Our journey to improving the health and wellness of our employees continues

- Health
- Dental
- Vision
- Spending Accounts
- Life Insurance
- Short-term Disability

Benefits Enrollment Guide 2017
Enrollment: November 1–24, 2016

For staff and faculty who are employees of Wake Forest Baptist Medical Center, Wake Forest University Health Sciences, Davie Medical Center, Lexington Medical Center, Community Physicians, and The Hawthorne Inn and Conference Center
Inside this Guide

- Your Benefits Guide
- Annual Enrollment Options
- Definitions
- Health Plan Highlights
- Health Plan Costs
- Pharmacy Information
- Dental Plan
- Vision Plan
- Other Benefits
- A Final Word About Health Care Coverage
- Notice of Privacy Practices
- Important Benefit Contacts

Our Strategic Vision is to improve the health of our employees and their families. Our plan design will serve the organization’s diverse employee population, meeting the need for value-based, accessible, high-quality health care. We will invest in the health of our employees by empowering them to live healthier lifestyles and sustaining a culture of wellness.

2017 Benefits

Our Medical Center’s mission is to improve health, and there is no better place to start than here at home with the health of our own employees and families.

A lot of work has gone into assembling benefit plans that can respond to the changing needs of the staff and faculty. Because we offer several benefit options and your needs may change from year-to-year, you have the opportunity to choose the right plan for your needs.

Read the contents of this guide closely as there are new benefit options for employees.

Enrollment: November 1–24, 2016

You and your family are encouraged to use Wake Forest Baptist Health’s coordinated care rather than seek care elsewhere. Not only will you receive care from one of America’s consistently top-ranked health systems, you will also pay less for your care with lower copays, deductibles and out-of-pocket maximums. You will also benefit from the availability of same day/next day primary care and priority specialty care appointments. To schedule an appointment, call 336-716-WAKE (9253).

We have significantly broadened our primary care network and increased our geographical coverage with our affiliation with Cornerstone Health Care. You will be able to see Cornerstone physicians at the same low rates as Wake Forest Baptist Health physicians. To find a Cornerstone provider, go to CornerstoneHealth.com/Providers-Locations.

What’s New

▸ Delivery at Lexington Medical Center and Wilkes Medical Center will be covered without coinsurance or deductible if the SmartStarts Prenatal Program is completed. See page 8.

▸ $100 incentive added for active participation in the MedCost Personal Care Management Program (PCM). See page 3.

▸ A Dependent Eligibility Audit will be conducted in early 2017 to verify that covered dependents meet the plan rules for enrollment. Dependents found ineligible will be removed from the health and dental plans. See page 3.

▸ Working Spouse Exclusion—Spouses who work full time (30 hours or more weekly) outside of the Medical Center with health coverage available from their employer will no longer be eligible for coverage effective January 1, 2017. Legal spouses who do not work full time are welcome to be covered. See page 3.

Focus on Wellness:
“We Help You Take Care of You”

All of our 2017 benefit plans offer generous health benefits, including—at no charge to you—annual physicals; wellness visits for women and children; colonoscopies; mammograms; bone density screenings; prostate screenings; HOPE Program for diabetes, asthma, COPD and hypertension management; low-dose CT scans for heavy smokers; smoking cessation classes; low-cost fitness centers and more! For more information, visit ActionHealthNow.com.
Your Benefits Guide

Your benefits are designed to provide you and your family with a competitive program of health benefits.

For more details on how the program works, refer to the plan documents and policies that govern the operation of each plan. The plan documents and policies are available at the Benefits Office and online at HR/Benefits.

This guide is designed to make enrollment easy, and includes information on how to enroll and a summary of benefit choices. You may change these benefits only during the enrollment period. If you have a qualified family status change during the year, you are allowed to add or remove spouses and dependents from your benefits, but you may not change your level of coverage.

If there are differences between this enrollment guide and the official plan documents and policies, the plan documents and policies will govern. This guide is not a contract of employment.

Enroll Online and On Time to Get the Benefits You Want

► Review this guide and log onto PeopleSoft Self Service to elect your new health, dental and vision benefit selections.
► Please remember you must re-enroll in Flexible Spending Accounts each year. They do not automatically continue.
► Your new benefit elections will begin on January 1, 2017. Payroll deductions for benefits will be on January 13, 2017, for employees paid biweekly, and January 26, 2017, for employees paid monthly.

$100 Personal Care Management (PCM) Incentive

Employees or dependents who have complex medical needs will be eligible for a $100 incentive for active participation in the MedCost Personal Care Management Program (PCM). The PCM plan provides enrolled patients help with prescription drug adherence, answers to treatment questions, support and encouragement in dealing with difficult and confusing medical conditions. $50 of the incentive will be paid after three phone meetings with a PCM nurse. The remaining $50 will be paid upon completion of the program.

Dependent Eligibility Audit

Early in 2017, the Medical Center will conduct an audit to verify that all dependents enrolled in the health and dental plans meet the requirements for enrollment. Employees with covered dependents will be required to provide documentation to Aon Hewitt, an outside firm, to confirm eligibility. For example, a covered spouse will be required to provide a copy of a legal marriage certificate to the audit company. Dependents found to be ineligible will be removed from the plans.

During Open Enrollment employees may add or delete dependents from the plans. Employees with questions about dependent eligibility should contact the benefits office at 336-716-3334 or benefits@wakehealth.edu.

Working Spouse Exclusion

For 2017, spouses who work full time (30 hours or more weekly) for an employer other than the Medical Center and have health insurance available from their employer are not eligible to enroll in the Medical Center’s health plan. Exceptions to the Working Spouse Exclusion include:

► Work for an employer that does not offer health insurance.
► Work for an employer that does not offer ACA creditable insurance coverage.
► Work part time (less than 30 hours weekly).
► Are self-employed.
► Are disabled.
► Are retired.

Employees who earn $17/hour or less and are covered under the Medical Center’s health plan will be eligible for a Medical Center contribution of up to $200 annually to a health care flexible spending account debit card. These contributions will be made in January and July.
Annual Enrollment Options

A Note About Your Eligible Dependents
You can enroll your eligible dependents for coverage. These dependents include your legal spouse for health, dental, vision and dependent life coverages, and your dependent children under age 26. Children who are mentally or physically handicapped may remain covered beyond the normal age limits if they have not been married, cannot support themselves and rely on you for primary support and care.

Dependent Out-of-Area Benefits
Each of the 2017 health plans will offer an Out-of-Area plan option for dependents. See out-of-area plan details below:
► Wake Health/Cornerstone Exclusive – Dependents living outside of the MedCost network (NC and SC), including college students, may see physicians where they are living. For example, the copays are the same as the MedCost network (PPO).
► Health Choice & Choice Plus Plans – Dependents living out of area, including college students, will be assigned a local network of physicians where they are living as if they are located in-network. For example, the copays are the same as the MedCost network (PPO). For planned inpatient and outpatient procedures not performed at a Wake Forest Baptist Health facility or by a Wake Forest Baptist physician, the MedCost charge will apply.

Making a Change During the Year
After November 24, 2016, you may not make changes in your benefit elections until the next annual enrollment period unless you have an IRS-qualified family or employment status change. If you have an IRS-qualified family or employment status change, you are allowed to add or remove a spouse or dependent.

Keep in mind that you can review your elections any time during the enrollment period and make any necessary changes. You should print a confirmation of your changes after you have submitted your election.

Enroll Online at Work or at Home
You can enroll from any internet-capable computer by going to WakeHealth.edu/Employees.htm. Then select the Peoplesoft-HR/Payroll Login hyperlink. Log in and select Self Service>Benefits>Benefits Enrollment. Another enrollment option is to visit us in Fresh Inspirations Café, Conference Room #2. For times and availability, visit our website under HR/Benefits. There will be benefit enrollment specialists on site to assist you. You can also come to the Benefits Department located at Piedmont Plaza 1, 4th floor, between 8 am and 5 pm, Monday–Friday.

Keep in mind that you can review your elections any time during the enrollment period and make any necessary changes. You should print a confirmation of your changes after you have submitted your election.

Open Enrollment Help Line: 336-716-3334
For IT help 24/7, call 336-716-HELP

Benefits Fair Dates
If you wish to learn more about your benefits, or have questions, be sure to attend one of the fairs at these locations:
► Wake Forest Baptist Medical Center
  Fresh Inspirations Café
  Wednesday, November 2 \ 7:30 am – 4 pm
► Davie Medical Center, Plaza One
  Conference Room, 4th Floor
  Friday, November 4 \ 7 am – 4 pm
► Lexington Medical Center
  Live Well Center
  Thursday, November 3 \ 7 am – 4 pm
Definitions

Copayment
A specific charge that you may be required to pay for a specific medical service or supply, also referred to as a “copay.”

Deductible
This is the portion of your medical expenses that is not covered by copay and you are responsible for 100%, until you reach your deductible. It’s like car insurance. Should you need to, you pay your deductible and then insurance kicks in to help pay.

The basics about annual health deductibles:
► Hospitalization, surgery and procedures are typically applied to your deductible.
► Lab tests, MRIs, CAT scans, surgical costs, anesthesia, physical therapy, medical devices usually go toward your deductible.
► Mental health, chiropractic care and other services may also go toward your deductible.
► Your premiums for health insurance are not applied toward the deductible. Deductibles are different for individuals and families. Deductibles are much lower if you seek your health care needs within the Wake Forest Baptist Health coordinated care network versus the MedCost network.

Coinsurance
Some people get confused about copay versus coinsurance. Just remember, they are not the same thing.

When you reach your deductible, you must pay a percentage of the remaining costs—this is the coinsurance amount.

Emergency Medical Condition
This is a serious medical condition or symptom resulting from injury or illness that arises suddenly and requires immediate care and treatment to avoid endangering life or health. Examples include, but are not limited to: heart attack, poisoning, loss of consciousness, convulsions and serious falls.

Annual Out-of-pocket Maximum
The most you pay during a calendar year beginning in January before your health insurance starts to pay 100% for covered essential health benefits. The limit includes deductibles, coinsurance and copayments, including prescription drugs. This limit does not include your cost of premiums or non-covered services.

NOTE: Keep in mind there are many health care services at no cost to you and your dependents where copays, deductible and coinsurance do not apply.

Employee Assistance Program (EAP)
Our Employee Assistance Program (EAP) provides counseling for personal and emotional issues. Our Employee Health Services and ActionHealth programs ensure that you can perform your job in a healthy and safe manner. Our goal is to protect your health and promote wellness. We have expanded our wellness programming, including technology to help keep you on track. For more details, please call 336-716-5493.
## Health Plan Highlights

### Deductibles

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
<td>MedCost Network</td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$2,500</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

Includes deductibles, coinsurance, medical and prescription copays.

### Annual Out-of-pocket Maximum

<table>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
<td>MedCost Network</td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$7,150</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$14,300</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

Includes deductibles, coinsurance, medical and prescription copays.

### Copay and Coinsurance

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
<td>MedCost Network</td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$0</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Specialist</td>
<td>$10</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>General Pediatrician</td>
<td>$0</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>10%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$10 (includes FastMed)</td>
<td>$35 copay</td>
<td>$10</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>10%</td>
<td>50%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Ob/Gyn wellness visits covered at no copay. Ob/Gyn specialist visit $20 copay at Wake Forest Baptist Health and Cornerstone, and $75 copay at a MedCost network provider.

Please see the MedCost website site for more details.
Health Plan Highlights (continued)

Emergency Room Copay (if not admitted as inpatient*)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Visit**</td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
<td>MedCost Network</td>
<td>WFBH/Cornerstone Coordinated Care Network</td>
</tr>
<tr>
<td>Non-emergency Visit</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
</tbody>
</table>

* Please see inpatient coverage below for benefits if admitted from the ER. Copay is waived.

** Emergency Medical Condition – This is a serious medical condition or symptom resulting from injury or illness that arises suddenly and requires immediate care and treatment to avoid endangering life or health. Examples include, but are not limited to: heart attack, poisoning, loss of consciousness, convulsions and serious falls.

Hospital & Surgical Fees

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care</td>
<td>10%</td>
<td>N/A</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Hospital Care</td>
<td>10%</td>
<td>N/A</td>
<td>40%</td>
</tr>
<tr>
<td>Surgeon/Physician Fees</td>
<td>10%</td>
<td>N/A</td>
<td>40%</td>
</tr>
</tbody>
</table>

Notes

► Ob/Gyn physicians – For routine care (such as PAP smears), the plan pays 100%. For non-routine care, Ob/Gyn physicians are considered specialists. Pregnancy is considered a “specialist” visit and one copay is charged with no copays for additional visits.

► Inpatient care requires precertification

► Infertility services
  • $15,000 Lifetime Maximum Dollar limit applies to medical and prescriptions combined.
  • Member pays 20% of contracted price of prescriptions, which must be filled at a Medical Center pharmacy.
  • Covered as other medical conditions except for dollar limits.
  • Services must be through the Wake Forest Baptist Health program.

► Must have three years of continuous service at the Medical Center and the patient must be insured by the Wake Health Choice Plus plan or Wake Health/Cornerstone Exclusive plan in order to qualify.

► Bariatric Surgery
  • $35,000 Lifetime Maximum for surgical-related expenses (including gastric sleeve).
  • See Summary Plan Description for guidelines.
  • Services must be through the Wake Forest Baptist Health program.
  • Benefits are limited to employee and spouse with three years of continuous coverage at the Medical Center and the patient must be insured by the Wake Health Choice Plus plan or Wake Health/Cornerstone Exclusive plan in order to qualify.

(continued on next page)
### Maternity Benefits

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WFBH/ Cornerstone Coordinated Care Network</td>
<td>MedCost Network</td>
<td>WFBH/ Cornerstone Coordinated Care Network</td>
</tr>
<tr>
<td>Maternity Physician</td>
<td>$10 copay (SmartStarts)</td>
<td>$50 copay (non-SmartStarts)</td>
<td>$20 copay (SmartStarts)</td>
</tr>
<tr>
<td>Maternity Hospital Charges</td>
<td>0% (deductible waived)*</td>
<td>10% (deductible waived)</td>
<td>0% (deductible waived)*</td>
</tr>
<tr>
<td>Maternity Hospital Charges</td>
<td>30% after deductible</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

* Applicable to Lexington Medical Center or Wilkes Regional Medical Center only.

### SmartStarts Prenatal Program

If you or your spouse are pregnant, you probably have many questions and need sound medical advice. MedCost offers a special program for patients who are pregnant to answer difficult questions. This program can also help prevent complications by teaching patients healthy habits and providing practical tips.

If you are enrolled in the SmartStarts Prenatal Program in the first trimester and the program is completed, the hospital delivery coinsurance and deductible will be waived at Lexington Medical Center or Wilkes Regional Medical Center only.

At all other hospitals, the delivery deductible will be waived if you enroll in the SmartStarts Prenatal Program in the first trimester and complete the program.

For example:

- **Under the Wake Health/Cornerstone Exclusive plan** – You pay 10% coinsurance for maternity services received from any MedCost network provider and the deductible is waived after SmartStarts Prenatal Program is completed.

- **Under the Wake Health Choice plan** – You pay 40% coinsurance for maternity services received from any MedCost network provider and the deductible is waived. If you do not enroll in SmartStarts, you pay 50% for network maternity services after deductible.

- **Under the Wake Health Choice Plus plan** – You pay 25% coinsurance for maternity services received from any MedCost network provider and the deductible is waived. If you do not enroll in SmartStarts, you pay 40% for network maternity services after deductible.

If you or your spouse are in the second or third trimester of pregnancy at the time you/your spouse become plan participants, you will not be subject to the reduction in coinsurance.

For more information about the SmartStarts Prenatal Program, call 1-800-795-1023.
Health Plan Costs

Health Plan Costs (Pretax)

<table>
<thead>
<tr>
<th></th>
<th>If You Are Paid Biweekly, Your Payment Is:</th>
<th>If You Are Paid Monthly, Your Payment Is:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time Staff</td>
<td>Part-time Staff</td>
</tr>
<tr>
<td>Wake Health/Cornerstone Exclusive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You only</td>
<td>$46.15</td>
<td>$210</td>
</tr>
<tr>
<td>You plus children</td>
<td>$147</td>
<td>$420</td>
</tr>
<tr>
<td>You plus spouse</td>
<td>$168.37</td>
<td>$443.08</td>
</tr>
<tr>
<td>You plus your family</td>
<td>$232.25</td>
<td>$580.62</td>
</tr>
<tr>
<td>Wake Health Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You only</td>
<td>$22.76</td>
<td>$189.69</td>
</tr>
<tr>
<td>You plus children</td>
<td>$78.83</td>
<td>$394.15</td>
</tr>
<tr>
<td>You plus spouse</td>
<td>$89.86</td>
<td>$408.46</td>
</tr>
<tr>
<td>You plus your family</td>
<td>$128.68</td>
<td>$525.23</td>
</tr>
<tr>
<td>Wake Health Choice Plus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You only</td>
<td>$54.14</td>
<td>$235.38</td>
</tr>
<tr>
<td>You plus children</td>
<td>$160.73</td>
<td>$459.23</td>
</tr>
<tr>
<td>You plus spouse</td>
<td>$193.85</td>
<td>$484.62</td>
</tr>
<tr>
<td>You plus your family</td>
<td>$254.77</td>
<td>$836.92</td>
</tr>
</tbody>
</table>

Exclusive Plan Highlights
- Employees and dependents must utilize Primary Care Provider with Wake Forest Baptist Health or Cornerstone. Exceptions for Ob/Gyn, General Pediatrics and Emergency Care. Otherwise there is no coverage.
- All Inpatient/Outpatient and ancillary surgical procedures must be performed at a Wake Forest Baptist Health facility.
- Cornerstone specialists are considered at the Wake Forest Baptist Health level of coverage; however, inpatient and outpatient surgery must be referred back to a Wake Forest Baptist specialist if the surgery cannot be performed at Wake Forest Baptist Medical Center, Wilkes Regional Medical Center, Davie Medical Center or Lexington Medical Center.
- Please contact 336-716-WAKE (9253) to schedule appointments with a Wake Forest Baptist Health physician. To find a Cornerstone provider, go to CornerstoneHealth.com/Providers-Location.

Out-of-Area Dependents
Each of the 2017 health plans will offer an Out-of-Area plan option for dependents. See Out-of-Area plan details below:
- Wake Health/Cornerstone Exclusive Plan – Dependents living outside of the area, including college students, will be assigned a local provider network. Dependents may use the assigned out-of-area network for all covered services and the copays will be same as a MedCost network provider. Dependents under the Exclusive plan may also seek care at a Wake Forest Baptist Medical Center provider at the highest local level.
- Health Choice & Choice Plus Plans – Dependents living out of area, including college students, will be assigned a local provider network. Dependents may use the assigned out-of-area network for all covered services and the copays will be same as a MedCost network provider.
Pharmacy Information

Wake Forest Baptist Health operates seven pharmacies that can be used by employees and patients.

In addition to the Medical Center retail pharmacies, you may use our mail-order pharmacy, which offers home delivery without shipping or handling fees. To enroll, employees may call 336-716-2982, or email rxmailorder@wakehealth.edu.

Maintenance and specialty drugs must be filled at a Medical Center Pharmacy or by mail order.

Outpatient Pharmacies

Outpatient Pharmacy and Gift Shop
Main floor, North Tower lobby \ 336-716-3363
Monday–Friday, 7 am – 9 pm
Saturday–Sunday, 9 am – 5 pm
Note: You may use the weekend hours even if you use one of the other outpatient pharmacies—we are able to electronically transfer prescriptions and information among our pharmacy locations.

Comprehensive Cancer Center Outpatient Pharmacy
First floor, Cancer Center \ 336-713-6808
Monday–Friday, 9 am – 6 pm

Downtown Health Plaza Outpatient Pharmacy
Martin Luther King Jr. Drive \ 336-713-9800
Monday–Wednesday, Friday, 8 am – 6 pm
Thursday, 9 am – 6 pm

Medical Plaza–Clemmons Pharmacy
2311 Lewisville-Clemmons Road \ 336-713-0900
Monday–Friday, 7:30 am – 7 pm
Saturday–Sunday, 8:30 am – 6 pm

Medical Park–Lexington Pharmacy
2316 S. Main St., Lexington \ 336-243-2428
Monday–Friday, 9 am – 6 pm
Saturday, 9 am – 1 pm

Davie Medical Center, Plaza 1–Bermuda Run Pharmacy
313 NC Hwy 801 N, Bermuda Run \ 336-998-1030
Monday–Friday, 8:30 am – 5 pm

Piedmont Plaza I Outpatient Pharmacy
1920 W. First St., Lobby \ 336-716-5800
Monday–Tuesday, Thursday–Friday, 8:30 am – 6 pm
Wednesday, 9 am – 6 pm

Prescription Drug Benefits

Generic use is mandatory. You pay the difference if you request brand name when generic is available.

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>WFBMC Pharmacy (30-day supply)</th>
<th>Non-domestic/ Retail Pharmacy Coverage Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$12</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred</td>
<td>$30</td>
<td>35% coinsurance with $35 minimum and $80 maximum</td>
</tr>
<tr>
<td>Non-preferred</td>
<td>$60</td>
<td>40% coinsurance with $60 minimum to $120 maximum</td>
</tr>
</tbody>
</table>

For generic and preferred brand maintenance drugs, you can get a three-month supply for a two-month copay.

Healthy Outcomes Partnership for Employees (HOPE)

Pharmacy Care Clinic administers an innovative program to care for employees and their dependents with diabetes, asthma, COPD or hypertension. Under the HOPE program, participants are offered enhanced care management and waived copays for certain medications and supplies. Participants must have MedCost insurance. To find out more about this program, please email hopeprogram@wakehealth.edu.
### Dental Plan

You have your choice of two dental options: **Wake Dental Choice** and **Wake Dental Choice Plus**. Both options cover services up to a reasonable and customary charge.

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Wake Dental Choice</th>
<th>Wake Dental Choice Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (<em>does not apply to preventive care or orthodontia</em>)</td>
<td>$50 Individual; $150 Family</td>
<td>$50 Individual; $150 Family</td>
</tr>
<tr>
<td>Annual Maximum Per Covered Individual (<em>does not include orthodontia</em>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum <em>Orthodontia benefit limited to dependents only, up to age 19.</em></td>
<td>$750</td>
<td>$1,750</td>
</tr>
<tr>
<td>Preventive Care (<em>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</em>)</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Restorative and Surgical Services (<em>includes: anesthesia, office visits, pulp cap, root canal, periodontal scaling, replantation, oral surgery</em>)</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Prosthetics (<em>includes: bridges, dentures, partials, inlays, onlays, crowns</em>)</td>
<td>Not covered</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Orthodontia and Dental Implants (<em>includes: treatment plan, retention appliance, full-banded orthodontia, and fixed or removable appliance for tooth guidance</em>) <em>Orthodontia benefit limited to dependents only, up to age 19.</em></td>
<td>Not covered</td>
<td>50%, no deductible</td>
</tr>
</tbody>
</table>

### Dental Plan Costs (Pretax)

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<thead>
<tr>
<th>If You Are Paid Biweekly, Your Payment Is:</th>
<th>If You Are Paid Monthly, Your Payment Is:</th>
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<tr>
<td>Full-time Staff</td>
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<td>Part-time Staff</td>
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<td>Wake Dental Choice</td>
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<tr>
<td>You only</td>
<td>$4.62</td>
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<tr>
<td>You plus children</td>
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<tr>
<td>You plus spouse</td>
<td>$10.15</td>
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<tr>
<td>You plus your family</td>
<td>$12.92</td>
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<td>Wake Dental Choice Plus</td>
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<tr>
<td>You only</td>
<td>$8.77</td>
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<tr>
<td>You plus children</td>
<td>$21.23</td>
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<tr>
<td>You plus spouse</td>
<td>$19.38</td>
</tr>
<tr>
<td>You plus your family</td>
<td>$24.92</td>
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</tbody>
</table>

Dental coverage is open access with MedCost. You can use any dentist you are comfortable with who is willing to file claims. If they will not, you can pay up front and submit charges for reimbursement to MedCost.
Vision Plan

An annual eye exam is provided to all staff and dependents enrolled in any of the three medical plans with a $15 copay.

You and your dependents must be enrolled in one of the health plans to be eligible to elect vision coverage. This vision plan covers the costs of glasses or contact lenses.

Please use your MedCost Health Plan Card when you get your annual eye exam.

MedCost administers the vision plan. Vision plan/materials coverage includes:

► Annual eye exam for $15 copay
► Lenses up to $100 annually
► Frames and/or contacts up to $175 annually
► Contact lens fitting at 100% up to $35 annually

Employees can purchase their frames, lenses or contacts from the vendor of their choice, but payroll deductions are only available if vision materials are purchased through Wake Forest Baptist Health Optical Designs.

Material Vision Plan Cost (Pretax)

<table>
<thead>
<tr>
<th></th>
<th>Health Plan Enrollees</th>
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<tr>
<td></td>
<td>If You Are Paid</td>
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<td></td>
<td>Biweekly</td>
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<tr>
<td>You only</td>
<td>$4.62</td>
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<tr>
<td>You plus child(ren)</td>
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<td>You plus spouse</td>
<td>$8.31</td>
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<tr>
<td>You plus family</td>
<td>$12</td>
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</tbody>
</table>

NOTE: If you only wish to have an annual eye exam, you do not have to elect this coverage. If you elect health coverage, you are entitled to an annual eye exam with a $15 copay.
Other Benefits

Spending Accounts

We offer two spending accounts that let you pay for certain out-of-pocket health care and dependent care expenses with tax-free dollars.

Health Care Flex Spending Account covers any IRS-approved health care expenses not paid by any other health care plans, such as deductibles, copays, eyeglasses and hearing aids. You can contribute up to $2,600 annually. The plan year runs from January 1 to March 15 of the following year. Claims for eligible expenses incurred during the plan year must be received by March 31 of the following year. Please keep in mind that all receipts must be submitted to MedCost for any IRS-approved transactions. A Health Care Flex Spending Account is for itemized pretax deductions just like when you itemize your income taxes.

Dependent Care Spending Account covers child or elder dependent care expenses incurred so that you (and your spouse, if you are married) can work or attend school full time. This includes care for your children under age 13 (or an elderly parent) in your home, an individual’s home or a licensed day care center. You can contribute up to $5,000 a year (or up to $2,500 if you are married and file separate tax returns).

To participate in a spending account, you must enroll each year during annual enrollment. Spending account elections do not roll over to the next plan year.

Health Care Flex Spending — Debit Card

If you participated in the Health Care Flex Spending Account, you automatically received a Benefits Debit Card that allowed you to pay eligible health care expenses with a simple swipe of the card. If you currently have a debit card, please do not discard. Your 2017 election will be automatically added to your existing card.

Life and AD&D Insurance

As a Wake Forest Baptist Health employee, you automatically receive basic life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you—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 approval by Cigna. If you elect additional life or disability coverage, Cigna will contact you to provide an Evidence of Insurability form.

Dependent Life Insurance

You also may purchase life insurance for your spouse and your eligible children in the amount of: $10,000 or $25,000 per spouse or child/children, subject to approval by Cigna.

Disability

Disability coverage pays a benefit if you are sick or injured and unable to work.

Short Term Disability (STD) pays a weekly benefit of 60% of your pay. Benefits begin after 30 or 60 consecutive days of hospitalization, sickness or injury and continues (as long as you are disabled) for up to 26 weeks. STD benefits will end on the date LTD benefits become payable to you. STD is an employee-paid option.

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 coverage is an employer-paid benefit for eligible employees.
A Final Word About Health Care Coverage

The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, requires employers who offer group health coverage to provide certain rights for staff and faculty, as described below.

Children’s Health Insurance Program Reauthorization Act

If you are eligible for health coverage, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance with the premiums.

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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or InsureKidsNow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Health Certificates

If your health coverage under the Wake Forest Baptist Health Benefit Program ends, you and your covered dependents will receive a certificate that shows your period of health coverage. You may need to furnish the certificate to another employer if you become eligible for another group health plan.

You and your dependents may also request a certificate within 24 months of losing medical coverage through MedCost by calling 336-774-4190, option 3.

Mastectomy Breast Reconstruction

The Women’s Health and Cancer Rights Act of 1998 guarantees coverage to any health plan member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that surgery.

Patients are entitled to coverage for:

► Reconstruction of the breast on which the mastectomy has been performed.
► Surgery and reconstruction of the other breast to produce symmetrical appearance.
► Prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes).

These services will be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these services is subject to applicable deductibles, coinsurance or copays.

Newborns’ and Mothers’ Health Protection Act

Under federal law, we may not restrict health plan benefits for the mother or newborn child to less than:

► 48 hours for any childbirth-related hospital stay following a vaginal delivery.
► 96 hours following a delivery by cesarean section.

However, the mother’s or newborn’s attending physician may discharge the mother or newborn earlier than 48 hours (or 96 hours as applicable) after consulting with the mother.

Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated less favorably for the mother or newborn than any earlier portion of the stay.

In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization to prescribe a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

(continued on next page)
Qualified Medical Child Support Orders
If a Qualified Medical Child Support Court Order (QMCSO) issued in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

► Name and last known address of the parent who is covered under this plan.
► Name and last known address of each child to be covered under this plan and type of coverage to be provided to each child.
► Period of time the coverage is to be provided.

QMCSOs should be sent to the plan administrator. Upon receipt, the plan administrator will notify you and describe the plan’s procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the plan. As a beneficiary covered under the plan, your child will be entitled to information that the plan provides to other beneficiaries under ERISAs reporting and disclosure rules.

Prescription drug coverage and Medicare prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. Because the Wake Forest Baptist Health plan’s coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep the Wake Forest Baptist Health coverage and not pay extra if you later decide to enroll in Medicare coverage. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year, you will have the opportunity to enroll in a Medicare prescription drug plan between Nov. 15 and Dec. 31.

Dependent Coverage to Age 26—
A Provision of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (Public Law 111-148), which was passed on March 23, 2010, as part of Health Care Reform, contains a provision requiring health plans that offer dependent coverage to provide coverage for all children to age 26. The law is effective for plan years beginning on or after September 23, 2010 (six months following the date of enactment of the law). This notice is being furnished to you in compliance with the requirements of the law.

Children under age 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status or the amount of financial support from the parent.

Coverage/premiums for children under age 26 will be the same as that offered to other dependent children.

If the parent/employee is not enrolled in the plan but is otherwise eligible, and a child qualifies for this new enrollment opportunity, the parent may enroll along with the child.

The child may enroll in any benefit package option that is offered under the plan, thereby allowing the parent to switch benefit package options.

If both parents of the eligible child have employer-sponsored coverage, the child may enroll in either plan. Neither plan can deny enrollment.

A child who qualifies for this new enrollment opportunity and is currently covered under COBRA may terminate COBRA coverage and enroll as a dependent of an active staff and faculty.

Coverage will end at the end of the month in which a child turns 26, or until coverage otherwise terminates as defined by the plan (refer to the summary plan description).
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:

• Your past, present, or future physical or mental health or condition.
• The provision of health care to you.
• 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.
• 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 pre-certification 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.

Notice of Privacy Practices (continued)
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 for marketing; 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: 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.
If you have questions about enrollment or need help enrolling online, you can visit one of the onsite enrollment centers or contact the Benefits Department in Human Resources at 336-716-3334.

**Benefit Provider Contact Information**

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<thead>
<tr>
<th>Benefit</th>
<th>Provider</th>
<th>Telephone</th>
<th>Web Address</th>
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<tbody>
<tr>
<td></td>
<td>Carolina Behavioral Health</td>
<td>1-800-475-7900</td>
<td><a href="http://www.cbhallc.com">www.cbhallc.com</a></td>
</tr>
<tr>
<td>Spending Accounts</td>
<td>MedCost</td>
<td>1-800-795-1023</td>
<td><a href="http://www.medcost.com">www.medcost.com</a></td>
</tr>
<tr>
<td>Elder Care Choices</td>
<td>Senior Services</td>
<td>336-748-2171 or 1-800-648-2171</td>
<td><a href="http://www.seniorservicesinc.org">www.seniorservicesinc.org</a></td>
</tr>
<tr>
<td>Benefits Hotline</td>
<td>Wake Forest Baptist Health</td>
<td>336-716-3334</td>
<td><a href="mailto:benefits@wakehealth.edu">benefits@wakehealth.edu</a></td>
</tr>
<tr>
<td>Life Insurance and Disability</td>
<td>CIGNA</td>
<td>1-800-362-4462</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
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