companies Inc. Go to www.anthem.com/login to find In-Network providers.

	Anthem Base Plan W60163		Anthem Buy-Up Plan W60163	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$75	$75	$50	$50
Family	3x individual deductible	3x individual deductible	3x individual deductible	3x individual deductible
Waived for Preventive Care?	Yes	Yes	Yes	Yes
Annual Maximum				
Per Person / Family	$1,000	$1,000	$3,000	$3,000
Preventive	100%	100%	100%	100%
Basic	70%	70%	80%	80%
Major	70%	70%	80%	80%
Orthodontia				
Benefit Percentage	Not covered	Not covered	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not covered	Not covered	Covered	Covered
Dependent Child(ren)	Not covered	Not covered	Covered	Covered
Lifetime Maximum	N/A	N/A	N/A	N/A
Benefit Waiting Periods	N/A	N/A	N/A	N/A

Employee Contributions (Bi Weekly 26 per yr)	
Base	
Employee	$10.26
Employee & Spouse	$20.27
Employee & Child(ren)	$20.83
Employee & Spouse & Child(ren) (Family)	$30.56
Buy-Up	
Employee	$15.52
Employee & Spouse	$30.66
Employee & Child(ren)	$34.95
Employee & Spouse & Child(ren) (Family)	$50.20

Vision Insurance

CareSTL Health provides vision insurance through Anthem Insurance Companies Inc. By visiting In-Network vision care providers, you will pay the least amount for vision care. To find In-Network providers, visit www.anthem.com/login or call 1-866-723-0515.

	Anthem Insurance Companies Inc All Employees W60163
Copay	
Routine Exams (Annual)	$10 copay
Vision Materials	
Materials Copay	$20 copay
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	Elective contacts covered $150 allowance, then 15% off remaining balance every 12 months
Frames	Covered at $150 allowance, then 20% off remaining balance every 24 months

Employee Contributions (Bi Weekly 26 per yr)	
Vision	
Employee	$2.46
Employee & Spouse	$4.93
Employee & Child(ren)	$5.28
Employee & Spouse & Child(ren) (Family)	$8.43

Life and AD&D Insurance

CareSTL Health provides the stated Basic Life and AD&D benefits to eligible employees.

Standard Insurance Company All Employees	
You	
Your Benefit	1 x annual earnings
Benefit Maximum	$300,000

*The above benefits begin to decrease at age 70.

Be sure to review/update your beneficiary information. This can be done at any time during the year.

Voluntary Life

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability (EOI).

If you did not purchase coverage during your initial eligibility coverage as a new hire, any election you make during the Open Enrollment period will be subject to Evidence of Insurability. If you are currently enrolled, during open enrollment you or your dependents may elect to increase your coverage by one increment up to the guarantee issue without EOI.

You may purchase Voluntary Life insurance with Standard Insurance Company if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect.

Voluntary Life Benefits			
	Benefit Increments	**Benefit Maximum**	**Guarantee Issue**
Employee	$10,000	$200,000	$200,000
Spouse	$5,000	$100,000*	$50,000
Child	$2,500	$10,000	$10,000

*Spouse amount may not exceed employee amount

How to Calculate Voluntary Life Premium			
$_____ Amount of Coverage	÷ 1,000 x	$_____ Unit Cost from Monthly Rate Table	= $_____

Voluntary Life Age/Rate Table		
Age as of January 1, 2023	**Your Rate per $1000 Benefit**	**Spouse Rate per $1,000 Benefit**
<30	$0.060	$0.060
30-34	$0.080	$0.080
35-39	$0.092	$0.092
40-44	$0.112	$0.112
45-49	$0.177	$0.177
50-54	$0.284	$0.284
55-59	$0.494	$0.494
60-64	$0.685	$0.685
65-69	$1.270	$1.270
70+	$2.278	$2.278
Dependent Child Life	$0.200	

Voluntary Short-Term Disability Insurance

CareSTL Health offers a short-term disability option through Standard Insurance Company. This benefit covers 60% of your weekly base salary up to $3,000/week. The benefit begins after 14 days of injury or illness and lasts up to 13 weeks. Please see the summary plan description for complete plan details.

NOTE: Your employer is paying for a portion of the premium. The rate is $0.35 per $10 of benefit of which you pay 20 percent of the cost. Your rate is shown in the calculator below.

Use this formula to calculate your premium payment:

_____	x 0.60 x	$0.07	÷ 10 =	_____	→	_____
Enter your weekly earnings (cannot be more than $5,000).		Rate per $10 of weekly benefit		This amount is an estimate of how much you'd pay each month.		To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Long Term Disability Insurance

Class 1: Physicians, Nurse Practitioners, Dentists, Officers, Directors & Pharmacists

CareSTL Health offers long-term income protection through Standard Insurance Company in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your monthly base salary up to $15,000. Benefit payments begin after 90 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

NOTE: Your employer is paying for a portion of the premium. The rate is 0.60 percent of your predisability earnings of which you pay 20 percent of the cost. Your rate is shown in the calculator below.

Use this formula to calculate your premium payment:

_____	x	0.12	÷ 100 =	_____	→	_____
Enter your monthly earnings (cannot be more than $25,000).		Rate Percentage		This amount is an estimate of how much you'd pay each month.		To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Class 3: All Other Members

CareSTL Health offers long-term income protection through Standard Insurance Company in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your monthly base salary up to $6,000. Benefit payments begin after 90 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

NOTE: Your employer is paying for a portion of the premium. The rate is 0.60 percent of your predisability earnings of which you pay 20 percent of the cost. Your rate is shown in the calculator below.

Use this formula to calculate your premium payment:

_____	x	0.12	÷ 100 =	_____	→	_____
Enter your monthly earnings (cannot be more than $10,000).		Rate Percentage		This amount is an estimate of how much you'd pay each month.		To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Worksite Products

Accident

Accidents can happen at any moment throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills. Our policy can help pick up where other insurance leaves off and provide cash to cover the expenses. Our accident coverage helps offer peace of mind when an accidental injury occurs. The below chart is a brief highlight of the benefits offered on the plan. For complete plan details, please review your certificate of coverage.

Accident Guardian			
	Employee	**Spouse**	**Child**
Accidental Death & Dismemberment	Option 1: $25,000 Option 2: $50,000	Option 1: $10,000 Option 2: $20,000	Option 1: $5,000 Option 2: $10,000
Chiropractic Visits	Option 1: $25 / visit Option 2: $50 / visit		
Dislocations	Option 1: Benefits range from $60-$2,000 Option 2: Benefits range from $120-$5,000		
Emergency Room Treatment	Option 1: $150 Option 2: $200		
Hospital / ICU Admission	Option 1: $1,500 Option 2: $2,000		
Hospital / ICU Confinement	Option 1: $300/day Option 2: $500/day		
Monthly Rate			
	Option 1 – Value Plan	Option 2 – Advantage Plan	
Employee	$11.50	$15.46	
Spouse	$9.12	$11.72	
Child(ren)	$10.25	$12.51	

Critical Illness

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Guardian group voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness. You have options for lump sum benefits of $10,000 or $20,000 for yourself, 50% of the employee amount to a maximum of $10,000 for your spouse and 25% of the employee benefit to a maximum of $5,000 for your child. Please refer to the Certificate of Coverage for complete plan details and lump sum payout details.

Critical Illness Age/Rate Table		
Age	**Employee Rate (per $1000 benefit)**	**Spouse Rate (per $1000 benefit)**
15-29	$0.690	$0.680
30-39	$0.980	$0.970
40-49	$1.810	$1.800
50-59	$3.230	$3.220
60-69	$4.910	$4.910
70-99	$9.550	$9.550
Child(ren)	$0.000	

Hospital Indemnity

Hospital Indemnity Guardian 00565006		
	Plan 1	**Plan 2**
Hospital/ICU Admission	$1000/admission; maximum of 2 admissions per person or 3 per covered family per year	$2000/admission; maximum of 2 admissions per person or 3 per covered family per year
Hospital/ICU Confinement	$100 per day to a maximum of 15 days per year, per insured individual	$200 per day to a maximum of 15 days per year, per insured individual
Monthly Rate		
Employee	$26.96	$52.26
Employee + Spouse	$48.01	$93.03
Employee + Child(ren)	$40.64	$78.77
Family	$61.69	$119.55

Contacts

Have Questions? Need Help?

CareSTL Health is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0829 or via e-mail at BRCMidwest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

Benefits Plan	Carrier	Phone Number	Website
Medical PPO	Anthem Insurance Companies Inc	1-833-578-4436	www.anthem.com
Dental PPO	Anthem Insurance Companies Inc	1-844-729-1565	www.anthem.com
Vision	Anthem Insurance Companies Inc	1-866-723-0515	www.anthem.com
Life and AD&D	Standard Insurance Company	800-628-8600	www.standard.com
Voluntary Life	Standard Insurance Company	800-628-8600	www.standard.com
Short Term Disability (STD)	Standard Insurance Company	800-368-2859	www.standard.com
Long Term Disability (LTD)	Standard Insurance Company	800-368-1135	www.standard.com
Voluntary Critical Illness	Guardian	1-800-627-4200	www.guardianantytime.com
Accident	Guardian	1-800-627-4200	www.guardianantytime.com

CareSTL Health
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Required Notices

Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

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

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

CareSTL Health
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314-367-5820 x 3164
michael.jenkins@carestlhealth.org

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

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
-
- **File a complaint if you feel your rights are violated**
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

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

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

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

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

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

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

How else can we use or share your health information?

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

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

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

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

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

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

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

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

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2023
- Michael Jenkins
    - 314-367-5820 x 3164
    - michael.jenkins@carestlhealth.org

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from CareSTL Health About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CareSTL Health 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. **CareSTL Health has determined that the prescription drug coverage offered by the $1500 PPO and $3000 HSA plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto 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 CareSTL Health coverage will be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2023
Name of Entity/Sender:	CareSTL Health
Contact--Position/Office:	Michael Jenkins
Address:	5471 Sr. Martin Luther King Dr., Saint Louis, MO 63112
Phone Number:	314-367-5820

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**.

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** 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** 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 July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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)
Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323,

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 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer name CareSTL Health	2. Employer Identification Number (EIN) 43-0917230	
3. Employer address 5471 Dr. Martin Luther King Drive	4. Employer phone number 314-367-5820	
5. City Saint Louis	6. State MO	7. ZIP code 63112
8. Who can we contact about employee health coverage at this job? Michael Jenkins		
9. Phone number (if different from above) 314-580-7809 x 3164	10. Email address Michael.ienkins@carestlhealth.org	

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

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full-time regular working at least 30 hours/week

  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Spouse, domestic partner and dependent children to age 26.

  - [ ] We do not offer coverage.

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

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

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

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