

A photograph of a man with a beard and a pink shirt carrying a young child on his shoulders. The man is smiling and holding a colorful kite with yellow, blue, and pink stripes. The child is also smiling and holding a green string. They are outdoors in a park-like setting with trees and a fence in the background.

2021 Benefits Open Enrollment Guide

**Enroll between
Oct. 26 – Nov. 13**

This document includes links. Easily move to another section by clicking on words in the banner. Visit a website by clicking a hyperlink. Go to another page by clicking the arrows on the side of the page.

Information on Medicare Part D Prescription Coverage can be found on [page 31](#).

Welcome to Benefits Open Enrollment 2021

Enroll between **Monday, Oct. 26 and Friday, Nov. 13**

The Wake Forest Baptist Health (WFBH) benefit plan options you have today will continue with minimal changes in 2021. Any changes are detailed in the *2021 Benefits Open Enrollment News* newsletter, which was mailed to your home and is also posted on the intranet with other enrollment resources.

Once you've explored the benefit options available to you, you're ready to enroll between **Monday, Oct. 26 and Friday, Nov. 13**. Your benefit elections will take effect Jan. 1, 2021. Choose your benefits carefully—you won't be able to make changes until the next open enrollment period unless you experience a qualifying life event (see "Making mid-year changes" on [page 5](#)).



Do I need to enroll?

Here's what happens to your benefits if you do not **enroll by Nov. 13**:

If you are currently enrolled, your current elections will roll over for 2021 **except**:

- **Health Savings Account (HSA)** contributions. You must make a new HSA contribution election each year.
- **Flexible Spending Accounts (FSAs)**: Health care and dependent care. You must make new elections for FSAs each year.

If you are NOT currently enrolled in WFBH benefits

You will have only core benefits automatically provided by WFBH for 2021 such as basic life, basic accidental death and dismemberment (AD&D), long-term disability (LTD) and business travel accident insurance. Your next opportunity to enroll will be the open enrollment period next fall for benefits to take effect Jan. 1, 2022.



The information presented in the 2021 Benefits Open Enrollment Guide is not intended to be construed as a contract between Wake Forest Baptist Health (WFBH) and any WFBH associate or former employee for purposes of employment or payment of benefits. In the event that the content of this guide or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document will control. WFBH reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage, by appropriate company action, without your consent or concurrence.

Enroll from anywhere!

Take some time to review your choices, then enroll at work, home or on any computer with Internet access 24/7. Just remember to act before the **Nov. 13** deadline!

If you enroll from the WFBH network

- 1 From the WFBH intranet, click the **HR** tab.
- 2 Click **PeopleSoft** in the left navigation pane.
- 3 Under the **PeopleSoft Human Resources/Payroll** heading, click the *PeopleSoft Self-Service – HR/Payroll Login* link.
- 4 Login and select *Main Menu, Self Service, Benefits*, then *Benefits Enrollment*.

Important! Before submitting your elections, **print the confirmation page** for your records. If you don't have a printer, you can take a clear photo of the confirmation page with your smartphone.

The benefits you elect will go into effect on Jan. 1. The first payroll deductions for benefits will be in your first paycheck in January.

? **Need more help?** Go to <https://www.wakehealth.edu/About-Us/Our-Website/ITS> for video tutorials that will walk you through installing, setting up, and logging into WFBH resources from a personal device.

To access PeopleSoft from a personal device

- 1 Go to <https://portal2.wakehealth.edu> in your web browser.
- 2 Enter your WFBH network username and password, and click the *Logon* button.
- 3 When prompted to enter your *tokencode* or select another method, enter **1** in the answer field and click the *Logon* button again. This will send a push notification to your mobile device.
- 4 Click the *green checkmark* on your mobile device to launch Citrix Receiver on your PC.
- 5 Scroll down and click the tile for *PeopleSoft HR-Payroll Login*.
- 6 Click the *.ica* file at the bottom of your computer screen to launch PeopleSoft.
- 7 Use your WFBH network username and password to login to PeopleSoft, and select *Main Menu, Self Service, Benefits*, then *Benefits Enrollment*.

BEFORE YOUR INITIAL LOGON – you must request access to the Remote Access Portal and register for RSA 2-factor authentication. Contact the Help Desk (**336-716-HELP** [4357]) for assistance with these processes.



alex® BENEFITS COUNSELOR

Let ALEX help you choose 2021 benefit options that fit you

ALEX® is an online, informative and entertaining decision-making support tool that walks you through your benefits options and helps you choose options that are best for you and your family. ALEX will ask you questions about your health care and other benefit needs (your answers remain anonymous, of course), crunch some numbers and recommend WFBH benefits that fit your personal situation. It's that easy!

Going through the entire ALEX experience and clicking every possible button can take about 30 minutes or so, but the actual duration of your experience will depend on your needs. Most users spend about 10 minutes with the tool.

ALEX is best experienced on a desktop computer, but you can also use it on an Android or iOS (Apple) mobile device.

Let ALEX help you choose your benefits for 2021! Go to www.myalex.com/wakehealth/2021.

Enrollment checklist

Before enrollment

- Read this guide to understand your options and costs.
- Compare your benefit options through ALEX, our online decision-making tool: www.myalex.com/wakehealth/2021.

During enrollment

- Log on to PeopleSoft (see instructions on the previous page).
- Update your contact information (phone number, email address) and be sure your mailing address is correct. We'll use this information to communicate with you about your benefits and to ensure that your benefit plan offerings are accurate.
- If you are enrolling dependents, have their birthdates and Social Security numbers on hand.
- If you are enrolling a dependent child who does not live with you, be sure to provide his/her physical address, so we can assign a provider network for him/her.
- Review your beneficiaries and make updates as needed.
- **Print a copy of the confirmation page** or take a picture of it with your smartphone and keep for your records.
- **Click the "Submit" button** to finalize your elections.

If you enroll your spouse in health coverage

If you want to enroll your spouse in a WFBH health plan and your spouse works full-time (30 or more hours per week) and is eligible for ACA-creditable medical coverage* through his or her employer (whether enrolled in that coverage or not), you will pay a surcharge in addition to the health plan premiums. The surcharge does not apply if your spouse is not employed, works part-time (fewer than 30 hours per week), is self-employed, is retired, or if you and your spouse both work for WFBH.

When you enroll online through PeopleSoft, you will be required to answer questions about your spouse's employment and eligibility for other coverage and elect the surcharge, if applicable.

The amount of the surcharge depends on the health plan you choose:

If you enroll yourself and your spouse in the:	You will pay a monthly spousal surcharge of:
Wake Select Plan or Wake Select OOA Plan	\$100
Wake Options Plan	\$200
Wake Health Savings Plan	\$200

* ACA-creditable coverage refers to a group health insurance plan that meets both the Minimum Essential Coverage and Minimum Value Standards under the Patient Protection and Affordable Care Act (ACA). Most employers with 50 or more employees offer ACA-creditable coverage.

Not making changes?

If you don't want to make any changes to your benefit elections for 2021 and you don't want to elect an FSA or HSA, you still should log into PeopleSoft to review your current elections and see any revised premiums that may apply for 2021.

After logging in, you can follow these steps to obtain a confirmation statement for your records.

- 1 Select *Main Menu, Self Service, Benefits*, then *Benefits Enrollment*.
- 2 Click the "Select" button.
- 3 Click the *Print Summary Confirmation* link, and either print a hard copy of the confirmation page or take a picture with your smartphone.



Eligibility

For you

You are eligible to enroll in benefits if you are a full-time (30 standard hours or more) or part-time (20 – 29 standard hours) employee.

For your dependents

Your eligible dependents include your:

Spouse	A person to whom you are legally married under state law and with whom you have a certificate of marriage.
Children	Your dependent children up to age 26. This includes your natural children, adopted children, stepchildren, foster children or children for whom you have a Qualified Medical Child Support Order. With certification, "child" may also include an adult child of any age if disabled and dependent on you for support.
Grandchildren	Your adopted grandchildren or grandchildren for whom you have legal guardianship.



Making mid-year changes

The benefit elections you make during open enrollment remain in effect for the benefit plan year (Jan. 1 through Dec. 31). You may change coverage only when you experience a qualifying life event, and you must do so within 31 days of the event.

Qualifying life events

- Change in status, which includes legal marital status, number of dependents, employment (yours, your spouse's or your dependent child's), change in residence (if the change impacts eligibility for benefits) and dependent eligibility (such as when dependent satisfies or ceases to satisfy eligibility requirements).
- Change due to a legal judgment, decree or court order.
- Entitlement to Medicare or Medicaid.
- Loss of coverage under a state's Children's Health Insurance Program (CHIP).
- Eligibility for premium assistance under Medicaid or CHIP.
- FMLA special requirements.

Important! You must make your enrollment changes **within 31 days** of the event by contacting the PeopleLink team at **PeopleLink.WakeHealth.edu** or calling **336-716-6464**. PeopleLink representatives are available 7:30 a.m. to 5 p.m., Monday – Friday.

Note: All changes must be consistent with your type of qualifying life event, and you will be required to submit proper documentation. PeopleLink will provide you with instructions on what documentation is needed and how to submit it.

? Contact PeopleLink at **336-716-6464** or **PeopleLink.WakeHealth.edu** for assistance.

Health

You have a choice between three health plans that are based on where you live: inside or outside the Wake Forest Baptist Health (WFBH) service area.

WFBH service area	Outside WFBH service area
① Wake Select Plan	① Wake Select Out-of-Area (OOA) Plan
② Wake Options Plan	② Wake Options Plan
③ Wake Health Savings Plan (with Health Savings Account)	③ Wake Health Savings Plan (with Health Savings Account)

WFBH service area

The **WFBH service area is based on your home ZIP code** and predominantly covers these counties: Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Guilford, Iredell, Randolph, Rockingham, Rowan, Stokes, Surry, Watauga, Wilkes and Yadkin. If your ZIP code crosses over county lines and your ZIP is in the service area, the determination will be based on your ZIP code and not your county of residence.

Will I get a new health plan ID card?

- If you change your health plan option or add or remove dependents for 2021, you will receive a new MedCost ID card.
- If you stay in your current plan and you continue to cover the same dependents for 2021, you will continue to use the ID card you have now.
- If you need a new ID card during the year, visit www.medcost.com to print a copy or request a replacement card.

Wake Select Plans

The **Wake Select Plan** offers the following:

- You and your covered dependents must receive care from a WFBH Network provider. Otherwise there is no coverage* and you are responsible for 100% of the costs.
- All inpatient, outpatient and ancillary surgical procedures must be performed at a WFBH facility.
- See the Summary Plan Description for a full list of WFBH facilities and exceptions for certain providers, including general pediatrics and emergency care.

* Exception: In the case of a true medical emergency, care is covered at any hospital emergency department. Coverage is available for covered dependents who live outside of the WFBH service area.

The **Wake Select Out-of-Area (OOA) Plan** is only offered to a limited number of employees who reside outside the WFBH service area. You and your covered dependents can choose a provider from one of these networks:

- WFBH Network, or
- MedCost Network.

You pay less when you go to a provider or facility within the WFBH Network. For example, you will have a \$10 copay if you go to a WFBH Network primary care physician (PCP); however, if you go to a MedCost Network PCP, you will have a \$40 copay.

If you go outside of these two networks for care, you are responsible for 100% of the costs.*

* Exception: In the case of a true medical emergency, care is covered at any hospital emergency department. Coverage is available for covered dependents who live outside of the WFBH and MedCost Networks.

Wake Options Plan

With the Wake Options Plan you and your covered dependents can choose a provider from one of these networks:

- WFBH Network, or
- MedCost Network.

You pay less when you go to a provider or facility within the WFBH Network. For example, you will have a \$10 copay if you go to a WFBH Network primary care physician (PCP); however, if you go to a MedCost Network PCP, you will have a \$40 copay.

If you go outside of these two networks for care, you are responsible for 100% of the costs.*

* Exception: In the case of a true medical emergency, care is covered at any hospital emergency department. Coverage is available for covered dependents who live outside of the WFBH and MedCost Networks.

Save money with the WFBH Network

No matter which plan you select, you and your family are encouraged to use the WFBH Network for health services. You'll receive care from one of America's top-ranked health systems AND you'll **have lower copays, deductibles, coinsurance and out-of-pocket maximums.**

If you earn \$17 per hour or less...

If you earn \$17 per hour or less, are full-time **and are covered under the WFBH Wake Select Plan, Wake Select OOA Plan or Wake Options Plan**, you will be eligible for a WFBH contribution of up to \$300 annually to a health care FSA debit card. These contributions will be made in January (\$150) and July (\$150).

Wake Health Savings Plan

The Wake Health Savings Plan is an IRS-qualified health plan that requires deductible and coinsurance in lieu of copays and features a tax-favored savings account called a Health Savings Account (HSA). Under this option, you pay 100% of the costs of all medical services (except preventive care) and 100% of prescription drug costs until your deductible has been met. After meeting the deductible, you pay coinsurance until you meet your out-of-pocket maximum.

You can contribute to an HSA tax-free, the account grows tax-free and money can be withdrawn tax-free as long as the funds are used for qualified expenses.

When you and your covered dependents need care, you can choose a provider from one of these networks:

- WFBH Network, or
- MedCost Network.

You pay less when you go to a provider or facility within the WFBH Network. If you go outside of these two networks for care, you are responsible for 100% of the costs.*

* Exception: In the case of a true medical emergency, care is covered at any hospital emergency department. Coverage is available for covered dependents who live outside of the WFBH and MedCost Networks.

How the Wake Health Savings Plan (with HSA) works

You put money into your HSA tax-free.

For 2021, you can contribute up to:

- \$3,600 individual
- \$7,200 family

You get medical care or fill a prescription.

You pay for services until you meet your deductible. You can use your HSA money (or save it to use later), or you can use money out of your own pocket.

You meet your deductible.

Your insurance kicks in after your health expenses reach this amount:

Wake Health Savings Plan	WFBH Network:	MedCost Network:
	\$2,000 individual/ \$4,000 family	\$4,000 individual/ \$8,000 family*

*No one individual pays more than \$7,900 out of pocket in 2021.

You pay coinsurance.

Every time you get covered care or prescription drugs, you'll pay coinsurance. Coinsurance is the percentage you pay for the cost of covered health care services after you meet your deductible.

Don't forget: In-network preventive care is covered at 100%.

You are protected by the out-of-pocket maximum.

Once you reach the plan's out-of-pocket maximum, your plan pays 100% of covered expenses. The out-of-pocket maximums are:

Wake Health Savings Plan	WFBH Network:	MedCost Network:
	\$4,000 individual/ \$8,000 family*	\$6,750 individual/ \$13,500 family*

*No one individual pays more than \$7,900 out of pocket in 2021.

Find out more about the HSA

See the HSA section on **page 25** of this guide for more details about the HSA and how it works.



Health plan comparison chart

Health plan feature	WFBH service area			Outside WFBH service area			
	Wake Select Plan ³	Wake Options Plan		Wake Health Savings Plan (with HSA option)		Wake Select Out-of-Area (OOA) Plan ⁵	
	WFBH Network	WFBH Network	MedCost Network	WFBH Network	MedCost Network	WFBH Network	MedCost Network
Annual Deductibles¹	\$1,000 individual \$2,000 family	\$1,000 individual \$2,000 family	\$3,000 individual \$6,000 family	\$2,000 individual \$4,000 family	\$4,000 individual \$8,000 family	\$1,000 individual \$2,000 family	\$4,000 individual \$8,000 family
Out-of-pocket maximums²	\$4,000 individual \$8,000 family	\$4,000 individual \$8,000 family	\$6,000 individual \$12,000 family	\$4,000 individual \$8,000 family ⁴	\$6,750 individual \$13,500 family ⁴	\$4,000 individual \$8,000 family	\$4,000 individual \$8,000 family
Copays and coinsurance							
Coinsurance after deductible	20%	20%	40%	20%	40%	20%	40%
ER (copay waived if admitted)	\$200	\$200	\$200	20%	20%	\$200	\$200
Preventive care	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PCP	\$10	\$10	\$40	20%	40%	\$10	\$40
Specialist	\$20	\$20	\$70	20%	40%	\$20	\$70

¹ In the **Wake Select, Wake Options and Wake Select OOA Plans**, you pay copays for some services without having to meet a deductible. For services that require a deductible: (a) if one covered person meets the individual deductible, the plan will begin paying benefits on that person's covered expenses; and (b) the family deductible is met when any combination of covered persons has expenses totaling the family deductible. In the **Wake Health Savings Plan**, the individual deductibles shown are for Employee Only coverage and the family deductibles apply to all other coverage levels. (Please note: there is no individual deductible in the Wake Health Savings Plan for coverage levels other than Employee Only.)

² Includes coinsurance and medical/Rx copays.

³ The Wake Select Plan requires that you use WFBH providers. Additionally, you can see a MedCost pediatrician for coverage. In the event of an emergency or if WFBH does not have a provider in the specialty that you seek, you may seek care from a provider in the MedCost network.

⁴ No one individual will pay more than \$7,900 in out-of-pocket expenses. This limit may change in future years to align with U.S. Department of Health and Human Services (HHS) requirements.

⁵ The Wake Select OOA Plan is only offered to a limited number of employees who reside outside the WFBH service area.

WFBH service area

Outside WFBH service area

Health plan feature	Wake Select Plan ³	Wake Options Plan		Wake Health Savings Plan (with HSA option)		Wake Select Out-of-Area (OOA) Plan ⁵	
	WFBH Network	WFBH Network	MedCost Network	WFBH Network	MedCost Network	WFBH Network	MedCost Network
Ob-Gyn preventive services	\$0 ⁶	\$0	\$0	\$0	\$0	\$0	\$0
Ob-Gyn non-routine services other than maternity services	\$20 ⁶	\$20	\$70	20%	40%	\$20	\$70
Urgent care	\$20	\$20	\$55	20%	40%	\$20	\$55
Mental health/substance abuse	\$10	\$10	\$40	20%	40%	\$10	\$40
Hospital & surgeon fees							
Inpatient	20%	20%	40%	20%	40%	20%	40%
Outpatient	20%	20%	40%	20%	40%	20%	40%
Surgeon/physician fees	20%	20%	40%	20%	40%	20%	40%
Maternity care⁷							
Maternity physician, hospital and/or birthing center charges	20% ⁸	20%	40%	20%	40%	20%	40%

³ The Wake Select Plan requires that you use WFBH providers. Additionally, you can see a MedCost pediatrician for coverage. In the event of an emergency or if WFBH does not have a provider in the specialty that you seek, you may seek care from a provider in the MedCost network.

⁵ The Wake Select OOA Plan is only offered to a limited number of employees who reside outside the WFBH service area.

⁶ You can see a MedCost Ob-Gyn for coverage.

⁷ Women who enroll in the SmartStarts prenatal program during their first 20 weeks of pregnancy and **complete the program** will receive a \$500 deductible credit to use toward delivery medical expenses.

⁸ The Wake Select Plan requires that you use WFBH providers and deliver at a WFBH facility in order to have maternity services covered by the plan.

2021 health plan costs (pre-tax)

Here are your bi-weekly and monthly costs for health plan coverage. These pre-tax rates do not include any spousal surcharge that may apply. See "If you enroll your spouse in health coverage" on [page 4](#).

Coverage level	Full-time employees		Part-time employees	
	Monthly	Bi-weekly	Monthly	Bi-weekly
Wake Select Plan				
You only	\$88.00	\$40.62	\$490.00	\$226.15
You plus children	\$277.00	\$127.85	\$979.00	\$451.85
You plus spouse	\$324.00	\$149.54	\$1,224.00	\$564.92
You plus family	\$444.00	\$204.92	\$1,713.00	\$790.62
Wake Options Plan				
You only	\$149.00	\$68.77	\$569.00	\$262.62
You plus children	\$471.00	\$217.38	\$1,135.00	\$523.85
You plus spouse	\$549.00	\$253.38	\$1,421.00	\$655.85
You plus family	\$755.00	\$348.46	\$1,986.00	\$916.62
Wake Health Savings Plan				
You only	\$137.00	\$63.23	\$478.00	\$220.62
You plus children	\$431.00	\$198.92	\$953.00	\$439.85
You plus spouse	\$502.00	\$231.69	\$1,193.00	\$550.62
You plus family	\$689.00	\$318.00	\$1,669.00	\$770.31
Wake Select OOA Plan				
You only	\$61.00	\$28.15	\$497.00	\$229.38
You plus children	\$194.00	\$89.54	\$994.00	\$458.77
You plus spouse	\$225.00	\$103.85	\$1,243.00	\$573.69
You plus family	\$309.00	\$142.62	\$1,740.00	\$803.08

If you are a stipend-paid fellow, your premiums are paid after-tax and differ from this chart. Premiums will display in PeopleSoft.

About the networks

WFBH Network: The WFBH Network includes providers and facilities that are part of WFBH, as well as AdventHealth Medical Group; Appalachian Regional Medical Associates; Catawba Valley Medical Center; Charles A. Cannon, Jr. Memorial Hospital; High Point Endoscopy; High Point Surgery Center; Hugh Chatham Memorial Hospital; Iredell Health Network; Premier Surgery Center, LLC; Randolph Hospital; Surgical Center of Greensboro; Wake Forest Baptist Health Outpatient Surgery – Clemmons; and Watauga Medical Center. See the Summary Plan Description for information about additional WFBH Network providers and facilities.

MedCost Network: MedCost has an extensive provider network across North Carolina, South Carolina, and Virginia.

 To find providers in each network go to www.medcost.com.

Dependents who live out-of-area

Our health plan offers coverage for dependents who live outside the WFBH service area or outside the MedCost Network area. Be sure your dependents' addresses are updated in PeopleSoft. Each dependent is assigned a local provider network in the state where the dependent resides. Here's how each plan pays benefits for out-of-area dependents.

Wake Select Plan

Dependents may use their assigned out-of-area network for all covered services, and the coverage will be the same as a WFBH Network provider.

Wake Options, Wake Health Savings and Wake Select OOA Plans

Dependents may use their assigned out-of-area network for all covered services, and the coverage will be the same as a MedCost Network provider. Dependents also have access to the WFBH Network when visiting the WFBH service area.

Ob-Gyn care

Routine care

For routine care (such as PAP smears), the plans pay 100%. For non-routine care, Ob-Gyn physicians are considered specialists.

Maternity care

Wake Forest Baptist Medical Center offers labor and delivery services, so maternity benefits under our plans are covered as follows:

- **Wake Select Plan.** Employees and dependents enrolled in this plan **must use WFBH Network providers and deliver at a WFBH Network facility in order to have maternity services covered by the plan.**
- **Wake Options, Wake Health Savings, and Wake Select Out-of-Area (OOA) Plans.** Employees and dependents enrolled in these plans have the option of using MedCost Network providers and delivering at a MedCost Network facility. Prenatal care with MedCost providers and delivery services at MedCost facilities are covered at the MedCost level of benefits.

Telehealth

Telemedicine has been a growing trend in healthcare, but since the coronavirus pandemic and the need for social distancing, it has become a viable option for delivering various types of care. If you haven't tried telemedicine through your WFBH health plan, here are a few good reasons to start:

- 1 Telemedicine provides quick access to convenient, confidential and affordable healthcare.
- 2 You can speak with a licensed provider about non-emergency health issues anywhere you are — at home, at work, or on vacation.
- 3 You can get a fast diagnosis and treatment for cold and flu symptoms, allergies, upper respiratory infections, skin problems and more.
- 4 Telemedicine providers can send a prescription to your local pharmacy, when medically necessary.

Contact your WFBH provider to schedule a telephone or video visit. You can also request an e-visit through myWakeHealth. If you are in need of immediate care that is not life-threatening, you may even be able to schedule a virtual visit with an emergency medicine specialist. Your telehealth visit costs are based on your health plan option, the type of provider you use and the services you receive.

24/7 Immediate Virtual Care

For your unexpected illness and injury

Emergency specialists can assess and help you get the right care at the right time.

If we decide you need an in-person visit, we can begin your care and help direct you to the most appropriate Wake Forest location for your needs (Primary care, Specialty care, Urgent Care, or Emergency Department).

As with all Wake Forest virtual visits, Medcost patients can receive virtual care for \$0 out of pocket. The service is always available by calling **1-844-WF-TEL-ED** (1-844-938-3533).

Parental leave and adoption assistance

WFBH supports employees and their families by offering parental leave and adoption assistance benefits.

Parental Leave. Bonding with your new child is your first priority after you welcome him or her into your life and we're proud to offer a parental leave benefit to let you do just that. All benefits-eligible employees who give birth to or adopt a child after having been actively employed with WFBH for at least 90 days will receive two weeks of paid parental bonding leave. For the parent who gives birth, this is in addition to the six-to-eight weeks of short-term disability benefits (if you elect short-term disability insurance) or salary continuation that may be payable. All non-birth and adoptive parents are also eligible for the two weeks of paid parental leave.

Adoption Assistance. Adding to your family by adopting a child is wonderful and exciting. However, we know it also involves a lot of planning, legal work and expense. WFBH can help you offset those costs with the adoption assistance benefit. Benefits-eligible employees who have been actively employed with WFBH for at least 90 days can use this benefit for adoption placements and expenses incurred related to the adoption of a child. Each family can be reimbursed up to \$5,000 per adoption, up to a family maximum of \$10,000 (two adoptions). Expenses that can be reimbursed include agency and placement fees, legal fees and court costs, travel and transportation costs, and other fees allowed by the IRS. You have 90 days from the date the adoption is finalized to submit your reimbursement request and supporting documentation (including a copy of the adoption decree).

SmartStarts Prenatal Program

If you or one of your covered dependents are pregnant, you probably have many questions. MedCost offers a special prenatal program for expecting patients to answer questions and offer sound medical advice. You can learn healthy habits and tips to prevent complications.

Women who enroll in the program during their first 20 weeks of pregnancy and successfully complete the program will receive a **\$500 deductible credit** to use toward delivery medical expenses.

 For more information about the SmartStarts Prenatal Program, call **888-334-0609**.

Having a Baby website

If you're expecting, be sure to explore the **Having a Baby** website on our intranet. You'll learn about the healthy pregnancy resources available to you, how to add your baby to your health plan coverage, steps for scheduling time off and returning to work, and more.

Healthy Futures

Healthy Futures is a personalized program offered by the Wake Forest Baptist Health Weight Management Center (WMC). The program is designed to help participants manage their weight during and after pregnancy. Based on a participant's specific needs, a multidisciplinary team provides services that may include nutritional counseling, behavioral support, and exercise training tailored for pregnancy.

Participation in Healthy Futures is voluntary for employees and dependents covered by a WFBH health plan who qualify. Contact the WMC at **336-716-6099** or go to www.wakehealth.edu/Treatment/m/Medical-Weight-Management/Healthy-Futures for more details.

Employee Assistance Program

The Employee Assistance Program (EAP) is provided as an employer-paid benefit to WFBH employees and their immediate family members. It is a confidential service in which trained counselors offer assessment and referral services to help resolve a range of personal or emotional concerns, including:

- Marital problems
- Depression
- Family difficulties
- Stress at home or work
- Anxiety
- Alcohol and drug abuse
- Grief

Services are available at no cost to the employee and immediate family members.

 To contact EAP or make an appointment, please call **336-716-5493**. All calls and appointments with EAP are strictly confidential.

Elder Care Choices

Elder Care Choices is an employer-paid benefit that provides resources and assistance for employees with caregiver concerns, Medicare questions and other long-term care needs. This benefit is provided at no cost to the employee.

 Elder Care counselors are available from 8 a.m. to 5 p.m., Monday through Friday. To contact Elder Care, call **336-748-2171** or email ecc@seniorservicesinc.org.

BestHealth For Us

BestHealth For Us, WFBH's employee wellness department, promotes a culture of wellness throughout the Wake Forest Baptist Health system. Everything they do is aimed at helping you live well, care well and be well. The program assists employees in making voluntary lifestyle changes that reduce their health risks and enhance their quality of life.

BestHealth For Us offers free programs and services such as health assessments, consults with registered dietitians and health coaches, classes, on-line wellness challenges and more. They want to help you live better by meeting your health goals, including:

- Healthy eating
- Diabetes management
- Fitness
- Tobacco cessation
- Stress management
- And more!

BestHealth For Us provides personalized and group support for your health goals – at no cost. Whether you want to reduce your blood pressure, lose weight, reduce stress, sleep better or lower your health risks, a registered dietitian or health coach can consult with you in person or by phone. Request an appointment on our Wellness Portal, besthealth4us.com.

In January 2021, employees will be invited to complete the 2021 Health Risk Assessment (HRA) and blood work. Benefits-eligible employees who complete both the HRA and blood work will be entered into two grand-prize drawings per month, from January through March. For more details, please visit besthealth4us.com.

Use the My MedCost Mobile App for health and dental



Once you've registered for an online account at www.MedCost.com,

you also can use the *My MedCost App* to access some of your favorite web features on your mobile device.

The App is free and available for quick download from iTunes and Android markets. With the **My MedCost App** you can:

- Review your ID card and email a copy to your doctor or dentist office.
- Order a new ID card.
- Review your health and dental claims.
- Check your flex balance.
- Look up a covered provider.
- Check your deductible and out-of-pocket status.
- Send a message to MedCost customer service.

To register for an online account, select **login** under the member portal at MedCost.com and follow the instructions to set up your account.

Health care terms to know

Coinsurance: The percentage of the total cost you pay for health care services after you've met the deductible. In other words, if you have a diagnostic test that costs \$200 and your plan has 10% coinsurance, you pay \$20.

Copay: A defined amount of money you pay for health care services. For example, if your plan includes a \$15 copay for a vision exam, that's what you'll pay for the visit—even if the total bill for the visit is higher.

Deductible: The amount you must pay out of pocket before your health plan begins to pay benefits for medical care other than services that have a copay.

In-network provider: A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.

Out-of-pocket maximum: The most you'll pay per benefit plan year for covered health expenses before the plan pays 100% of covered medical services including prescription drug expenses.



Prescription coverage

If you enroll in a WFBH health plan, you automatically receive prescription coverage. Your cost will be lower if you use WFBH pharmacies for acute prescriptions (less than 30 days). Other retail pharmacies may be used for acute prescriptions, but may require a higher copay or coinsurance.

Maintenance and specialty medications must be filled at a WFBH pharmacy or through the Employee Prescription Mail Service. Enrollees in the Wake Select Plan, Wake Options Plan and Wake Select OOA Plan can get a three-month supply of generic or preferred brand maintenance medications for a two-month copay at WFBH pharmacies (including the Employee Prescription Mail Service).

Your copays and coinsurance for up to a 30-day supply of medication are shown in the chart below.

Medication type	Wake Select, Wake Options and Wake Select OOA Plans		Wake Health Savings Plan (with HSA option)	
	WFBH Pharmacy (30-day supply) copay	Non-WFBH/retail pharmacy copay	WFBH Pharmacy (30-day supply) copay	Non-WFBH/retail pharmacy copay
Deductible	Combined with health deductible	Combined with health deductible	Combined with health deductible	Combined with health deductible
Out-of-pocket maximum	Prescription copays and coinsurance apply to your health plan out-of-pocket maximum.	Prescription copays and coinsurance apply to your health plan out-of-pocket maximum.	Costs of covered prescription medications apply to your health plan out-of-pocket maximum.	Costs of covered prescription medications apply to your health plan out-of-pocket maximum.
Generic	\$12	\$20	20%	40%
Preferred	\$30	35% coinsurance with \$35 minimum to \$80 maximum	20%	40%
Non-preferred	\$60	40% coinsurance with \$60 minimum to \$120 maximum	20%	40%

Note: Prescriptions will be automatically dispensed as generic if available. You are required to pay the brand name copay (if applicable) *plus the difference in cost between the brand name and generic* if you or your doctor chooses a brand name when a generic is available. The additional cost you pay in this case would not apply to your health plan deductible or out-of-pocket maximum.

Cornerstone Health Care and Wilkes Medical Center currently do not have a WFBH pharmacy on location. Employees at these locations and their covered dependents who are enrolled in the Wake Select Plan, Wake Options Plan or Wake Select OOA Plan may use a local retail pharmacy for their 30-day acute medications and pay the WFBH pharmacy copays.

High Point Medical Center employees and their covered dependents who are enrolled in the Wake Select Plan, Wake Options Plan or Wake Select OOA Plan may fill 30-day acute medications at a local retail pharmacy for WFBH copays.

Maintenance and specialty medications must be filled via the Employee Prescription Mail Service or at a WFBH pharmacy.

Why generic?

Using generic medications reduces costs for you and WFBH. A generic is basically a more affordable version of a brand medication:

- Same active ingredients.
- Same quality standards.
- Costs around 80% less than name brand medications.

Healthy Outcomes Partnership for Employees

Pharmacy Care Clinic administers an innovative program to care for employees and their dependents with diabetes, asthma, COPD or hypertension. Healthy Outcomes Partnership for Employees (HOPE) Program participants must be covered by a WFBH health plan. All program participants are offered enhanced care management for the conditions listed above. Wake Select Plan, Wake Options Plan and Wake Select OOA Plan enrollees also receive waived copays for certain medications and supplies. Wake Health Savings Plan enrollees will have access to certain medications and supplies at no cost after meeting their health plan deductible.

 To find out more about this program, please call **336-716-5946** or email HopeProgram@WakeHealth.edu.

Using the Employee Prescription Mail Service

No more waiting in line at the pharmacy. Save time by receiving prescriptions at home.

- Possible savings with lower-cost mail delivery pricing.
- 90-day refills on most medicine.
- Refill your prescription online, via smartphone, telephone or email.
- Pharmacists are available by phone to answer your questions.
- Free standard shipping.

Please note that prescriptions for controlled substances mailed to the home will require an adult 21 years of age or older to be present to sign for the package once it arrives.

 To enroll, go to Prescriptions.WakeHealth.edu or call **336-716-2982**.

Outpatient and specialty pharmacies

Wake Forest Baptist Health operates these pharmacies that can be used by employees and patients. Hours are subject to change.

Winston-Salem	North Tower Outpatient Pharmacy Wake Forest Baptist Medical Center Main floor, North Tower	336-716-3363 Open 24 hours a day.
	Comprehensive Cancer Center Pharmacy Wake Forest Baptist Medical Center First floor, Comprehensive Cancer Center	336-713-6808 Mon.–Fri.: 9 a.m.–6 p.m.; Sat.: 9 a.m.–5 p.m.; closed Sun.
	Downtown Health Plaza Pharmacy 1200 N. Martin Luther King Jr. Drive	336-713-9677 Mon.–Fri.: 8 a.m.–7 p.m.; Sat: 9 a.m.–1 p.m.; closed Sun.
	Piedmont Plaza Pharmacy Piedmont Plaza I Lobby, 1920 W. First St.	336-716-5800 Mon.–Fri.: 8:30 a.m.–6 p.m.; closed Sat. and Sun.
	Specialty Home Infusion Wake Forest Baptist Medical Center Ground floor, North Tower	336-713-8075 Mon.–Fri.: 7 a.m.–6 p.m.; closed Sat. and Sun.
	Specialty Pharmacy Wake Forest Baptist Medical Center Second floor, North Tower	336-713-7776 Mon.–Fri: 8 a.m.–5 p.m.; Sat: 9 a.m.–5 p.m; closed Sun.
Bermuda Run	Bermuda Run Pharmacy Davie Medical Center, Plaza 1 329 NC Highway 801 N.	336-998-1030 Mon.–Fri.: 8:30 a.m.–6 p.m.; closed Sat. and Sun.
Clemmons	Medical Plaza–Clemmons Pharmacy 2311 Lewisville–Clemmons Road	336-713-0900 Mon.–Fri.: 7:30 a.m.–7 p.m.; Sat. and Sun.: 8:30 a.m.–6:30 p.m.
High Point	High Point Medical Center Retail Pharmacy 601 North Elm St.	336-878-6599 Mon., Wed., Fri.: 7 a.m.–3:30 p.m.; Tues., Thurs.: 9:30 a.m.–6 p.m.; closed Sat. and Sun.
Lexington	Medical Park Lexington Pharmacy 2316 S. Main St.	336-243-2428 Mon.–Fri.: 9 a.m.–6 p.m.; Sat.: 9 a.m.–1 p.m.; closed Sun.

Need a prescription filled over the weekend? If the outpatient pharmacy you normally use is not open, we can electronically transfer prescriptions and information to another of our pharmacies that has weekend hours. Check the list for a pharmacy near you.

Dental

You can choose between two dental options: Wake Dental Choice and Wake Dental Choice Plus. Both options cover services up to a reasonable and customary charge.

Plan feature	Wake Dental Choice	Wake Dental Choice Plus
Annual deductible (does not apply to preventive care or orthodontia)	\$50 individual; \$150 family	\$50 individual; \$150 family
Annual maximum per covered individual (does not include orthodontia)	\$750	\$1,750
Orthodontia lifetime maximum Orthodontia benefit limited to dependent children only, up to age 19.	Not covered	\$2,000
Preventive care (includes: oral exams [2 per year], prophylaxis [2 per year], topical fluoride up to age 15 [2 per year], emergency treatment of pain, bitewing X-rays [1 per year], full mouth services [once every 3 years], sealants, space maintainers)	100%, no deductible	100%, no deductible
Restorative and surgical services (includes: anesthesia, office visits, pulp cap, root canal, periodontal scaling, replantation, oral surgery)	80% after deductible	80% after deductible
Prosthetics (includes: bridges, dentures, partials, inlays, onlays, crowns and dental implants)	Not covered	50% after deductible
Orthodontia (includes: treatment plan, retention appliance, full-banded orthodontia and fixed or removable appliance for tooth guidance.) Orthodontia benefit limited to dependent children only, up to age 19.	Not covered	50%, no deductible

2021 dental plan costs (pre-tax)

Coverage level	Full-time employees		Part-time employees	
	Monthly	Bi-weekly	Monthly	Bi-weekly
Wake Dental Choice				
You only	\$17.00	\$7.85	\$28.00	\$12.92
You plus children	\$37.00	\$17.08	\$62.00	\$28.62
You plus spouse	\$36.00	\$16.62	\$60.00	\$27.69
You plus family	\$45.00	\$20.77	\$76.00	\$35.08
Wake Dental Choice Plus				
You only	\$29.00	\$13.38	\$50.00	\$23.08
You plus children	\$73.00	\$33.69	\$125.00	\$57.69
You plus spouse	\$67.00	\$30.92	\$113.00	\$52.15
You plus family	\$86.00	\$39.69	\$147.00	\$67.85

If you are a stipend-paid fellow, your premiums are paid after-tax and differ from this chart. Premiums will display in PeopleSoft.

Choose any dentist you want

Dental coverage is open access with MedCost. This means **you can visit the dentist of your choice**. If your dentist will not file claims to MedCost on your behalf, you can pay your dentist up front, then file a claim with MedCost for reimbursement.

 Call MedCost Customer Service at **888-334-0609** or visit [MedCost.com](https://www.MedCost.com).

Vision

Our vision plan is provided through Community Eye Care (CEC).

The vision plan helps pay for routine periodic eye exams, eyeglasses, contacts and related supplies. When you visit CEC providers, you receive discounted services and the plan pays a percentage of your cost. For out-of-network providers, you must file a claim to receive any applicable reimbursements.

Some advantages of the CEC vision plan include:

- **Extensive network:** CEC has a large network of private practice doctors, including our WFBH providers, and major retail chains. Whether you are looking for an optometrist, ophthalmologist, retail optical center or online eyewear retailer, CEC's got you covered. Our interactive provider search tool, located online at cecvision.com/search, makes it easy to find the right provider for you.
- **Wellness:** Routine eye care is important for your overall health and well-being. Undiagnosed diseases, such as diabetes, high blood pressure and glaucoma can be detected during an annual eye exam. As a CEC member, you can even purchase non-prescription sunglasses to protect your eyes from the sun. Non-prescription sunglasses must be purchased at an optical center that sells prescription eyewear to be covered by your eyewear allowance.
- **Children's benefits and retinal screening:** See [page 21](#) for details.

Protect your eyes with an eye exam

An annual eye exam may allow your doctor to identify medical conditions before they become serious. Comprehensive eye exams check for serious vision-threatening problems such as glaucoma, macular degeneration, cataracts, high blood pressure, high cholesterol and diabetic eye disease.

Adults should have a comprehensive eye exam annually. For more vision information, contact CEC at **888-254-4290** or go online to www.cecvision.com.

Feature	Benefit	Limit
Vision exam	\$15 copay	Once each calendar year
Eyewear (includes frames and lenses, contact lenses, special lens options, or any combination)	\$275 allowance* with \$0 copay	Once each calendar year
Contact lens fitting, refitting or evaluation	\$15 copay	Once each calendar year

*If you purchase glasses (frames and/or lenses) and exceed the allowance, most CEC network providers offer a 20% discount on the balance (i.e., retail minus \$275). If you purchase contact lenses and exceed the allowance, most CEC providers offer a 10% discount on the balance.

If you go out of network for vision care

If you get a vision exam or eyewear from an out-of-network provider, you will still receive the full covered benefit. You pay the provider at the time of service and submit a claim to CEC. You will be reimbursed for the full cost of the vision exam (minus the \$15 exam copay) and/or the cost of your eyewear, up to the \$275 allowance. The plan will pay up to \$100 for a contact lens fitting and up to \$80 for a contact lens evaluation with an out-of-network provider. To learn more about filing an out-of-network claim, go to cecvision.com/oonform.

2021 vision plan costs (pre-tax)

Coverage level	Full-time and part-time employees	
	Monthly	Bi-weekly
You only	\$7.98	\$3.68
You plus children	\$16.52	\$7.62
You plus spouse	\$16.52	\$7.62
You plus family	\$25.51	\$11.77

If you are a stipend-paid fellow, your premiums are paid after-tax.

Additional vision plan benefits

Children's benefit

CEC provides a vision benefit for children who are under the age of 13 and who are enrolled in the vision plan:

- An additional eye exam each benefit plan year, and
- A new pair of glasses each benefit plan year if their prescription changes by 0.5 diopter or greater (contacts not included).

The second eye exam is covered in full with no copay. The second pair of glasses is covered up to the \$275 eyewear allowance. Services must be obtained from an in-network CEC provider, and members will be reimbursed for the additional benefits.

Routine retinal screening

A routine retinal screening is covered once per year. Providers can charge a copay of up to \$39, but the exam will be covered after the copay. This is an enhancement to the annual vision exam.

Will I get a new vision ID card?

- If you enroll in the vision plan for the first time for 2021, you will receive a new CEC ID card.
- If you stay in the plan for 2021, you will continue to use the ID card you have now—even if you make changes to who you'll cover under the vision plan for 2021.

Flexible spending accounts

Flexible spending accounts (FSAs), administered by MedCost, help you save money on taxes by paying for a single year's eligible health care and dependent care expenses with pre-tax dollars. You choose the amount of pre-tax money you want to have deducted from your paycheck, and it will be deposited directly into your FSA. You must elect these accounts each year. You cannot change your contribution rate during the year unless you experience a qualifying life event like marriage or the birth of a child. So make sure you plan ahead! See "Making mid-year changes" on [page 5](#).

Health care FSA

Even though your benefits cover many of your health care expenses, you may need to pay some costs out of pocket. Eligible employees not enrolled in the Wake Health Savings Plan can contribute **up to \$2,750** each year to the health care FSA to pay for copays, deductibles, coinsurance and other out-of-pocket medical, dental, vision or prescription costs for you or your dependents. The full amount you elect to contribute to your health care FSA is available in your account on the first day of the benefit plan year. Your contributions will be deducted from your paycheck evenly over the calendar year.

Eligible expenses include:

- Medical expenses: copays, deductibles, coinsurance.
- Dental expenses: deductibles and copays, braces.
- Vision expenses: prescription glasses, contact lenses, copays.
- Prescription costs.
- Over-the-counter medications with a prescription.
- Hearing aids and batteries.
- And much more!

A convenient way to pay for health care expenses

Once enrolled in the health care FSA, you will automatically receive an FSA debit card. The card makes it easy to use funds in your health care FSA—and you don't pay any fees to use the card. You can use your debit card to pay eligible expenses at most healthcare providers that display the Visa® logo.

Your entire annual contribution amount to your health care FSA account is available on your card on Jan. 1, or the date your account becomes effective, to pay for eligible health care expenses.

You will need to provide documentation to MedCost upon request to support your expenses, such as an explanation of benefits (EOB) from your insurance carrier or detailed receipts that include the date of the service or purchase, the payment amount, the provider or store name, a description of the service or item purchased, and the name of the person receiving the item.

If you had a flexible spending account in 2020 and currently have a debit card, please **keep your card** for 2021. Your 2021 election will be automatically added to your existing card. If your current card is scheduled to expire, MedCost will mail a new card to your home address listed in PeopleSoft. New cards are mailed 30 – 45 days prior to the card expiration date.

Important health care FSA dates

Payroll contribution period	Jan. 1 to Dec. 31, 2021
Period to incur expenses	Jan. 1, 2021 to March 15, 2022
Period to file claims for 2021	Jan. 1, 2021 to March 31, 2022

Note: If you also enroll in a dependent care FSA for 2021, you will be able to use your FSA debit card for both accounts. See "Using an FSA debit card to pay for dependent care expenses" on [page 23](#) for details.

 You have secure, 24-hour access to your account status, transaction details and plan balance information by visiting [MedCost.com](https://www.MedCost.com).

Dependent care FSA

The dependent care FSA offers you a tax-free way to pay for eligible dependent care expenses throughout the year. You can contribute **up to \$5,000** each year to the dependent care FSA to pay for dependent day care expenses on a pre-tax basis if both you and your spouse work, your spouse goes to school full-time or your spouse isn't able to provide self-care. If both parents of a dependent child are employed by WFBH, they must share the benefit with a maximum total contribution of \$5,000.

The way it works is that you contribute money to your dependent care FSA through payroll deduction. Then you either use your FSA debit card to pay your daycare provider or use personal funds to pay your provider and file a claim with MedCost to be reimbursed. However, remember that you can only access up to the balance in your account at any given time.

Eligible expenses include: Daycare, day summer camp, after-school programs and preschool expenses for children 12 years old and younger or disabled dependents of any age. Sleep-away or overnight camps are not covered. You may also use this account to pay for adult daycare services for an elderly parent who is your tax dependent.

Dependent care FSA funds cannot be used to pay for your dependents' medical, prescription, dental and vision expenses that aren't covered by insurance. If you want to contribute money on a pre-tax basis to pay for those expenses, you would need to elect the health care FSA.

Important dependent care FSA dates

Payroll contribution period	Jan. 1 to Dec. 31, 2021
Period to incur expenses	Jan. 1 to Dec. 31, 2021
Period to file claims for 2021	Jan. 1, 2021 to March 31, 2022

Using an FSA debit card to pay for dependent care expenses

If you elect a dependent care FSA for 2021, you will have access to an FSA debit card to use for your eligible dependent day care expenses.

- **If you elect both a health care FSA and a dependent care FSA for 2021, you can use the same FSA debit card to pay for both types of expenses.** Money will be automatically deducted from the correct FSA based on the merchant ID associated with the provider where you use your FSA debit card. (Note: dependent care expenses are paid based on the amount you have actually contributed to your account at the time you use the card. See "Important note about dependent care expenses" below.)
- **If you elect a dependent care FSA for 2021 and you do not already have an FSA debit card,** you will receive an FSA debit card for 2021.
- **If you had a flexible spending account in 2020 and currently have a debit card, please keep your card for 2021.** Your 2021 election will be automatically added to your existing card. If your current card is scheduled to expire, MedCost will mail a new card to your home address listed in PeopleSoft. New cards are mailed 30 – 45 days prior to the card expiration date.

Important note about dependent care expenses

Since you can only access up to the balance in your dependent care FSA at any given time, the amount available on your FSA debit card for dependent day care expenses will be limited to your account balance at the time you use the card.

Use it or lose it!

Any money left in your flexible spending accounts at the end of the benefit plan year will be forfeited under IRS rules. That's why it's so important that you plan your expenses carefully and conservatively and not put more money in your FSA than you think you'll spend within a year on allowed health care or dependent care costs.

Need help or more information?

- For complete lists of eligible expenses, visit:
 - Health care: IRS Publication 502 at <https://www.irs.gov/publications/p502> or [MedCost.com](https://www.MedCost.com)
 - Dependent care: IRS Publication 503 at <https://www.irs.gov/publications/p503>
- To view balances, file claims, upload receipts and more: [MedCost.com](https://www.MedCost.com)
- For claims: Go to www.MedCost.com/members; log in to your account; and click the *Flex/HRA Claims* Quick Link in the right navigation pane.
- For questions:
 - Medcost: Call **888-334-0609** from 8:30 a.m. to 5 p.m. Monday through Friday or go to [MedCost.com](https://www.MedCost.com). For requests outside normal business hours, email MedCost Customer Service Contact Center at mbscs@MedCost.com. MedCost will respond to your request within 24 hours.
 - PeopleLink: Call **336-716-6464** or go to [PeopleLink.WakeHealth.edu](https://www.PeopleLink.WakeHealth.edu)



Health Savings Account

If you enroll in the Wake Health Savings Plan, you may be eligible to contribute to a Health Savings Account (HSA). The HSA is a personal savings account that you can use for health care expenses. You set aside money—tax-free. Then, use the money to pay for medical, dental or vision care—such as office visits, lab work, X-rays and prescriptions—now or in the future.

If you enroll in the Wake Health Savings Plan option for the first time for 2021, an HSA will be opened for you if you elect to make your own HSA payroll contribution. Your HSA will be administered by HSA Bank, WFBH's HSA vendor.

If you are already enrolled in the Wake Health Savings Plan, you should make an HSA contribution election for 2021 during open enrollment. HSA contribution elections must be made each year.

The HSA debit card

If you are newly electing to make contributions to an HSA for 2021, you will receive an HSA debit card. If you already have an HSA debit card, you can continue to use that debit card for qualified expenses incurred in the new benefit plan year. You can manage your account online on HSA Bank's website: [HSABank.com](https://www.hsabank.com). Or, download the HSA Bank Mobile App to access your account, 24 hours a day, seven days a week. You can check your account balances, view activity, file claims and much more.

If you are newly electing an HSA, watch for your Welcome Kit soon after your account is opened.

For a complete list of IRS-qualified medical expenses (that you can pay with your HSA funds), visit [irs.gov](https://www.irs.gov) or go to [hsabank.com/IRSQualifiedExpenses](https://www.hsabank.com/IRSQualifiedExpenses).

Eligibility

You are **not** eligible for the HSA if you:

- Are enrolled in Medicare.
- Are covered by another health care plan that's not a high-deductible health plan.
- Can be claimed as a dependent on someone else's tax return.
- Are covered by veterans' benefits and have used Veterans Affairs medical services within the past three months.*
- Are enrolled in or covered by a health care flexible spending account (FSA) or health reimbursement account (HRA), including one through your spouse's/domestic partner's employer. The monies in an existing health care FSA must be spent completely or forfeited after any grace period in order to be eligible to contribute to an HSA.

*Veterans who have a service-connected disability can participate in an HSA regardless of when they received VA benefits.

Restrictions apply if you have a health care FSA in 2020

If you have a WFBH health care flexible spending account (FSA) in 2020 and you want to elect the Wake Health Savings Plan and contribute to an HSA beginning in January 2021, you must exhaust your entire 2020 health care FSA election **and** file for all reimbursements before Dec. 31, 2020. If you do not spend your entire 2020 health care FSA election and file for all reimbursements by Dec. 31, 2020, you will not be eligible to contribute to an HSA until April 1, 2021.

How much you can contribute

You can contribute to your HSA up to the IRS maximums each year if you're eligible. Your contribution limit for the year can change based on your personal situation.

For 2021, you can contribute:

- Up to \$3,600 if you have Wake Health Savings Plan Employee Only coverage.
- Up to \$7,200 if you cover one or more dependents in the Wake Health Savings Plan.

If you're age 55 or older, you can contribute an additional \$1,000 in catch-up contributions.

Note: If you become enrolled in Medicare, you will cease to be eligible to make or receive HSA contributions.

Can I enroll in an HSA and in a health care FSA?

You cannot enroll in both an HSA and a health care FSA. Also, you may not make contributions to an HSA while your spouse or domestic partner is enrolled in a general purpose health care FSA.

6 reasons to consider an HSA

- 1 You can use it...or keep it.**
Any money you don't use by the end of the benefit plan year rolls over and earns interest.
- 2 You enjoy triple tax advantages.**
 - Tax-free contributions, lowering your taxable income and helping you save money.
 - Tax-free growth as your balance grows (either with interest or investments).
 - No tax penalty for withdrawing funds for use on qualified health expenses at any time.
- 3 You can take it with you.**
If you leave WFBH, you take your HSA funds with you. You can even use your HSA funds to help pay for COBRA, if needed.
- 4 You're in control.**
You decide how much to spend or save and when to use (or not use) your money.
- 5 It stays with you for the long haul.**
If you're able to save your HSA funds over time, you can use them for qualified expenses during retirement.
- 6 It has real growth potential.**
You can invest your balance to earn even more. You may begin investing once you have a minimum account balance of \$1,000.

Life and AD&D

Wake Forest Baptist Health's life and AD&D coverage offers you and your dependents financial protection in the event of your death or accidental dismemberment. This coverage is provided through Cigna.

Basic life and AD&D insurance

As a WFBH employee, you automatically receive basic life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you—generally equal to one times your annual salary, rounded up to the next \$1,000 (up to \$200,000). Life and AD&D coverage is an employer-paid benefit for eligible employees.

Supplemental life insurance

If you think you need more coverage than the basic coverage provides, you may buy supplemental life and AD&D insurance equal to one, two, three or four times your basic annual salary, rounded up to the next \$1,000, subject to the maximum benefit level and approval by Cigna.

If you add or increase supplemental life coverage during open enrollment, your election is not guaranteed to be approved. You will receive an email in December with a link to Cigna's online *Evidence of Insurability* (EOI) form. The EOI process is sometimes called providing "evidence of good health" and is used to qualify for certain amounts of life insurance. You must complete the EOI process and be approved by Cigna before new or increased coverage can take effect.

Dependent life insurance

You also may purchase life insurance in the amount of \$10,000 or \$25,000 for your spouse and/or for each of your eligible children. If you add or increase life insurance for your spouse, you will receive an email in December with a link to Cigna's online EOI form. Your spouse must complete the EOI process and be approved by Cigna before new or increased coverage can take effect. Children are not required to complete the EOI process.

See [page 28](#) for your costs for life insurance coverages.

Your life insurance beneficiary

Your beneficiary is the person(s) who will receive your life insurance benefits when you die. Your beneficiary can be a person or multiple people, charitable institutions or your estate. Once named, your beneficiary remains on file until you make a change. You should regularly review and, if necessary, update your beneficiary designations. If you don't, life insurance benefits may be distributed differently than you had planned, may result in additional taxes and may unnecessarily delay the process of finalizing payment to your loved ones.

You can review your life insurance beneficiary information and make updates any time online by accessing PeopleSoft and going to *Main Menu, Self Service, Benefits* then *Benefits Summary*. Select the *Life or Supplemental Life* link then click the edit button to update beneficiaries. You need to return to the Benefits Summary to update both coverages.

Supplemental life and AD&D insurance rates

Your supplemental life and AD&D insurance costs are based on your age and eligible earnings as of your birthday.

Age	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Monthly rate per \$1000	0.048	0.059	0.085	0.128	0.202	0.312	0.378	0.580	0.940
Bi-weekly rate per \$1000	0.022	0.027	0.039	0.059	0.093	0.144	0.174	0.268	0.434

How to calculate your per pay period cost

Go to PeopleSoft to view your life insurance costs. Or you can choose to calculate per pay period costs yourself by using this formula:

Multiply your annual pay by the multiple selected and then round up to the next \$1,000.

Divide this amount by \$1,000 and multiply by the monthly or bi-weekly (depending on how you are paid) rate shown in the table.

$$\begin{array}{ccccccc}
 \$ & & \times & & = \$ & & \div \$1,000 = & & \times & & = \$ \\
 \text{Annual pay} & & \text{Coverage amount} & & \text{Rounded to next} & & & & \text{Rate from table} & & \text{Your per pay cost} \\
 & & \text{1 - 4x pay} & & \$1,000 & & & & & &
 \end{array}$$

For example, if you are age 37, earn \$40,000 per year, are paid bi-weekly and choose 2 x your pay in life insurance, here's how you would calculate your costs:

$$\$40,000 \times 2 = \$80,000 \div \$1,000 = \$80 \times \$0.027 = \$2.16 \text{ your bi-weekly cost.}$$

Since supplemental life and AD&D premiums are based on current salary, your premiums will increase if your salary increases. Premiums will also increase after your birthday when you reach age 35, 40, 45, 50, 55, 60, 65 or 70.

Dependent life insurance rates

	Monthly	Bi-weekly
Spouse coverage amount		
\$ 10,000	\$1.80	\$0.83
\$ 25,000	\$3.60	\$1.66
Child coverage amount		
\$ 10,000	\$0.90	\$0.42
\$ 25,000	\$2.25	\$1.04

Disability

Wake Forest Baptist Health offers disability coverage to protect you in case you cannot work for an extended period of time due to an illness, injury or other condition. This coverage is provided through Cigna.

Short-term disability

Short-term disability (STD) pays a weekly benefit for eligible employees of 60% of your pay, up to a maximum benefit of \$1,500 per week, minus any other income you may be receiving. Benefits begin after 14 or 30 consecutive days of hospitalization, sickness or injury and continue as long as you are disabled (up to 26 weeks). STD benefits will end on the date long term disability benefits become payable to you. STD is an employee-paid option.

STD monthly rates

14-day waiting period	\$0.709
30-day waiting period	\$0.436
Rate is per \$10 of benefit	

If you elect to add STD coverage or increase coverage (going from the 30-day waiting period option to the 14-day option), your election is not guaranteed to be approved. You will receive an email in December with a link to Cigna's online *Evidence of Insurability* (EOI) form. The EOI process is sometimes called providing "evidence of good health." You must complete the EOI process and be approved by Cigna before new or increased coverage can take effect.

How to calculate your per pay period cost

Go to PeopleSoft to view your disability insurance costs. Or you can calculate per pay period costs yourself by using this formula.

$$\begin{array}{ccccccccccc}
 \$ & & \div 52 = & \$ & & \times 0.6 \div 10 & = & \$ & & \times & = & \$ & & \times 12 = & \$ & & \div 26 = & \$ \\
 \hline
 \text{Annual pay} & & & \text{Weekly pay} & & \text{Per \$10 of covered benefit} & & \text{Cannot exceed \$1,500} & & \text{Rate for coverage: \$0.709 or \$0.436} & & \text{Monthly cost} & & \text{Annual cost} & & & \text{Your bi-weekly cost} \\
 \hline
 \end{array}$$

For example, if you choose the 14-day waiting period option and your annual pay is \$35,000, here's how your bi-weekly costs are calculated:
 $\$35,000 \div 52 = \$673.08 \times 0.6 = \$403.85 \div 10 = \$40.39 \times 0.709 = \$28.64 \times 12 = \$343.68 \div 26 = \$13.22$.

Long-term disability

Long-term disability (LTD) benefits begin after you have been disabled for more than 180 days. The coverage ensures that you will receive 60% of your pay for the duration of your disability until age 65 (or older, if your disability begins on or after age 62) or until other plan limitations have been met. LTD benefits may be reduced by amounts of other income you receive. LTD coverage is an employer-paid benefit for eligible employees. There is no action required on your part; WFBH will automatically enroll you in the LTD plan if you're eligible.

Contacts

For questions about	Vendor	Phone	Website/Email
All WFBH benefits	PeopleLink	336-716-6464	PeopleLink.WakeHealth.edu
Health, dental, and flexible spending accounts (FSAs)	MedCost	888-334-0609	www.MedCost.com
Vision	Community Eye Care	888-254-4290	www.cecvision.com
Health Savings Account (HSA)	HSA Bank	800-357-6246	www.hsabank.com
Prescription coverage	WFBH pharmacies	N/A	See page 18 for a list of outpatient and specialty pharmacies.
	Employee Prescription Mail Service	336-716-2982	To enroll, go to www.Prescriptions.WakeHealth.edu .
	Optum	866-770-0204	www.optumrx.com
Life/AD&D and disability coverage	Cigna	800-362-4462	www.Cigna.com
Mental health and substance abuse	Carolina Behavioral Health Alliance	800-475-7900	www.cbhallc.com
SmartStarts Prenatal Program	MedCost	888-334-0609	www.medcost.com/members/care/maternity
Healthy Futures	WFBH Weight Management Center (WMC)	336-716-6099	www.wakehealth.edu/Treatment/m/Medical-Weight-Management/Healthy-Futures
Elder Care Choices	Senior Services	336-748-2171	www.seniorservicesinc.org
ALEX® benefits decision-making support tool	N/A	N/A	www.myalex.com/wakehealth/2021
Legal insurance	ARAG	800-247-4184	ARAGlegalcenter.com (access code: 14200wfb)
Pet insurance	Nationwide	877-738-7874	poi8.PetInsurance.com/benefits/ncbh-npr
Healthy Outcomes Partnership for Employees (HOPE) Program	WFBH Pharmacy Care Clinic	336-716-5946	HopeProgram@wakehealth.edu
Advance Care Planning	WFBH	336-716-4745	http://intranet.wakehealth.edu/departments/bioethics/advance-care-planning Karen Lordeman-Rowdy at klowdy@wakehealth.edu Linda Childers at lchilder@wakehealth.edu

Other benefits offerings

Legal insurance

Legal insurance helps you address everyday situations like dealing with traffic tickets, resolving warranty issues or buying a home. ARAG offers legal insurance that features in-office services, telephone advice and online resources. Enroll during WFBH's open enrollment period, **Oct. 26 – Nov. 13.**

 For details, call **800-247-4184** or visit [ARAGlegalcenter.com](https://www.araglegalcenter.com) and enter access code **14200wfb**.

Pet insurance

The My Pet Protection insurance plan is available to benefits-eligible employees through Nationwide. Use any vet, and get 90% reimbursement on the bill. Enroll at any time.

 For details, visit poi8.PetInsurance.com/benefits/ncbh-npr.

Advance Care Planning

Advance Care Planning can help you and your loved ones make important decisions about your health care in situations where you may not be able to do so for yourself. Wake Forest Baptist Health offers employees in-services (refer to BestHealth For Us or intranet calendars for monthly schedule), free tools to assist with this process, including videos, documents and links to other resources, all listed on the Advance Care Planning intranet web page. Project staff will assist employees to complete and notarize forms.

For assistance please contact:

Karen Lordeman-Rowdy at klrowdy@wakehealth.edu or Linda Childers at lchilder@wakehealth.edu.

If you have Advance Directives, be sure to review your documents to ensure they accurately reflect your current values and beliefs regarding your healthcare decisions and your choice of Health Care Power of Attorney.



Legal notices

You have the right to request and receive (free of charge) paper copies of any of the enrollment materials, including the legal notices. Send your request to PeopleLink at **336-716-6464** or PeopleLink.WakeHealth.edu.

Important Notice from Your Employer-Sponsored Health Plan 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 your employer-sponsored health plan 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 also may offer more coverage for a higher monthly premium.**
- 2. Your employer-sponsored health plan has determined that the prescription drug coverage offered by your employer-sponsored health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15th to Dec. 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 health coverage may be affected. However, in most situations, self-funded group health coverage with prescription drug coverage will not be affected if a member decides to join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current health coverage, be aware that you and your dependents may not be able to get the coverage back until the next open enrollment period. The exception to this is a 'change in status' event that causes a loss of other coverage.

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 your employer-sponsored health plan 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 also will get it before the next period you can join a Medicare drug plan, and if this coverage through your employer-sponsored health plan 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 also may 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 for personalized help. (See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.)
- Call **1-800-MEDICARE** (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: Oct. 14, 2020
Name of Entity/Sender: Plan Administrator
Plan: Wake Forest Baptist Medical Center
& Affiliates Employee Benefits Plan
Contact—Position/Office: Benefits Department
Address: Medical Center Boulevard,
Winston-Salem, NC 27157
Phone Number: **336-716-6464**

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1. Your past, present, or future physical or mental health or condition;
2. The provision of health care to you; or
3. The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator, as designated in your Summary Plan Description.

EFFECTIVE DATE

This Notice is effective August 15, 2013.

OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

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

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Plan Sponsor protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- About a death that we believe may be the result of criminal conduct; and about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/ authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. In most situations, we send mail to the employee/member. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply -- for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

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

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at the following website: <http://www.medcost.com/>
To obtain a paper copy of this notice, contact the Plan Administrator.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator.

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Regulations generally do not ‘preempt’ (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights.

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, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website:

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/default.htm>

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

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>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <https://dhcftp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilyare.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://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

<http://www.oregonhealthcare.gov/index-es.html>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:

<https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/hipp/>

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

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

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565
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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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; 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. If you would like more information on WHCRA benefits, call MedCost at **888-334-0609**.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any otherwise covered hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending providers, 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

NOTICE REGARDING WELLNESS PROGRAM

BestHealth For Us is a voluntary wellness program available to all eligible WFBH employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Wellness Program Components

If you choose to participate in the wellness program, you will be asked to:

- Complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).
- Complete a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, ratio, glucose, A1C.
- Other wellness program offerings include: biometric screenings, weight loss classes, stress management classes, smoking cessation classes, lactation classes, Register Dietitian (RD) one-on-ones, Health Coaching one-on-ones, and online wellness challenges. It is important to note that these are not all part of the health plan. The only thing that is reimbursed through the plan is Health Coaching and RD one-on-one and Health Coach and RD lead group classes.

Any information provided by you as part of your participation in the above program(s) will be used to help you understand your current health and potential health risks and may also be used to offer you services through the wellness program. Services that might be available include disease management programs and case management programs offered by MedCost Benefit Services, LLC. You are encouraged to share your results or concerns with your own doctor.

Incentive Program(s)

You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will be eligible for monthly drawings and earning credits that may be traded in for prizes.

Employees who choose not to participate in the wellness program will not be penalized.

Reasonable Accommodations Available

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive (or avoid the penalty), you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Gretchen Bayne at BestHealth For Us.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and WFBH may use aggregate information they collect to design a program based on identified health risks in the workplace, BestHealth For Us will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, and as expressly permitted by law (as described in the WFBH Summary Plan Document). Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a Health Coach or RD within BestHealth For Us who will receive information in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact PeopleLink at **336-716-6464**.