



BAPTIST HEALTH®

**EMPLOYEE**

**BENEFITS**

**GUIDE**

**2021**

**STAFF**



**BENEFITS**  
CENTERED ON YOU

OCTOBER 2020



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Baptist Health cares for its employees. In fact, many say that at Baptist, we are like family. “Benefits Centered On You” means that we are intentional with our actions and initiatives. The focus of our benefits offerings takes into account every employee’s life cycle. It requires listening to our employees through surveys, focus groups and employee comments so that as we make changes, we are addressing relevant needs.



Please take time to review the benefit information provided in this guide, as it offers an extensive overview of your health and welfare benefit options. This includes details about eligibility, enrollment and the plans available to you. It also explains how life changes and changes in your employment status can affect your benefits. We recommend you keep this guide for future reference.

Go to BEN> HR Portal, under the Benefits section, to find information on how to access Workday and more useful documents to help you enroll.

### **ENROLLING IN YOUR 2021 BENEFITS PLAN IS EASY!**

Workday can be accessed through the Baptist Employee Network (BEN) at <https://baptisthealth.sharepoint.com/sites/ben/Pages/default.aspx> and when you are on the go by using the Workday app.

Disclaimer: Baptist Health has made every effort to accurately report the information in this guide. If any information contained in this guide conflicts with the applicable official plan documents and insurance agreements of Baptist Health, the official plan documents and insurance agreements will govern.

# A Century of *Commitment* to the *Health* of Our *Communities*

## MISSION

Baptist Health demonstrates the love of Christ by providing and coordinating care and improving health in our communities.

## SHARED VISION

Baptist Health will lead in clinical excellence, compassionate care and growth to meet the needs of our patients.

## FAITH-BASED VALUES

Integrity, Respect, Compassion, Excellence, Collaboration and Joy.

## COMMITMENT TO PATIENT SAFETY

Continuously improve patient outcomes through a culture of safety and clinical excellence.

## Employer-Provided Benefits



BENEFITS  
CENTERED ON YOU

The following benefits are included in your total compensation at no cost to you:

### Time Away From Work

- Paid Time Off
- Family Medical Leave
- Personal Leave
- Maternity/Paternity Leave

### Education

- Tuition Reimbursement
- Student Loan Refinancing Tools

### Life Insurance

- Basic Employee Life and Accidental Death & Dismemberment (AD&D) insurance

### Disability Insurance

- Long-Term Disability (LTD) (for full-time employees scheduled to work at least 32 hours per week)

### Retirement Benefits

- 403(b) Plan with company match
- Roth provision included with company match



The **Medical Plan** is administered by Anthem Health Plans. Anthem administers the **Enhanced PPO**, **Core PPO**, and **HDHP** using the Anthem BlueCross BlueShield Network. Please see page 12 for a summary of coverage options and premiums. Baptist Health continues to provide excellent healthcare services through the compassion and expertise of our employees. When our employees need care for themselves or their loved ones and use a Baptist Health facility, out-of-pocket costs are less.

**Medical plans are available including a High Deductible Health Plan with a Health Savings Account (HSA).**

- A High Deductible Health Plan (HDHP) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Being covered by an HDHP is a requirement for having a Health Savings Account.
- A Health Savings Account (HSA) is a tax-advantaged account that can be used to pay for current and future medical expenses. An HSA works with an HDHP, and allows you to use before-tax dollars to pay your provider or reimburse yourself for your eligible out-of-pocket medical expenses for you, your spouse, and your dependents, which in turn saves you tax dollars and increases your spendable income.

**Maintenance Medications**

Baptist Health System has retail pharmacies located at each of our 9 hospitals. Effective January 1, 2021, maintenance medications must be filled at a Baptist Health Retail Pharmacy. Existing prescriptions for maintenance medications not filled at a Baptist Health Retail Pharmacy may continue to be filled up to a total of 2 refills. Remaining refills for any maintenance medication must be transferred to a Baptist Health Retail Pharmacy. The Prescription Transfer Form can be found on [HR Portal > Benefits](#).

A **Preventive Plan** is offered to all employees, including PRN and temporary employees. This plan covers only minimum essential services as defined by the Affordable Care Act. These include screening and wellness services. This plan is not comparable to the Enhanced PPO, Core PPO, and HDHP. It does not cover conditions caused by illness or accident. For example, it does not cover a visit to the emergency room or an urgent care center for illness treatment. Please review and consider carefully before electing this plan.

**The Accident and Critical Illness coverage** is offered through UNUM with guarantee issue for 2021 and a \$100 wellness benefit.

**Whole Life and LTC Rider** will help protect your savings from being drained by this expensive care. Most important, this coverage allows you to use the benefit whether you receive care at home, or in a long-term care facility, an adult day care, or a nursing home.

**The Employee Assistance Program (EAP)**, is offered through **Magellan Healthcare**. Magellan has many features to offer including online self-guided therapy modules and legal counseling (800-327-7354).

**Identity Theft benefit through Allstate Identity Protection** is offered to you. InfoArmor has joined the Allstate corporation and will now be called Allstate Identity Protection. This allows you to cover yourself or your entire family on a comprehensive plan that offers pre-existing coverage and full identity restoration.

**Pet Insurance benefit** is offered through Nationwide Insurance. You will be able to choose from 2 plans:

- My Pet Protection with Wellness
- My Pet Protection

Premiums for benefit coverage will be deducted from each paycheck. Deductions for 2021 are spread evenly over each of the 26 pay periods.

**My Benefits Mentor Tool** is a tool available to assist with making benefit enrollment decisions. The My Benefits Mentor Tool, powered by IBM Watson, will help to provide you with personalized, data-driven plan recommendations to assist you with making benefit elections. This tool is available during the enrollment process through Workday and on [HR Portal > Benefits](#).



**Tobacco-use/Alternative Healthcare Rates:** When you enroll, you will see questions about tobacco use, and if your spouse has medical plan coverage available through their employer.

- Baptist Health implemented these rates to encourage tobacco users to quit and to offset the additional cost associated with providing healthcare to tobacco users. Tobacco use remains the single largest preventive cause of disease and premature death in the nation. It also contributes to chronic and serious diseases, leading to higher healthcare costs.
- It is good stewardship to promote choices where preventable illness can be reduced. It is especially valuable for the individual. Encouraging employees and their families to be tobacco-free is a proactive way to help manage healthcare costs.

**Tobacco-use rates apply to the *Medical* insurance plans only.** The Affordable Care Act (ACA) defines “tobacco use” as the regular use of any tobacco product, including cigarettes, cigars, chewing tobacco, snuff and pipe tobacco, four or more times per week in the past six months. This is the definition adopted by Baptist Health for you and/or your spouse. In addition, consistent with our current policy regarding tobacco use on our campus, the use of e-cigarettes four or more times per week will also be included in the definition of tobacco use.

**Supplemental Spousal Premium applies to the *Medical* insurance plan only.** A Supplemental Spousal Premium is added to the applicable employee medical plan rate (e.g., non-tobacco or tobacco rates) when covering an employee’s spouse who has access to medical insurance through their own employer. The Supplemental Spousal Premium for medical plan coverage is \$100 per month (or \$46.15 when spread over 26 pay periods).

**Base Long-Term Disability (employer-paid benefit).** Employee buy-up options are available.

**Medical Expense Reimbursement Program (MERP).** Under MERP, you would elect to cover you and your family under your spouse’s medical plan. MERP would reimburse you for eligible medical care expenses and premium differences incurred, based on the Enhanced PPO plan. Co-pays, deductibles and coinsurance reimbursed up to \$17,100 per year for employee + spouse, employee + children or family coverage, or up to \$8,850 for “employee only” coverage. Allowed charges for services received at a Baptist Health facility are reimbursed at 100%, and reimbursed at 75% for non-Baptist Health facilities.

For more information on the MERP and eligibility qualifications, please refer to **HR Portal > Benefits** and/or contact **Catilize Health** at **877.872.4232**, 8:30AM-8PM EST.

**Hospital Indemnity – Unum.** New product offering for 2021: Hospital Indemnity helps covered employees and their families cope with the financial impact of a hospitalization. You can receive benefits when you’re admitted to the hospital for a covered accident, illness or childbirth.

**Livongo.** Livongo is a new Diabetes Management Program being offered 11/1/2020. More information will be available soon.

A new maternity program is being offered 1/1/2021 through **Optum®** for support, education and resources associated with pre-term births and NICU admissions. Neonatal Resource Services provides information and support when having a baby that needs extra care. Optum® offers information and support throughout pregnancy and after giving birth.

## FOR MORE INFORMATION

For additional benefits information and helpful FAQ resource documents, go to the **HR Portal > Benefits** section.



My Benefits Mentor with Watson can help you make an informed decision by guiding you to the best-fit plan for your healthcare needs.

## My Benefits Mentor with Watson is designed to:

- Deliver personalized, data-driven plan recommendations on any device
- Use actual historical claims to compare against upcoming plan options to determine the best-fit plan
- Help calculate costs for planned expenses
- Offer short- and long-term HSA guidance

## How can I access My Benefits Mentor?

A link to My Benefits Mentor is located on Workday and HR Portal > Benefits.

## When is My Benefits Mentor available for me to use?

My Benefits Mentor is available to you during open enrollment to support your benefits selection decisions.

## Support Process

### System Availability Access

When users experience system availability access problems, please call 877.843.6796 and select the System Availability option to report the issue. This support is available 24 hours per day, 7 days a week.



You will enroll in your 2021 benefits through Workday. For Unum products, (Accident, Critical Illness and Whole Life with Long-Term Care) you will link to the Unum enrollment screens from Workday. Detailed enrollment instructions are available on HR Portal > Benefits.

## Accessing WORKDAY from Baptist Health

1. Open your web browser to access BEN. This is the homepage on all Baptist Health computers. The BEN address is <http://home.bhsi.com>
2. On the sidebar in the top left corner of BEN, click on HR Portal.
3. Once in the HR Portal, click on Workday.
4. Click on Employees and Contractors.
5. Your username and password will be the same that you use to log in to your computer at work.

## If you are not on a Baptist Health Network

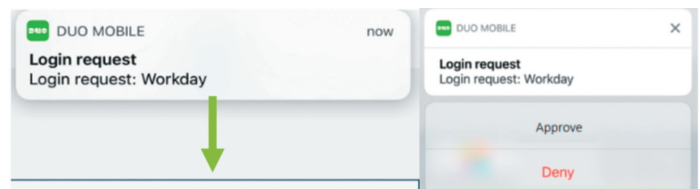
1. Open your web browser and navigate to <http://ben.bhsi.com>. This is the BEN@Home main page.
2. Under the Workday section, click on Workday.
3. Click on Employees and Contractors.
4. Your username and password will be the same that you use to log in to your computer at work.
5. If you are enrolled in DUO or are required to use DUO, you will be prompted for DUO authentication. If you are not a DUO user, you will be successfully logged in to My Workday.

## When you are on the go

1. Install the Workday App on your device. See page 9 for information on installing and configuring the Workday App.
2. From the Workday App, tap Employees and Contractors.
3. Your username and password will be the same that you use to log in to your computer at work.
4. If you are enrolled in DUO or are required to use DUO, you will be prompted for DUO authentication. If you are not a DUO user, you will be successfully logged in to Workday.

## DUO Authentication

1. If you are enrolled in DUO, you will be prompted to Send Me a Push, Call Me, or Enter a Passcode.
2. If you choose Send Me a Push and have the DUO App installed on your device, you will receive a banner notification at the top of your screen.
3. Pull or Swipe Down this notification from the top of your screen and then tap Approve.



4. Choosing Call Me will call your registered device. You will be prompted to press a key to approve authentication.
5. Choosing Enter a Passcode will send a text message with a temporary, one-time use code to your registered device and prompt you to enter the received code.
6. After successfully authenticating with DUO, you will be logged in to Workday.

Note: For DUO Multifactor Authentication Self Service, visit BEN > Applications > My Applications, or search for multifactor in the search box.

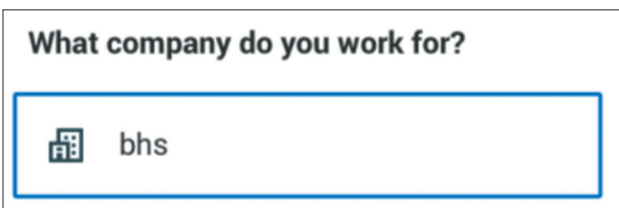
All Managers must be enrolled in DUO for Workday mobile access. If you are required to use DUO and are not enrolled, you will receive an error when logging in.



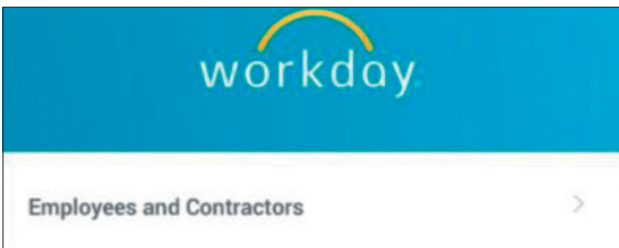
## Installing the WORKDAY Mobile App

If you have a previous version, uninstall and reinstall the Workday app on your device to ensure the latest version and full functionality.

1. From your device, navigate to the App Store (for Apple iOS devices) or Google Play Store (for Android Devices).
2. Tap Search and enter Workday.
3. Tap Install.
4. Tap Open to launch the Workday app.
5. Tap the Let's get started button.
- 6.



When prompted, enter **bhs** under Company ID.

7. 

To log in, tap Employees and Contractors.

8. Your username and password will be the same that you use to log in to your computer at work.
9. If you are enrolled in **DUO** or are required to use DUO, you will be prompted for **DUO authentication**. If you are not a DUO user, you will be successfully logged in to Workday.
10. Tap OK to enable push notifications if desired.
11. You may set up a PIN and Touch ID. **See Mobile Authentication** for more information.

## Mobile Authentication

Note: Mobile users can sign in to Workday mobile apps with a Personal Identification Number (PIN) for faster access. Please note that the PIN, like your password, will expire every 90 days and you will have to validate yourself through the initial credentials page to set your PIN to a new 4-digit PIN.

1. Sign in to Workday. A prompt appears, asking if you want to set up a PIN.
2.
  - a. Enter a 4-digit PIN.
  - b. For Apple iOS devices, you may use Enable Touch ID (see below).
3. Tap the **checkmark**.
4. Confirm the PIN by entering the characters again and then tapping the **checkmark**.
5. Tap Allow to enable push notifications if desired.

## Touch ID (Enabled IOS Devices Only)

When setting up the PIN, users with enabled devices may see a prompt asking to Enable Touch ID (depending on your company's security).

6. Tap to set the **Touch ID** toggle to the on position. Touch ID will be enabled now and on future logins.
7. Place your finger on the Home button. Login is automatic.





## Are my dependents eligible for medical, dental, and vision coverage?

If you are an eligible employee, your legal spouse and children up to age 26 are considered eligible dependents. Mentally or physically disabled children older than 26 are eligible if the disability occurred before age 26. Children include biological, adopted, step, and foster children. Legal documentation is required.

## What if I don't have a computer for enrolling?

Please visit Human Resources and someone will be happy to assist you.

## What levels of coverage are available with Baptist Health benefit plans?

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

## What is the new hire election period?

New hires have 30 days from their date of hire to elect current year benefits. Benefits will be active on the first day of the month following or the coincident event date.

## May I make changes during the year?

Yes, you may make changes to your benefits during the year if you have a qualifying event or change in family status. Once you experience such an event, you must make any changes within 30 days. You may add or drop coverage or change coverage levels (i.e., Employee Only, Employee + Spouse, etc.). However, you may not change plans (i.e., HDHP to Enhanced PPO, etc.) until the next Open Enrollment period.

Qualifying event or family status changes may include:

- Marriage, divorce, legal separation, annulment, or death of spouse.
- Birth, adoption, or death of a dependent child.
- The beginning or end of an employee's or spouse's employment.
- Change in spouse's employment from full-time to part-time, or part-time to full-time.
- You, your spouse, or a dependent child becomes eligible or ineligible for coverage.
- A court order requiring you, your spouse, or a former spouse to provide coverage for a child.
- An employed spouse changes benefits under a plan sponsored by his or her employer during a mid-year enrollment.
- A change in your employment status that causes you to lose or gain eligibility for certain benefits.

Any change you make to your benefits must be consistent with the change in your family status. For example, if your spouse loses medical coverage through his or her employer, you may add your spouse to your Baptist Health coverage. **You must submit a change in benefits through Workday within 30 days of a family status change.** Newborns are covered under the medical plans for the first 30 days. Newborns must be added to Workday within 30 days of date of birth.

For more information on how to manage your benefits, go to [BEN](#) > HR Portal under the Benefits section.

## FOR MORE INFORMATION

Additional Frequently Asked Questions, (FAQs), and other information on benefit coverage for 2021, are posted on the Baptist Employee Network, (BEN). Go to <https://baptisthealth.sharepoint.com/sites/ben/Pages/default.aspx> > HR Portal link on BEN, then click on Workday or access via mobile device using the Workday app.

# Medical Benefits

All plans will be administered by Anthem Health Plans utilizing the Anthem BlueCross BlueShield network.

## Administered by Anthem

### Who is eligible?

You are eligible for medical coverage if you are regularly scheduled to work at least 24 hours per week, (0.6 - 1.0 FTE). You can choose personal coverage (for yourself only), or coverage for you and your spouse, you and your children, or your whole family.

Dependent children may be covered until the end of the month in which they turn 26.

Baptist Health offers THREE medical plan options:

1. Enhanced PPO
2. Core PPO
3. HDHP

### Enhanced and Core PPO

You must receive care from doctors, hospitals, and other healthcare providers in the plan's network, except in an emergency. Advantages of the Enhanced PPO and Core PPO plans include a high level of coverage, lower copays and out-of-pocket costs at Baptist Health facilities and coverage of routine and preventive care. There is also opportunity to participate in a Flexible Spending Account (FSA) with participation in either PPO plan.

### High Deductible Health Plan

You must receive care from doctors, hospitals, and other healthcare providers in the plan's network, except in an emergency. Advantages of the HDHP plan include 0% co-insurance after deductible for most services in Baptist Health facilities, lower out-of-pocket costs at Baptist Health facilities, and coverage of routine and preventive care. There is also opportunity to participate in a Health Savings Account (HSA) and an HSA Compatible Flexible Spending Account with participation in the HDHP.

### Prescription Drug Coverage

All medical plans use the MedImpact prescription program, which has three co-pay levels based on the cost of the medication.

This program requires the use of generic drugs when available. If you or a covered dependent buy a brand name drug when the generic equivalent is available, you must pay the difference in cost between the brand name and the generic drug, plus any applicable co-pay, regardless of who (you, your spouse, your dependent child(ren), or your doctor) is requesting the brand name medication.

This means if your physician writes on the prescription "dispense as written," you will receive the drug named in the prescription, and you will be required to pay the difference in cost, plus the applicable co-pay. [Remember to ask your physician about the availability of generics.]

Employees on the medical plan receive discounted co-pays when filling their prescriptions at the Baptist Health Outpatient Pharmacies (see Medical Plan Summaries for details).

To check which tier your medication falls under, visit the MedImpact pharmacy drug list under Provider Links on the HR Portal>Benefits section.

You will continue to have two cards (one for medical and one for pharmacy). You must present your new medical ID card to the hospital or your physician for the new benefits to apply.

#### Note about Schedule 2 prescriptions:

If you have a Schedule 2 prescription, you will need a new prescription from your physician. A new prescription will be required every time the drug is filled.

### Medication not covered by your insurance?

#### No problem!

We're proud to be able to help you with your health care costs by including iRx Program® inside your Baptist Health ID Card from MedImpact at no cost. This program gives you discounts on brand name and generic prescription medications not covered by your insurance.

- Instant savings with no qualifying.
- Accepted at more than 60,000 participating pharmacies.
- Absolutely no enrollment fees and no monthly or ongoing fees.
- There's no limit to the number of times the program can be used.
- And best of all, you already have it! It's in your Baptist Health ID Card.

**It's easy to save – and it's automatic!** When your prescription is not covered by your insurance, iRx Program® automatically steps in to provide you a discount. It's that simple!



Scan QR code for more information about Medical coverage on the Virtual Benefits Fair.

## Administered by Anthem

### Precertification of Medical Services

All medical plan options require you to obtain advance approval (precertification) before receiving certain services, including, but not limited to:

- Specified surgical procedures
- Major diagnostic procedures (MRI, PET scans)  
Procedures or treatments using new technologies
- Inpatient admission
- Skilled nursing care
- Transplants
- Home healthcare and home health supplies
- Mental health or substance abuse care (inpatient or outpatient)

To obtain precertification, please call **866.643.7087**. This number is also listed on the back of your medical ID card. This card is available online.

Four charts below: Employee Cost \$XX.XX | Employer Cost (\$XX.XX)

STANDARD			
	2021 Plan Rates		
Coverage (Bi-Weekly)	Enhanced PPO	Core PPO	HDHP
Employee Only	\$62.08 (\$285.24)	\$39.29 (\$288.96)	\$10.18 (\$294.98)
Employee + Spouse	\$180.64 (\$548.72)	\$132.49 (\$556.83)	\$67.85 (\$571.06)
Employee + Child(ren)	\$148.07 (\$477.10)	\$106.80 (\$484.05)	\$54.76 (\$498.37)
Family	\$266.64 (\$740.58)	\$199.99 (\$751.93)	\$102.74 (\$764.92)

TOBACCO SURCHARGE ONLY (+\$100 / MONTH)			
	2021 Plan Rates		
Coverage (Bi-Weekly)	Enhanced PPO	Core PPO	HDHP
Employee Only	\$108.23 (\$239.08)	\$85.45 (\$242.80)	\$56.33 (\$248.83)
Employee + Spouse	\$226.79 (\$502.56)	\$178.64 (\$510.68)	\$114.00 (\$524.90)
Employee + Child(ren)	\$194.23 (\$430.94)	\$152.95 (\$437.90)	\$100.92 (\$452.22)
Family	\$312.79 (\$694.43)	\$246.15 (\$705.78)	\$148.89 (\$718.76)

WORKING SPOUSE SURCHARGE ONLY (+\$100 / MONTH)			
	2021 Plan Rates		
Coverage (Bi-Weekly)	Enhanced PPO	Core PPO	HDHP
Employee Only			
Employee + Spouse	\$226.79 (\$502.56)	\$178.64 (\$510.68)	\$114.00 (\$524.90)
Employee + Child(ren)			
Family	\$312.79 (\$694.43)	\$246.15 (\$705.78)	\$148.89 (\$718.76)

TOBACCO + WORKING SPOUSE SURCHARGE (+\$200 / MONTH)			
	2021 Plan Rates		
Coverage (Bi-Weekly)	Enhanced PPO	Core PPO	HDHP
Employee Only			
Employee + Spouse	\$272.95 (\$456.41)	\$224.80 (\$464.52)	\$160.15 (\$478.75)
Employee + Child(ren)			
Family	\$358.94 (\$648.28)	\$292.30 (\$659.63)	\$195.05 (\$672.61)

Your physician, hospital, or a family member may call for you if you are unable to do so. However, keep in mind that you are responsible for your and/or your spouse's or dependents' precertification.

We recommend verification of your healthcare provider participation and level of tier coverage prior to every service.

**Be sure your doctor is a member of the network; if he or she is not, the care you receive may not be covered, or may be covered at a lower benefit level, and your out-of-pocket costs may be more than you expect. Please call Anthem to verify your provider is in network.**

# Medical Plan Summaries



**BENEFITS**  
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## Administered by Anthem

MEDICAL SERVICES	2021 ENHANCED PPO		2021 CORE PPO		2021 HDHP	
	Baptist Health	Anthem Network	Baptist Health	Anthem Network	Baptist Health	Anthem Network
<b>Account Contribution</b>						
Single	N/A		N/A		\$500	
Dependent Coverage	N/A		N/A		\$1,000	
<b>Deductible</b>						
Single	\$0	\$2,000	\$0	\$3,500	\$2,800	\$4,000
Family	\$0	\$4,000	\$0	\$7,000	\$5,600	\$8,000
<b>Out-of-Pocket Limit</b>						
Single	\$3,000	\$6,000	\$4,500	\$5,750	\$2,800	\$6,650
Family	\$6,000	\$12,000	\$9,000	\$11,500	\$5,600	\$13,300
Preventive Care	CIF <sup>1</sup>					
<b>Physician Services</b>						
Baptist Virtual Urgent Care <sup>3</sup>	\$20	N/A	\$20	N/A	0%*	25%*
Office Visit PCP/Spec	\$30 / \$60	\$50 / \$80	\$40 / \$80	\$60 / \$100	0%*	25%*
Office Procedures	CIF <sup>1</sup>	CIF <sup>1</sup>	15%*	30%*	0%*	25%*
OP/IP	10%*	25%*	15%*	30%*	0%*	25%*
Retail Clinics	\$30 / \$60	\$50 / \$80	\$40 / \$80	\$60 / \$100	0%*	25%*
<b>Diagnostic Services</b>						
Office Lab/X-ray	10%*	25%*	15%*	30%*	0%*	25%*
Outpatient Lab/X-ray	CIF <sup>1</sup>	25%*	CIF <sup>1</sup>	40%*	0%*	25%*
OP Advanced Imaging	\$75 copay	25%*	\$250 copay	\$250 copay; 40%*	0%*	25%*
<b>Allergy Services</b>						
Testing	CIF <sup>1</sup>	CIF <sup>1</sup>	CIF <sup>1</sup>	CIF <sup>1</sup>	0%*	25%*
Serum	CIF <sup>1</sup>	CIF <sup>1</sup>	15%*	30%*	0%*	25%*
Injections	\$5	\$10	\$10	\$15	0%*	25%*
<b>Urgent/Emergency Care</b>						
Urgent Care Facility	\$40	\$60 <sup>2</sup>	\$50	\$100 <sup>2</sup>	0%*	25%* <sup>2</sup>
Emergency Room	\$150 copay		\$250 copay		0%*	
<b>Facility Services</b>						
Inpatient	\$500 copay	25%*	\$2,000 copay	\$3,000/admit 40%*	0%*	25%*
Observation Stay	\$200 copay	25%*	\$600 copay	\$1,000 copay; 40%*	0%*	25%*
Outpatient Surgery	\$200 copay	25%*	\$600 copay	\$1,000 copay; 40%*	0%*	25%*
<b>Behavioral Health</b>						
Office Visit	\$30	\$50	\$40	\$60	0%*	25%*
Other Outpatient	\$30	\$50	\$40	\$60	0%*	25%*
Inpatient	\$500 copay	25%*	\$2,000 copay	\$3,000/admit; 40%*	0%*	25%*



## Administered by Anthem

MEDICAL SERVICES	2021 ENHANCED PPO		2021 CORE PPO		2021 HDHP	
	Baptist Health	Anthem Network	Baptist Health	Anthem Network	Baptist Health	Anthem Network
Therapy Services						
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation Services and Pulmonary Rehabilitation Services	\$30 copay per visit	\$40 copay per visit	\$40 copay per visit	\$60 copay per visit	0%*	25%*
Chiropractic Services (up to 20 visits per year)	\$30 copay per visit		\$40 copay per visit		0%*	
Other Services						
Vision (1 exam every 12 months)	\$30 copay per visit		\$40 copay per visit		25%*	
Infertility	Copays and deductibles will apply based on place of service. Lifetime Max is \$10,000 for medical and \$10,000 for pharmacy.		Copays and deductibles will apply based on place of service. Lifetime Max is \$10,000 for medical and \$10,000 for pharmacy.		Copays and deductibles will apply based on place of service. Lifetime Max is \$10,000 for medical and \$10,000 for pharmacy.	
Therapeutic Services (including but not limited to Chemotherapy, Radiation Therapy, IV Therapy and Dialysis)	\$0	25%*	\$0	40%*	0%*	25%*
Skilled Nursing Facility/Rehabilitation Facility (60 days per plan year)	\$0	25%*	\$0	40%*	0%*	25%*
Home Health (up to 100 visits per plan year)	\$0	25%*	\$0	40%*	0%*	25%*
Hospice	\$0 (Not subject to deductible)		\$0 (Not subject to deductible)		0%*	
Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices and Medical Supplies	No Baptist Provider Available	\$500 annual copay	No Baptist Provider Available	\$500 annual copay	No Baptist Provider Available	25%*

\*after annual deductible met

<sup>1</sup>CIF = Covered in Full

<sup>2</sup>If not an emergency medical condition under ACA, otherwise same as BH

<sup>3</sup>Four free Virtual Urgent Care visits per calendar year; \$20 Copay after four free visits are met



## Administered by MedImpact

	2021 ENHANCED PPO		2021 CORE PPO		2021 HDHP**	
	BH Pharmacy	Retail Pharmacy	BH Pharmacy	Retail Pharmacy	BH Pharmacy	Retail Pharmacy
<b>Prescription Drug</b>						
RX Deductible	No Deductible		No Deductible		Combined with Medical	
Single	No Deductible		No Deductible		\$2,800	\$4,000
Family	No Deductible		No Deductible		\$5,600	\$8,000
RX Out-of-Pocket Limit					Combined with Medical	
Single	\$1,400		\$1,400		\$2,800	\$6,650
Family	\$2,800		\$2,800		\$5,600	\$13,300
<b>Retail</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>
Preventive	\$0	\$20	\$0	20%; \$25-\$75	0% after deductible is met	25% after deductible is met
Tier 1	\$5	\$20	10%; \$15-\$60	20%; \$25-\$75		
Tier 2	15%; \$25-\$60	25%; \$40-\$75	25%; \$35-\$130	35%; \$50-\$155		
Tier 3	25%; \$45-\$100	35%; \$65-\$120	35%; \$45-\$240	45%; \$65-\$270		
<b>Mail</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>	<b>BH Pharmacy</b>	<b>Retail Pharmacy</b>
Preventive	\$0	Must fill at Baptist Health Pharmacy*	\$0	Must fill at Baptist Health Pharmacy*	0% after deductible is met	Must fill at Baptist Health Pharmacy*
Tier 1	\$10		10%; \$40-\$150			
Tier 2	15%; \$70-\$150		25%; \$100-\$340			
Tier 3	25%; \$120-\$250		35%; \$120-\$610			

\* Maintenance medications must be filled at a Baptist Health Retail Pharmacies. Prescriptions for current maintenance medications may be filled at a retail pharmacy two times, then must be converted to a Baptist Health Retail Pharmacy for ongoing prescriptions.

\*\* HDHP Deductible and OOP's Cross apply

\*\* HDHP Plan will co-mingle/combine medical and pharmacy and apply the Anthem Facility Tier 2 Deductible for Other Pharmacies



## Services

Where available, Baptist Health Outpatient Pharmacies offer full prescription services, vaccines and over-the-counter medications. Most specialty medications are also available, avoiding the need to use a separate pharmacy for medications such as Humira®, Enbrel® and many others.

### MyChart

Create an Epic MyChart account to manage your prescriptions. MyChart allows you to view and refill your prescription. A notification will be sent when your prescription is ready for pick-up. A MyChart app is also available for further convenience when requesting refills and viewing your medication profile and history.

### Auto Refill

Automated refills save you time; no need to call in or drop off prescriptions. Your prescriptions are ready when you need them and we will let you know when they are filled. Our staff will contact your provider ahead of time when you're out of refills.

### Med Synch

Pharmacy staff can coordinate your refills so you can pick them up on a single day each month. Many people miss doses of their regular medications and Med Synch can make you more likely to take them. Med Synch does the following:

- Eliminates the need to call in multiple prescription refills
- Allows you the convenience of fewer trips to the pharmacy
- Provides an opportunity to meet with your pharmacist on a monthly basis to discuss your medications

### Discounts

Employees on the medical plan receive discounted co-pays when filling their prescriptions at the Baptist Health Outpatient Pharmacies (see Medical Plan Summaries for details).

### Maintenance Medications

Retail Pharmacies are open in all 9 of our hospitals and effective 2021, maintenance medications must be filled at Baptist Health Retail Pharmacies. Prescriptions for current maintenance medications may be filled at a non-Baptist retail pharmacy two times per prescription, then must be converted to a Baptist Health Pharmacy for ongoing prescriptions. The Prescription Transfer Form can be found on [HR Portal > Benefits](#).

## Locations

Currently, Baptist Health has retail pharmacies in nine hospitals:

<b>Corbin</b> 606.526.8335	<b>Richmond</b> 859.626.0076	<b>La Grange</b> 502.225.5500
<b>Lexington</b> 859.639.3900	<b>Louisville</b> 502.928.6930	<b>Hardin</b> 270.706.1256
<b>Madisonville</b> 270.825.5954	<b>Paducah</b> 270.575.5870	<b>Floyd</b> 812.948.7404







## Administered by Wage Works/Health Equity

### There are three types of FSAs:

**Health Care FSA** allows reimbursement of qualifying out-of-pocket medical, dental and vision expenses. This option is for employees who are covered on the Enhanced PPO and Core PPO plans.

**Limited FSA** allows reimbursement of qualifying out-of-pocket dental and vision expenses. This option is for employees who are covered on the High Deductible Health Plan (HDHP). If you are enrolled in an HSA account, your spouse may hold an HSA-compatible FSA, for dental and vision expenses only. If both spouses hold an HSA with their employer, the combined contributions may not exceed the family contribution per year (\$7,200).

**Dependent Day Care FSA** allows reimbursement for work-related dependent day care expenses for dependents under the age of 13 or dependent adults incapable of self-care.

### Who is eligible?

You are eligible if you are a regular employee scheduled to work at least 24 hours per week.

### How does an FSA work?

An FSA lets you set aside money on a pre-tax basis to use for certain types of eligible expenses. You pay no taxes on the money you contribute to your FSA.

You can use the Health Care FSA to cover tax-deductible medical expenses not paid by your medical plan or other coverage, like deductibles and co-pays.

You can use the Dependent Day Care FSA to cover dependent day care expenses that allow you – or you and your spouse – to work. You may not use the Dependent Day Care FSA if your spouse is not working, unless he or she is incapacitated or a full-time student.

### How much may I contribute?

You may contribute up to \$2,750 per year (\$105.76 per paycheck) to the Health Care FSA and Limited FSA, and \$5,000 a year (\$192.31 per paycheck) to the Dependent Day Care FSA. If you are not married or if you and your spouse file separate tax returns, the limit for the Dependent Day Care FSA is \$2,500 per year (\$96.15 per paycheck).

### How do I use the spending accounts to cover my expenses?

There are several ways to use your flexible spending account for covered expenses:

- Use your HealthEquity Healthcare Visa® debit card
- Use your smartphone or mobile device
- Pay online
- Pay the charges and file a claim online

You automatically receive a Visa debit card with the new enrollment. Your previous card will be loaded with the new year contribution. When you use the card, the amount of covered expenses is automatically deducted from your spending account. However, you may be requested to send supporting documentation to HealthEquity afterward. You will receive instructions with your debit card.

### What if I Do Not Use All of the Money in My Spending Account(s)?

IRS tax rules specify that you may carry over up to \$550 into 2021 to be used for eligible Health Care FSA expenses incurred 1/1/2021 - 12/31/2021. If your remaining balance exceeds \$550, the portion that exceeds \$550 will be forfeited. For example, assume you have \$800 remaining in your Health Care FSA as of 12/31/2020. You can elect to contribute to the Health Care FSA for 2021 and your total Health Care FSA balance at the beginning of the year will be a \$550 carryover. In this example, you will forfeit \$250 (\$800 balance less \$550 carryover). So, plan carefully before deciding how much you want to contribute.

If your employment with Baptist Health ends, you may submit claims for services you received before your employment ended.

**You have 90 days after your employment ends to submit these claims. Claims must be incurred prior to term date.**

Contributions to Flexible Spending Account
<b>Healthcare and Limited Flexible Spending Accounts:</b> Maximum per year of \$2,750, or \$105.76 per paycheck
<b>Carryover Provision:</b> You may carry over up to \$550 of your Health Care FSA balance remaining at the end of the year.
<b>Dependent Day Care Flexible Spending Account:</b> Maximum of \$5,000 per year, or \$192.31 per paycheck
<b>If you are not married or if you and your spouse file separate tax returns,</b> the limit for the Dependent Day Care FSA is \$2,500 per year (\$96.15 per paycheck).



Scan QR code for more information about HealthEquity coverage on the Virtual Benefits Fair.

## Administered by HealthEquity

### What is an HSA?

An HSA is a tax-advantaged account that can be used to pay for current and future medical expenses. An HSA works with an HDHP, and allows you to use pre-tax dollars to pay your provider or reimburse yourself for your eligible out-of-pocket medical expenses for you, your spouse, and your dependents, which in turn saves you tax dollars and increases your spendable income.

#### You may only open or contribute to an HSA when you elect an HDHP that meets the following guidelines:

- Annual deductible of at least \$1,400 (single) or \$2,800 (family)
- Annual out-of-pocket expenses (deductibles, co-pays, and other amounts, not premiums) not exceeding \$6,900 (single) or \$13,800 (family)

Your maximum annual contribution to an HSA in a calendar year is determined by several factors, including: the maximum annual contribution limit set by the IRS (subject to cost-of-living adjustments), the type of coverage you elect (single or family), and your age.

HSA contribution limits for 2021		
The "combined" annual maximum contribution amount between employee and employer cannot exceed the 2021 IRS limit for Single/Family.		
	Single	Family
Under 55 years old	\$3,600	\$7,200
55 -64 years old	\$4,600	\$8,200

### HSA Enrollment

Baptist Health employees have to open an account through the HR portal or through the HealthEquity website. After providing all information requested in the required fields, the account will open automatically, if the employee meets requirements.

Once the account is initiated for activation, the Customer Identification Program (CIP) process will begin:

- The facilitating custodian, HealthEquity, will verify certain identifying information per USA PATRIOT ACT regulation for each person who opens an account.
- If additional information is required, the participant will receive a letter in the mail requesting the information needed. If response is not provided by the participant within 90 days, or the identity of the participant cannot be verified, the account will be redeemed and closed.

### How does an HSA work?

When you enroll in the HDHP and elect an HSA, an account will be created for you through HealthEquity. You will be given access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts, and submit requests for reimbursements.

#### Benefits to You:

- An HSA is your account. Funds in your HSA stay with you, even if you change jobs.
- HSA balances roll forward each year.
- You contribute to the HSA tax-free. An HSA reduces your taxable income. The money is tax-free both when you deposit it and when you take it out to cover qualified medical expenses.
- The money you spend for eligible expenses is tax-free.
- Your funds grow tax-free. An HSA grows with you. If you maintain a minimum balance of \$2,000, your additional funds may be invested in mutual funds yielding tax-free earnings.
- Until you turn 65, withdrawals you use for non-eligible expenses will be taxed at your regular income tax rate, plus an additional 20% penalty will apply. Once you are age 65, withdrawals for non-eligible expenses are taxed at your regular income tax rate, but no additional penalty will apply.

## FOR ADDITIONAL INFORMATION

Please call HealthEquity at 877.924.3967 – representatives are available 24/7 to assist you – or visit [www.healthequity.com](http://www.healthequity.com).



## Administered by HealthEquity

### HSA Eligibility Guidelines

To be eligible to make contributions to an HSA, you must satisfy the following conditions established by law.

	If "Yes"	If "No"
1. Can you be claimed as a dependent on another person's tax return?	You are not eligible for an HSA.	Proceed to question #2.
2. Are you enrolled in Medicare?	You are not eligible for an HSA.	Proceed to question #3.
3. Are you enrolled in a qualified high-deductible health plan (HDHP) with a minimum annual deductible of at least \$1,400 for single coverage and \$2,800 for family coverage?	Proceed to question #4.	You are not eligible for an HSA.
4. Do you or family members covered under the HDHP have additional health coverage under another plan?	Proceed to question #5.	Proceed to question #6.
5. If you answered yes to question #4, is this other health coverage an HDHP?	Proceed to question #6.	You are not eligible for an HSA.
6. Do you or family members covered under the HDHP currently participate in a tax-deferred health care Flexible Spending Account (FSA)?	You are not eligible for an HSA.	You are eligible for an HSA. Proceed to calculate your annual contributions.

### Are you eligible for an HSA?

You must be covered under an HDHP to qualify for an HSA. The provider of your health plan should be able to tell you if the plan satisfies HDHP requirements. See the Frequently Asked Questions section for more details on eligibility.

### How much money could you save?

Because they are not included in your take-home pay, all HSA contributions are free from federal, state, local, and FICA taxes. Here's an example of how your HSA can save you a significant amount of money each year.

This example is based on a single tax filing for the annual income listed.

	With HSA	Without HSA
Annual income	\$50,000	\$50,000
Pre-tax contribution to HSA	\$3,000	\$0
Taxable income	\$47,000	\$50,000
Estimated taxes (22%)	\$10,340	\$11,000
After-tax expenses	\$0	\$3,000
Take-home income	\$36,660	\$36,000
<b>Tax savings</b>	<b>\$660</b>	<b>\$0</b>

Baptist Health will contribute a per-pay contribution prorated annually, \$500 (\$19.23 per pay) for single coverage or \$1,000 (\$38.46 per pay) annually for dependent coverage in the HDHP plan for 2021. For those with base annual pay of less than \$50,000, Baptist Health will contribute on a per-pay basis, \$700 (\$26.92 per pay) annually for single coverage or \$1,200 (\$46.15 per pay) annually for dependent coverage in the HDHP for 2021.

# Preventive Health Services



**BENEFITS**  
CENTERED ON YOU

## Administered by Anthem

SERVICES	FREQUENCY	REDUCTION	AGE REQUIREMENT
Alcohol & Drug Misuse Screening, Assessment & Counseling	1 Per Year		
Aortic Aneurysm Screening, Abdominal Ultrasound	Once	Male	65 to 75 years
Aspirin to Prevent Cardiovascular Disease			Men age 45 to 79, women age 55 to 79
Autism Spectrum Disorder Screening		Young Children	18 and 24 months
Behavioral Assessments		Children	Younger than 18 years
Blood Pressure Screening			
Breast & Ovarian Cancer Susceptibility, Genetic Risk Assessment & BRCA Counseling & Evaluation	1 Per Lifetime	Female with family history of increased risk of the BRCA 1 or 2 gene mutation; Prior Authorization Required	
Breast Cancer Chemoprevention Counseling		Female at increased risk	
Breast Cancer Screening, Mammography	1 Per Year		35 years & older
Breastfeeding Support, Certain Supplies & Counseling including a \$225 allowance for breastfeeding equipment rentals or purchases, upon receipt. Certain supplies for breastfeeding equipment will be reimbursed at cost when receipt is submitted.	With Each Birth		18 years & older
Cholesterol/Lipid Screening	1 Per Year		
Colorectal Cancer Screening: Colonoscopy, Flexible Sigmoidoscopy, Digital Rectal Exam, Air Contrast Barium Enema, CT Colonography (requires prior authorization), Guaiac Fecal Occult Blood Test (gFOBT), or Fecal Immunochemical Test (FIT)	1 Per Year		50 years & older (or less than 50 years of age if at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society)
Contraceptive Methods (FDA Approved) and Counseling including: Diaphragm with Spermicide; Generic Oral Contraceptives; Hormonal Patch, Vaginal Ring, and Injection; Implanted Devices; and Sterilization Procedures		Female	18 years & older
Dental Carries Chemical Prevention: Oral Fluoride Supplementation			6 months up to 5 years
Depression Screening	1 Per Year		10 years & older
Developmental Screening	1 Per Year		Younger than 3 years
Diabetes Screening (Type II)		Asymptomatic adults with sustained blood pressure greater than 135/80	
Falls Prevention in Older Adults: Counseling and Preventive Medication		Exercise or physical therapy and vitamin D medication to prevent falls in a community dwelling	
Folic Acid Supplementation (0.4 - 0.8mg Per Day)		Females planning or capable of pregnancy	
Gynecological Exam, Including Cervical Cytology (PAP test)	1 Per Year	Female	Per current American Cancer Society recommendations
Healthy Diet and Physical Activity Counseling	1 Per Year	Adult patients with hyperlipidemia or other known risk factors for cardiovascular & diet-related chronic disease	

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## Administered by Anthem

SERVICES	FREQUENCY	REDUCTION	AGE REQUIREMENT
Hematocrit or Hemoglobin Screening		Children	1 to 4 years
Hepatitis B Virus Infection Screening		Persons at high risk of infection	
Hepatitis C Virus Infection Screening		Persons at high risk of infection	One time screening for persons born between 1945 and 1965
Human Immunodeficiency Virus (HIV) Infection Screening & Counseling			15 - 65 years and other ages at increased risk of infection
Human Papillomavirus (HPV) DNA Testing	Every 3 Years	Female	30 years & older
Intimate Partner Violence Screening & Counseling	1 Per Year		
Iron Supplementation		Infants	6 to 12 months at increased risk of anemia
Lead Screening	1 Per Year	Children at risk of exposure	Younger than 18 years
Lung Cancer Screening with low-dose computed tomography	1 Per Year	Prior Authorization Required	55 to 80 years who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years
Newborn & Infant Office Visits including Height, Weight and Body Mass Index (BMI) measurements	Per MD		0 to 24 months
Newborns: Screening for Hearing Loss, Hemoglobinopathies, Hypothyroidism, PKU, Sickle Cell Disease, Prophylactic Ocular Gonococcal Medication			Newborns
Obesity Screening & Counseling	1 Per Year		6 years & older
Osteoporosis Screening (Bone Density Study)	1 Per Year	Female	60 years & older
Pregnancy: Screening for Bacteriuria, Chlamydia, Folic Acid Supplementation, Gestational Diabetes, Hepatitis B, HIV, Iron Deficiency Anemia, Rh Incompatibility, Syphilis & Tobacco Use Counseling		Female	
Prostate Exam	1 Per Year	Male	50 years & older
Prostate Specific Antigen Test (PSA)	1 Per Year	Male	50 years & older
Routine Office Visits	1 Per Year		
Sexually Transmitted Disease (STD) Counseling & Screening Including Chlamydia, Gonorrhea, Syphilis	1 Per Year	Increased risk of STD	
Sun Exposure & Risk for Skin Cancer Counseling			10 to 24 years
Syphilis		Persons at high risk of infection	
Tobacco Use Screening, Counseling & Interventions	1 Per Year		5 years & older
Tuberculin Testing		Children at increased risk	Younger than 18 years
Visual Acuity Screening	1 Per Year		Younger than 18 years
Well Child Office Visits including Height, Weight and Body Mass Index (BMI) Measurements	1 Per Year	Children	24 months to 18 years
Well Woman Office Visits	1 Per Year	Female	

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## Administered by Anthem

SERVICES	AGE REQUIREMENT
Immunizations/Vaccines	
Diphtheria, Tetanus, Pertussis (DTaP)	Minimum age 6 weeks
Haemophilus Influenza Type B (HIB)	Minimum age 6 weeks
Hepatitis A	Minimum age 12 months
Hepatitis B	
Human Papillomavirus (HPV)	9 to 26 years
Influenza	Minimum age 6 months for trivalent inactivated influenza vaccine (TIV); 2
Meningococcal	6 weeks Hib-MenCY; 9 months Menactra; 2 years & older Menveo
Measles, Mumps, Rubella (MMR)	Minimum age 12 months
Pneumococcal	Minimum age 6 weeks for pneumococcal conjugate vaccine (PCV); 2 years
Polio Vaccine, Inactivated (IPV)	Minimum age 6 weeks
Rotavirus	First dose to be given between 6 weeks & 14 weeks 6 days of age
Tetanus	19 years & older
Varicella	Minimum age 12 months
Zoster	60 years & older

### Preventive Plan

All employees, including PRN and temporary, are eligible.

This plan **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunizations and routine health screenings. It does not cover conditions caused by accidents or illnesses. This plan satisfies the federal healthcare reform Individual Mandate.

	Total Rate	Employee Contribution	Employer Contribution
Employee	\$9.18	\$8.26	\$0.92
Employee + Spouse	\$19.28	\$17.35	\$1.93
Employee + Children	\$16.52	\$14.87	\$1.65
Family	\$26.62	\$23.96	\$2.66

Preventive Health Services	
Well Child Exams	Covered in Full (not subject to deductible)
Well Adult Exams	
Prescription Drugs	
Pharmacy Benefits provided through MedImpact 844.513.6008	
Lifetime Maximum Benefit	
The Lifetime Maximum Benefit available under this plan is Unlimited.	

The list of Covered Preventive Services includes A and B Recommendations from the U.S. Preventive Services Task Force (USPSTF) provided at <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations> and other Preventive Services found on [www.healthcare.gov](http://www.healthcare.gov) as required by the Affordable Care Act. Baptist Health may add or remove services based on recommendations of the most current medical literature, the USPSTF and [www.healthcare.gov](http://www.healthcare.gov).

Adolescent & childhood immunizations are covered per 2014 recommended age-appropriate immunization schedules approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Practice, [www.healthcare.gov](http://www.healthcare.gov) and the U.S. Department of Health & Human Services Centers for Disease Control & Prevention.

**Lifetime Maximum Benefit:** The Lifetime Maximum Benefit available under this plan is Unlimited.

**Dependent Eligibility-** An individual must be either: the lawful spouse of the participant or a dependent child of the participant who is under the age of twenty-six (26) years. Eligibility for coverage for a participant's dependent child is not based on financial dependency, residency, student status, marital status, or employment. A "child" for purposes of dependent eligibility means a participant's newborn, minor or young adult child under the age of twenty-six (26), and includes a natural-born child, a step-child, a child legally placed for adoption, a legally adopted child, a child for whom legal guardianship has been awarded, or a child for whom the participant has a legal obligation under a divorce decree or other court order, including a qualified medical child support order, to provide health care coverage. A participant required by a court or administrative order to provide health coverage for a child must submit proof of such order at the time application for the child is made in accordance with the requirements for Qualified Medical Child Support Orders (QMCSO) provided in the General Provisions section of this SPD. A participant's temporary custody of a child is not sufficient to establish dependent eligibility under this Plan. Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

**Certificate Year-** Plan benefits are based on each successive 12-month period starting on the Effective Date of the Administrative Services Agreement.

**Retail Clinics** are health care clinics located in retail stores, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventive health care services. They are sometimes referred to as "convenient care clinics" or "retail-based clinics." These clinics are usually staffed by nurse practitioners (NPs) or physician assistants (PAs) but some are staffed by physicians. Retail clinics are covered at the primary care physician (PCP) benefit level.

Please review all limits carefully, as we will not pay benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

The Summary of Benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Summary Plan Description and Summary of Benefits. In the event of a conflict between the Summary Plan Description and this description, the terms of the Summary Plan Description will prevail.

## Administered by MedImpact

The list of ACA preventive medications that the Plan covers at 100% is subject to change. You can find out if a medication is an ACA preventive prescription drug by calling Member Help at 844.513.6008.

Or you can log onto [mp.medimpact.com/phi](https://mp.medimpact.com/phi), select “Drug Price Check,” and enter the name of the prescription drug to find out your share of the cost.

Specified preventive prescription drugs are covered by the plan at 100% for all of the plan’s options with a prescription from the member’s physician.

These ACA preventive medications currently include the following:

- Generic prescription drug contraceptives, diaphragms, cervical caps, and Nonoxynol 9 for female covered persons.
- Generic breast cancer risk-reducing prescription drugs for female covered persons with no prior diagnosis of breast cancer.
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription drug and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without Prior Authorization. This benefit is provided for up to two tobacco cessation attempts per Plan Year. Quantity limits apply.
- Folic acid – for female members.
- Aspirin – for members age 45 years or older.
- Fluoride dental products – for members between 6 months of age and 6 years of age.
- Iron – for members between 6 and 12 months of age.



# Medical Expense Reimbursement Program (MERP)

Employees that are eligible for the medical plans offered by Baptist Health may consider MERP.

If your spouse has group medical coverage available from their employer, the MERP could be a good option for you! Under the MERP, you would elect to cover you and your family under your spouse's plan and the MERP would reimburse you for eligible medical care expenses and premium differences incurred under your employed spouse's group medical plan.

Co-pays, deductibles and co-insurance are reimbursed to you up to \$8,550 for "employee only" coverage or \$17,100 per year for employee + spouse, employee + children or family coverage. Allowed charges for services received at a Baptist Health facility are reimbursed at 100% while allowed charges for services received at a non-Baptist Health facility are reimbursed at 75%. If you are currently enrolled in a Baptist Health medical plan and choose to move to your spouse's employer-sponsored medical plan, you will be eligible to enroll in the MERP. Please note that special rules apply for those who may elect to participate in their spouse's plan if it is a high-deductible plan supported with either a health savings account (HSA) or a health reimbursement account (HRA). For more information on the MERP and eligibility qualifications, please refer to **HR Portal > Benefits** section.

## Who is eligible?

You are eligible if you are regularly scheduled to work at least 24 hours per week (.06 - 1.0 FTE), currently enrolled in a MERP or a Medical plan offered by Baptist Health and have group Medical and Prescription Drug Coverage available elsewhere (i.e., spouse's plan, or retiree benefits). The MERP does not apply to coverage elected through Medicare, TriCare Retiree, Individual Plans or a High Deductible Plan with an HSA.

## What does the plan cover?

The Medical Expense Reimbursement Program will be administered by Catilize Health and will cover the following:

- Reimbursement of co-pays, co-insurance, and deductibles up to a maximum of \$8,550 Single and \$17,100 Family.
- For Baptist facilities, you will be reimbursed 100% of co-pays, deductibles, and co-insurance, up to the maximum.
- At non-Baptist facilities, you will be reimbursed 75% of co-pays, deductibles, and co-insurance, up to the maximum.
- The MERP will reimburse you the difference between the monthly premium amount you would have paid under the Baptist Health Medical Enhanced PPO Plan in 2021 and the monthly premium amount your spouse will pay for coverage under their employer's plan.
- If you qualify for a reimbursement, you will receive it on your second paycheck each month.

## How does the plan work?

- Enroll in Spouse's employer-sponsored or retiree group medical plan.
- Waive coverage in the Baptist Health System Medical Plan.
- Enroll in MERP in Workday.

You will receive a MERP identification card that you will present in conjunction with your alternate health plan identification card at your doctor and hospital visits.

- NOTE: Certain pharmacies such as Walgreens, CVS and mail order do not take the MERP card so you will have to request reimbursement by filing a paper claim.
- NOTE: If you have a health flexible spending account (FSA), you may use it for eligible dental and vision expenses. You may only use your health FSA for medical expenses that are not reimbursed to you under the MERP. For example, if you receive care at a non-Baptist facility, you could use your FSA for 25% of expenses the MERP does not reimburse.

## Employee Protection

You may elect coverage into the Baptist Health employee health plan if your spouse experiences a qualified event, such as a family status change, loss of employment or their entitlement to group health plan coverage. You may also elect a health plan offered through Baptist Health during the next open enrollment period.

## QUESTIONS?

Contact Catilize Health at 877.872.4232 from 8:30AM-8PM EST.



Scan QR code for more information about MERP coverage on the Virtual Benefits Fair.





## Powered by Magellan

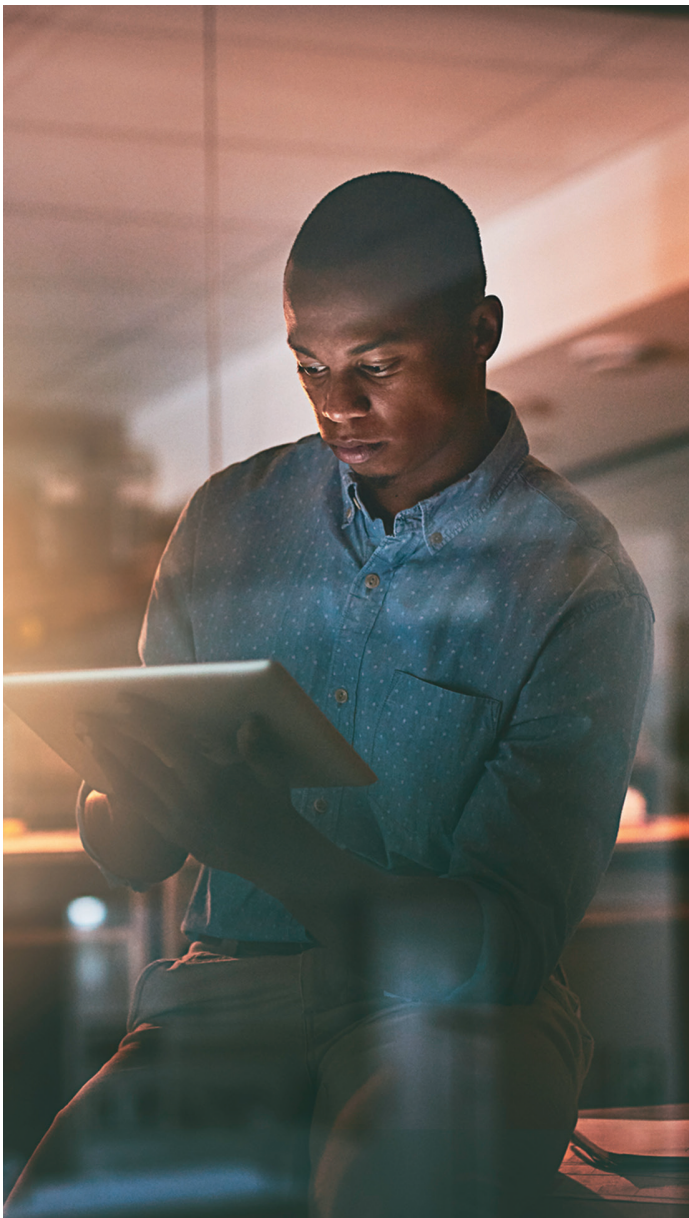
### Online Resources

Baptist Health EAP offers an interactive Web service that provides 24-hour access to an extensive library of nationwide Work Life resources and interactive tools.

Contact us 24 hours a day at 800.327.7354.

TDD# for the hearing impaired 800.456.4006.

Access online resources/services by registering at [magellanascend.com](https://magellanascend.com).



### Confidential Counseling

Our short-term counseling services can help you find solutions to problems ranging from family or workplace frustrations to alcohol or drug abuse. Our professional master's level clinicians define the problem, provide support, and offer guidance and referrals. Baptist Health EAP offers up to 5 confidential counseling sessions for you or anyone living in your home. Contact Magellan EAP for more information or to schedule a session.

### Web-Based Confidential Care

Magellan offers online cognitive behavioral therapy programs that are an enhancement to traditional telephonic and face-to-face care. The self-guided programs cover several areas, including; depression, substance use, anxiety, insomnia and obsessive compulsive disorder.

### Legal Services

Baptist Health EAP offers a free 60-minute consultation with an in-network attorney and a 25% discount off the attorney's hourly rate if you choose to retain that attorney. Access to wills, advance directives and other legal documents are available on our website at [magellanascend.com](https://magellanascend.com).

### Financial Services

Employees and their household members can speak with a financial professional at no charge regarding such issues as retirement planning, debt consolidation, funding a child's college education, mortgage loan options and a variety of other financial concerns. Callers receive up to 60 minutes of telephonic consultation per issue. Financial information, tools and calculators are available on our website at [magellanascend.com](https://magellanascend.com).

### Work Life Referral Services

Our Work Life consultants will assess your needs, pinpoint appropriate resources, and suggest guidelines for evaluating those resources. We will also follow up to ensure your satisfaction with our service. Our consultants can locate resources in a variety of areas, including: child care, elder care, educational information, health and wellness, pet services, and daily living services.



Scan QR code for more information about Magellan coverage on the Virtual Benefits Fair.



## Administered by Delta Dental

All plans are administered by Delta Dental. We offer two dental plans:

- Delta Dental PPO Plus Premier
- Delta Dental PPO

### Who is eligible?

You are eligible for dental coverage if you are regularly scheduled to work at least 24 hours per week. You can choose personal coverage (for yourself only), or coverage for you and your spouse, you and your children, or your whole family. Dependents may be covered until the end of the month in which they turn 26.

### Preventive Care

As part of the Baptist Health commitment to preventive care and wellness, the dental plans cover up to three regular cleanings per year. In addition, your preventive services will not track toward your annual maximum out of pocket.

### What does each plan cover?

#### Delta Dental PPO Plus Premier

This plan provides access to the Delta Dental Premier network, plus additional savings if you choose a PPO-participating dentist. This plan includes adult orthodontia (12-month waiting period).

#### Delta Dental PPO

This plan covers preventive and basic services only, and reduced benefits and potential balance billing (and increased out-of-pocket costs) will apply if you use a provider outside the network.

#### SPECIAL RULES FOR ORTHODONTIC COVERAGE AND MAJOR SERVICES

There is a 12-month waiting period for major services and orthodontic coverage, unless you have 12 months of continuous dental coverage prior to your effective date with Delta Dental. A Certificate of Credible Coverage from the prior carrier is required.

#### ENHANCED COVERAGE FOR HIGH-RISK CONDITIONS

Delta Dental provides enhanced coverage for plan members with certain high-risk medical conditions, including:

- Diabetes with gum disease
- Pregnancy and gum disease
- Persons at risk for infective endocarditis, a serious heart infection
- Kidney failure
- Weakened immune system (for example, due to chemotherapy, radiation therapy, or HIV)

Ask your dentist and/or doctor if you are in one of these high-risk categories.

## Administered by Delta Dental

The dental plan covers regular cleanings up to three times per year - and even more often for people with high-risk health conditions.

	DELTA DENTAL PPO PLUS PREMIER	DELTA DENTAL PPO	
	PPO or Premier Dentist	PPO Dentist	Premier Dentist
Deductible	\$50 Individual \$150 Family	\$50 Individual \$150 Family	\$50 Individual \$150 Family
<b>Diagnostic &amp; Preventive</b>			
Exams, cleanings, fluoride, and space maintainers	100%	100%	75%
Routine Cleanings (3 per calendar year)	100%	100%	75%
Emergency Palliative Treatment	100%	100%	75%
Sealants (up to age 16)	100%	100%	75%
Radiographs - X-rays	100%	100%	75%
<b>Basic Services</b>			
Minor Restorative Services - fillings and crown repair	80%	80%	60%
Endodontic Services - root canals	80%	80%	60%
Periodontic Services - to treat gum disease	80%	80%	60%
Oral Surgery Services - extractions and dental surgery	80%	80%	60%
<b>Major Services</b>			
Major Restorative Services - crowns	50%	0%	0%
Prosthodontic Services - bridges and dentures	50%	0%	0%
Relines and Rebase - to dentures	50%	0%	0%
Fixed Prosthodontic Repair - to bridges	50%	0%	0%
Implants	50%	0%	0%
<b>Orthodontia Services</b>			
Orthodontic Services (Braces) No Age Limit	50% up to \$2,500 Lifetime Max	0%	0%
Annual Maximum (not including Preventive Care)	\$2,500	\$2,500	
Waiting Period	12 months on major and ortho services	none	
<b>Cost Per Pay Period</b>			
Employee Only	\$13.68	\$7.36	
Employee + Spouse	\$29.40	\$17.98	
Employee + Children	\$26.65	\$18.22	
Family	\$46.68	\$28.51	



Scan QR code for more information about Dental coverage on the Virtual Benefits Fair.



## Administered by EyeMed

### Who is eligible?

You are eligible for vision coverage if you are regularly scheduled to work at least 24 hours per week. Dependents are covered until the end of the month in which they turn 26.

### What does each plan cover?

#### Enhanced

The Enhanced plan includes all of the benefits of the Essential plan (e.g., a comprehensive eye exam and one pair of glasses), plus it gives you a greater allowance for frames and lenses or contacts.

#### Essential

The Essential plan covers the basics of healthy vision, including a comprehensive eye exam and benefits for a basic pair of prescription glasses or contact lenses.

### How does the plan work?

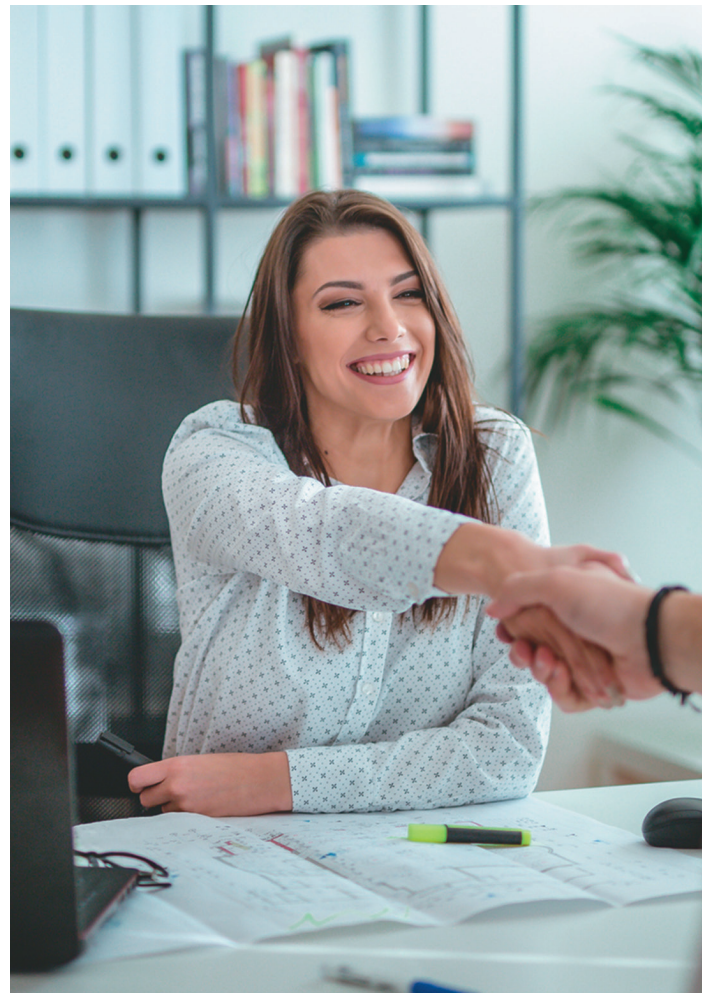
When you enroll in the EyeMed plan, you will receive an ID card to use whenever you receive covered services.

### What to Do When You Need Covered Vision Care

1. You can find a network eye doctor in your area from the provider list located under Provider Links in the HR Portal on BEN
2. Select Insight Network, then the EyeMed directory
3. Call for an appointment and identify yourself as an EyeMed member
4. Show your ID card when you visit; you'll pay any required co-pays at that time

### All plans administered by EyeMed. There are two plans being offered:

- An Enhanced plan with higher benefit allowances
- An Essential plan with lower payroll contributions



## Administered by EyeMed

	ENHANCED	ESSENTIAL
Service	Member Cost	Member Cost
Exam with Dilation as Necessary	\$0 Copay	\$10 Copay
Exam Options:		
Standard Contact Lens Fit and Follow-Up	\$0 Copay, Paid-in-full fit and two follow-up visits	Up to \$55
Premium Contact Lens Fit and Follow-Up	\$0 Copay, 10% off retail prices, then apply \$55 allowance	10% off Retail Price
Frames:		
Any available frame at provider location	\$0 Copay; \$160 Allowance, 20% off balance over \$160	\$0 Copay; \$130 Allowance, 20% off balance over \$130
Standard Plastic Lenses (Every 12 months)		
Single Vision	\$10 Copay	\$10 Copay
Bifocal	\$10 Copay	\$10 Copay
Trifocal	\$10 Copay	\$10 Copay
Lenticular	\$10 Copay	\$10 Copay
Standard Progressive Lens	\$10 Copay	\$75
Lens Options:		
UV Treatment	\$0 Copay	\$15
Tint (Solid and Gradient)	\$0 Copay	\$15
Standard Plastic Scratch Coating	\$0 Copay	\$0 Copay
Standard Polycarbonate - Adults	\$0 Copay	\$40
Standard Polycarbonate - Kids under 19	\$0 Copay	\$0 Copay
Standard Anti-Reflective Coating	\$0 Copay	\$40
Polarized	20% off retail price	20% off retail price
Photocromatic/Transitions Plastic	\$75	\$75
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	\$0 Copay; \$160 allowance, 15% off balance over \$160	\$0 Copay; \$130 allowance, 15% off balance over \$130
Disposable	\$0 Copay; \$160 allowance, plus balance over \$160	\$0 Copay; \$130 allowance, plus balance over \$130
Medically Necessary	\$0 Copay, Paid-in-Full	\$0 Copay, Paid-in-Full
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network owned and operated by LCA Vision	15% off Retail Price or 5% off promotional price	15% off Retail Price or 5% off promotional price
Additional Pairs Benefit:		
Eyeglasses	Members also receive a 40% discount off complete pair eyeglass purchases	Members also receive a 40% discount off complete pair eyeglass purchases
Frequency		
Examination	12 Months	12 Months
Frame	12 Months	24 Months
Lenses or Contacts	12 Months	12 Months
Cost Per Pay Period (26)		
Employee Only	\$6.54	\$2.19
Employee + Spouse	\$10.85	\$3.63
Employee + Children	\$12.63	\$4.22
Family	\$16.93	\$5.66



Scan QR code for more information about Vision coverage on the Virtual Benefits Fair.



## Administered by Reliance Standard

### Who is eligible?

You are eligible for life insurance coverage if you are an active, regular employee scheduled to work at least four hours a week. Temporary and PRN (pro re nata or “as needed”) employees are not eligible.

### Basic Employee Life & AD&D Insurance

Baptist Health provides every eligible employee with basic life and accidental death & dismemberment (AD&D) insurance coverage. Employees may purchase supplemental life coverage.

Along with protection for your family if you die, the AD&D portion of this coverage provides additional benefits if you die as a result of a covered accident. This accidental death benefit will be in the same amount as the life insurance benefit. Benefits are also paid if you suffer loss of sight or a limb as a result of a covered accident.

### Supplemental Employee Life Insurance

During Open Enrollment only, you may increase your supplemental coverage by \$100,000/year. For example, if you did not choose extra coverage when you were first hired, you may choose additional life insurance in \$10,000 increments – up to a maximum of \$100,000 per year – during Open Enrollment. Your total life insurance for yourself (basic and supplemental combined) may not be more than \$850,000.

### Spouse Life Insurance

You may purchase life insurance for your spouse in increments of \$20,000 (e.g., \$20,000, \$40,000, \$60,000) up to a maximum of \$100,000. Spousal coverage may be added up to one \$20,000 increment during open enrollment for eligible employees.

**If both you and your spouse are Baptist Health employees, you are not eligible for double coverage.**

### Benefit Reductions Starting at Age 70

Basic Life, Supplemental Employee and Spouse Life Insurance amounts are reduced if you are still actively at work when you reach age 70 or older. The reductions are as follows:

- Age 70 - 65% of original amount (coverage is reduced by 35%)
- Age 75 - 50% of original amount (coverage is reduced by half)

**For example, if you turn 71 and your spouse is 58, both your benefits will be reduced since premium is based on the employee’s age. If your spouse should die, you would receive a benefit equal to 65 percent of the original spouse life benefit.**

#### Options

##### Basic Life and AD&D Insurance

- Full-Time Employees: 1x your annual earnings
- Part-Time Employees: \$10,000

##### Supplemental Employee Life and AD&D Insurance

- Full-Time Employees: Increments of \$10,000 (\$10,000, \$20,000...) up to \$100,000 per year to maximum of \$500,000  
Cost: See chart on next page – based on employee’s age at the time of pay period
- Part-Time Employees: \$10,000  
Cost: See chart on next page – based on employee’s age at the time of pay period

##### Spouse Life Insurance

- Full-Time Employees: Increments of \$20,000 up to \$100,000  
Cost: See chart on next page – based on employee’s age at the time of pay period
- Part-Time Employees: \$10,000

**Rounded UP to nearest \$500**

**Maximum combined employee coverage (basic and supplemental) may not exceed \$850,000**

## Administered by Reliance Standard

### Dependent child life insurance

You may purchase \$10,000 of life insurance coverage for your dependent children up to age 26. (Coverage is \$500 for children from live birth to six months. There is no coverage for stillbirths). The cost for this coverage is \$1.02 per pay period, no matter how many eligible children you have.

### Supplemental life insurance

The chart below shows the post-tax cost per pay period of supplemental life insurance for both full-time and part-time employees.

Full-Time Employees Supplemental Life & Spouse Life		Part-Time Employees Supplemental Life	
Rate per \$1,000 of coverage per 26 pay periods		Flat cost for \$10,000 per 26 pay period	
Age	Cost	Age	Cost
< 35	\$0.037	< 35	\$0.369
35 - 39	\$0.046	35 - 39	\$0.425
40 - 44	\$0.055	40 - 44	\$0.054
45 - 49	\$0.102	45 - 49	\$0.978
50 - 54	\$0.148	50 - 54	\$1.477
55 - 59	\$0.240	55 - 59	\$2.400
60 - 64	\$0.258	60 - 64	\$2.585
65 - 69	\$0.415	65 - 69	\$4.154
70 - 74	\$0.812	70 - 74	\$8.086

*Please note: Cost per pay will be calculated based on your age at the time of the pay period deduction. Your cost per pay could change if your birthday (during the plan year) moves you into a new age-band. Please see above for examples.*

### Supplemental Employee Life Insurance Example:

Beth is a 49-year-old full-time employee who elects \$50,000 of supplemental coverage. Her cost per \$1,000 is \$0.102, so her cost per pay period is \$5.10 ( $50 \times \$0.102 = \$5.10$ ). Beth turns 50 in May, which moves her into a new age-band and changes her rate per \$1,000 to \$0.148. Her new cost per pay is \$7.40 ( $50 \times \$0.148 = \$7.40$ ).

John is a 45-year-old full-time employee who elects \$50,000 of supplemental coverage. His cost per \$1,000 is \$0.102, so his cost per pay period is \$5.10 ( $50 \times \$0.102 = \$5.10$ ). John turns 46 in October, which does not move him into a new age-band. His cost per pay continues to be \$5.10.

### Spouse Life Insurance Example:

Dave is a 36-year-old full-time employee. He chooses \$40,000 of spouse life coverage for his wife, Leslie. The cost of Leslie's coverage is based on Dave's age, so the cost per \$1,000 of coverage for Leslie is \$0.046, and the total cost per pay period for her coverage is \$1.84 ( $40 \times \$0.046 = \$1.84$ ). Dave turns 37 in September, which does not move him into a new rate band. His cost per pay for Leslie continues to be \$1.84.



Scan QR code for more information about Reliance Standard Life Insurance coverage on the Virtual Benefits Fair.

# Long-Term Disability (LTD)

## Administered by Reliance Standard

### Who is eligible?

You are eligible to participate in the LTD plan if you are an active employee scheduled to work at least 32 hours per week. There is no medical underwriting requirement.

### How does the plan work?

Benefits begin after you've been totally disabled for 90 days.

Benefit: 50 percent of covered monthly earnings – up to a maximum benefit of \$4,000 per month – for regularly scheduled to work, full-time employees. If your benefits from other sources equal 50 percent or more of your regular monthly earnings, you will receive a minimum benefit from the plan of 10 percent or \$100 per month.

**You have the option to purchase additional Long-Term Disability coverage. The buy-up option is 60 percent of covered monthly earnings – up to a maximum benefit of \$6,000 per month.**

### LTD Example:

#### Baptist Health-Provided Benefit

Your annual earnings:  
\$30,000

Divide by 12 for monthly earnings:  
\$2,500

Multiply monthly earnings x 50%:  
\$1,250 (monthly benefit)

### LTD Buy-Up Example:

Your annual earnings:  
\$30,000

Divide by 12 for monthly earnings:  
\$2,500

Multiply monthly earnings x 60%:  
\$1,500 (monthly benefit)





## Administered by Reliance Standard

Short-Term Disability Rate Chart	
Age	Cost (26 pay)
< 30	\$0.426
30 - 34	\$0.450
35 - 39	\$0.350
40 - 44	\$0.223
45 - 49	\$0.208
50 - 54	\$0.300
55 - 59	\$0.325
60 - 64	\$0.508
65 +	\$0.684

To apply for STD benefits, an employee must fulfill the minimum waiting period of seven (7) calendar days before becoming eligible. Exhaustion of accrued time off (e.g., PTO and/or EIB) is not required in order to receive STD benefit coverage.

**PLEASE NOTE:** Cost per pay will be calculated based on your age at the time of the pay period deduction. Your post-tax cost per pay could change if your birthday (during the plan year) moves you into a new age band. Please see above for examples.

### Who is eligible?

You are eligible to participate in the STD plan if you are a regular employee scheduled to work at least 32 hours per week.

### How does the STD plan work?

STD benefits begin on the eighth day of an absence due to injury or illness that occurs while you are off duty. If you are eligible and choose to participate, the STD program provides a 50% of earnings benefit, not to exceed \$1,500 per week.

You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation if:

1. The disability begins in the first twelve (12) months after your effective date; AND
2. You have received medical treatment or consultation (including pregnancy), during the three (3) months immediately prior to your effective date of insurance. The time you had coverage under the prior carrier's program counts toward satisfying this requirement.

STD benefits may be paid up to 12 weeks, at which time you become eligible for Long-Term Disability (LTD) benefits. The actual length of time for which benefits are paid must be approved by the plan. For example, absences for maternity are covered up to six weeks for a normal delivery or eight weeks for a caesarean section.

If you take FMLA leave for maternity, STD benefits will cover only the medically necessary portion of the leave, not the entire 12-week FMLA period.

The cost of STD coverage is based on employee's age and weekly benefit. To determine cost:

1. Calculate weekly benefit:  $\text{annual salary} \div 52 \text{ weeks} \times 50\% = \text{weekly benefit}$
2. Determine rate: See STD Rate Chart on the left
3. Calculate per pay cost:  $\text{weekly benefit} \div 10 \times \text{rate} = \text{cost per pay period}$



## Administered by Reliance Standard

### STD Example:

Matthew is a 34-year-old full-time employee with an annual salary of \$30,000. The cost of Matthew's STD coverage is based on his age and weekly benefit at the time of the pay period.

- First, determine his weekly benefit:  $\$30,000 \div 52 \text{ weeks} = \$576.92 \text{ per week} \times 50\% = \$288.46 \text{ weekly benefit}$ .  
Matthew's rate based on his age is \$0.450. So his cost per pay period will be \$12.98 ( $\$288.46 \div 10 \times \$0.450 = \$12.98$ )
- Matthew turns 35 in August, which moves him into a new age band and changes his rate to \$0.350. His new cost per pay is 10.09 ( $\$288.46/10 \times \$0.350 = \$10.09$ ).

Denise is a 40-year-old full-time employee with an annual salary of \$45,000. The cost of Denise's STD coverage is based on her age and weekly benefit at the time of the pay period.

- First, determine her weekly benefit:  $\$45,000 \div 52 \text{ weeks} = \$865.38 \text{ per week} \times 50\% = \$432.69 \text{ weekly benefit}$ .  
Denise's rate based on her age is \$0.223. So her cost per pay period will be \$9.64 ( $\$432.69 \div 10 \times \$0.223 = \$9.64$ ).
- Denise turns 41 in April, which does not move her into a new rate band. Her cost per pay continues to be \$9.64.

### STD Example - Pregnancy:

#### Example 1:

Jane went to her doctor on 10/15/2020 and found out she is pregnant and will be having a baby in 2021. Jane did not elect Voluntary Short Term Disability in 2020 and is considering enrolling in 2021. Will her pregnancy be covered?

- Jane's pregnancy in 2021 would not be covered as she was treated for that condition in 2020, prior to enrolling in the STD plan.
- Jane has a knee injury in 2021 which requires surgery, and she will be out due to this disability for her knee. Jane would be covered for this disability that occurred in 2021 as she had not been treated for that condition prior to her enrollment.

#### Example 2:

Mary enrolled in the STD plan effective 1/1/2020. In January of 2021, she has a doctor appointment and finds out she is pregnant and will be having a baby in 2021. Will her pregnancy be covered?

- Mary would be covered for the disability related to her pregnancy as she was enrolled in the plan and her condition and doctor visit occurred after her initial enrollment.

You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation if:

1. The disability begins in the first twelve (12) months after your effective date; AND
2. You have received medical treatment or consultation (including pregnancy), during the three (3) months immediately prior to your effective date of insurance.



## Administered by Unum

### Who is eligible?

You are eligible for Critical Illness plan through Unum if you are legally authorized to work in the United States and actively working a minimum of 24 hours per week at a U.S. location. Spouses ages 17 and up must reside in the United States to receive coverage. Dependent children, newborns to age 26, are automatically covered at no extra cost and their coverage is 50% of your amount.

### What is covered

The Critical Illness insurance policy can pay a lump-sum benefit at the diagnosis of a covered illness. It is not a substitute for a health benefit plan.

This plan pays a specified dollar amount if you are diagnosed with a covered condition. Benefit is paid as a lump sum that can be used for costly out-of-pocket expenses like co-pays, deductibles, child care and travel – or however you choose. No physical is required for eligibility; guaranteed issue is available for you and your spouse. Premiums are based on your age at policy issue and do not increase due to age.

#### Annual Wellness Benefit:

\$100 per calendar year per insured individual (Mammogram, Pap Smear, Blood Test for Triglycerides, Colonoscopy, EK, Stress Test on a bicycle or treadmill, Fasting Blood Glucose Test, Serum Cholesterol Test to determine HDL and LDL levels.)

A full list of covered tests will be provided in your certificate.

#### Recurrence Benefit:

You can receive an additional payment if you have a second occurrence of benign brain tumor, heart attack, coma or stroke - as long as 12 months have passed between the two diagnoses. Recurrent Benefit pays 100% of your coverage amount.

### Voluntary Critical Illness

CRITICAL ILLNESS BENEFITS*	Option 1	Option 2	Option 3
Heart Attack	\$10,000	\$20,000	\$30,000
Stroke	\$10,000	\$20,000	\$30,000
Coronary Artery Bypass Surgery	\$2,500	\$5,000	\$7,000
Major Organ Transplant	\$10,000	\$20,000	\$30,000
End Stage Renal Failure	\$10,000	\$20,000	\$30,000
Cancer	100%	100%	100%
Carcinoma in Situ	25%	25%	25%
Benign Brain Tumor	\$10,000	\$20,000	\$30,000
Coma as the result of Severe Traumatic Brain Injury	\$10,000	\$20,000	\$30,000
Blindness	\$10,000	\$20,000	\$30,000
Occupational HIV	\$10,000	\$20,000	\$30,000
Permanent Paralysis as the result of a Covered Accident	\$10,000	\$20,000	\$30,000

\*Insured employees are eligible for 100% of the benefit amounts listed; covered dependents are eligible for 50% of the employee benefit amount. Please refer to the policy for complete details about these covered conditions.

**To enroll in the Unum Critical Illness coverage, go to Workday> Benefits> Unum Voluntary Benefit Enrollment**

## Administered by Unum

### Critical Illness Rates

Post-tax premiums for the Critical Illness coverage are determined by your age and tobacco/non-tobacco use status. You may choose the coverage level that best covers you and your dependents. See the appropriate age rate and tobacco/non-tobacco status rates in the tables featured on the right.

With Cancer Employee Bi-Weekly Premium With Wellness based on Benefit Amounts		
\$10,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$3.21	\$4.41
25-29	\$3.21	\$4.41
30-34	\$3.21	\$4.41
35-39	\$6.44	\$10.55
40-44	\$6.44	\$10.55
45-49	\$6.44	\$10.55
50-54	\$12.76	\$21.71
55-59	\$12.76	\$21.71
60-64	\$20.05	\$32.10
65-69	\$26.24	\$39.39
70+	\$32.61	\$44.47
\$20,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$5.28	\$7.68
25-29	\$5.28	\$7.68
30-34	\$5.28	\$7.68
35-39	\$11.75	\$19.96
40-44	\$11.75	\$19.96
45-49	\$11.75	\$19.96
50-54	\$24.39	\$42.30
55-59	\$24.39	\$42.30
60-64	\$38.98	\$63.07
65-69	\$51.35	\$77.65
70+	\$64.08	\$87.81
\$30,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$7.36	\$10.96
25-29	\$7.36	\$10.96
30-34	\$7.36	\$10.96
35-39	\$17.05	\$29.38
40-44	\$17.05	\$29.38
45-49	\$17.05	\$29.38
50-54	\$36.02	\$62.88
55-59	\$36.02	\$62.88
60-64	\$57.90	\$94.04
65-69	\$76.45	\$115.91
70+	\$95.56	\$131.15

With Cancer Spouse Bi-Weekly Premium With Wellness based on Benefit Amounts		
\$5,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$2.17	\$2.77
25-29	\$2.17	\$2.77
30-34	\$2.17	\$2.77
35-39	\$3.78	\$5.84
40-44	\$3.78	\$5.84
45-49	\$3.78	\$5.84
50-54	\$6.95	\$11.42
55-59	\$6.95	\$11.42
60-64	\$10.59	\$16.61
65-69	\$13.68	\$20.26
70+	\$16.87	\$22.80
\$10,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$3.21	\$4.41
25-29	\$3.21	\$4.41
30-34	\$3.21	\$4.41
35-39	\$6.44	\$10.55
40-44	\$6.44	\$10.55
45-49	\$6.44	\$10.55
50-54	\$12.76	\$21.71
55-59	\$12.76	\$21.71
60-64	\$20.05	\$32.10
65-69	\$26.24	\$39.39
70+	\$32.61	\$44.47
\$15,000 Benefit Amount		
Issue Ages	Non-Tobacco	Tobacco
<25	\$4.25	\$6.05
25-29	\$4.25	\$6.05
30-34	\$4.25	\$6.05
35-39	\$9.09	\$15.25
40-44	\$9.09	\$15.25
45-49	\$9.09	\$15.25
50-54	\$18.58	\$32.01
55-59	\$18.58	\$32.01
60-64	\$29.51	\$47.58
65-69	\$38.79	\$58.52
70+	\$48.35	\$66.14



Scan QR code for more information about Unum coverage on the Virtual Benefits Fair.



## Administered by Unum

### Who is eligible?

You are eligible for the Accident plan if you are regularly scheduled to work at least 24 hours per week. You must be legally authorized to work in the United States and actively working at U.S. location to receive coverage. Spouses and dependent children from birth until their 26th birthday, regardless of marital or student status, must reside in the United States to receive coverage.

### What does the plan cover?

There are things that you or your family do daily that may lead to an accidental injury and unexpected expenses.

This coverage can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.

### How does the plan work?

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

### Accident Benefit Example

Child dislocates knee in athletic event (plan pays per incident)

Payout	Services
\$150	Physician Treatment
\$250	Emergency Room Treatment
\$300	Medical Imaging Test (MRI,MR,CT,CAT,EEG)
\$600	Physical Therapy (6 visits @ \$100.00)
\$300	Follow-up physician visits (2 visits @ \$150.00)
\$1,600	<b>Total Paid to Employee</b>

### Annual Wellness Benefit:

\$100 per calendar year per insured individual (Mammogram, Pap Smear, Blood Test for Triglycerides, Colonoscopy, EK, Stress Test on a bicycle or treadmill, Fasting Blood Glucose Test, Serum Cholesterol Test to determine HDL and LDL levels.)

A full list of covered tests will be provided in your certificate.

The UNUM Accident Policy is guarantee issue during initial enrollment period, or at annual open enrollment.

Learn more about UNUM's Accident Plan:  
[http://unum.mkt2189.com/vimeo/Accident\\_CTA\\_EN-1789.html](http://unum.mkt2189.com/vimeo/Accident_CTA_EN-1789.html)

Bi-Weekly Premium (includes Wellness)	
Employee Only	\$3.73
Employee + Spouse	\$6.46
Employee + Child	\$7.43
Employee, Spouse + Child	\$10.16

To enroll in the Unum Accident coverage, go to  
Workday> Benefits> Unum Voluntary Benefit Enrollment



Scan QR code for more information about Unum coverage on the Virtual Benefits Fair.

# Accident Plan continued



**BENEFITS**  
CENTERED ON YOU

Covered Injuries	Benefit Amount	Emergency and Hospitalization Benefits	Benefit Amount	Lodging (per night up to 30 days per accident)	\$150
<b>Fractures</b>		<b>Ambulance</b> (ground, once per accident)	\$400	<b>Rehabilitation unit confinement</b> (per day up to 15 days; max 30 days per calendar year)	\$100
Open reduction (dependent on location of injury)	\$150 to \$7,500	Air Ambulance	\$1,500	<b>Accidental death and other covered losses</b>	
Closed reduction (dependent on location of injury)	\$75 to \$3,750	<b>Emergency Room Treatment</b>	\$250	<b>Accidental Death*</b>	
Chips	25% of closed amount	<b>Emergency treatment in physician office/urgent care facility</b> Either ER room or Primary Care/Specialist/Urgent Care benefit is payable once per covered accident		Employee	\$50,000
<b>Dislocations</b>		Primary Care Physician	\$150	Spouse	\$20,000
Open Reduction (dependent on location of injury)	\$300 to \$6,000	Specialist	\$150	Child	\$10,000
Closed Reduction (dependent on location of injury)	\$150 to \$3,000	Urgent Care Facility	\$150	*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee- \$150,000; Spouse- \$60,000; Child- \$30,000	
<b>Burns</b>		<b>Hospital admission</b> (admission or intensive care admission once per covered accident)	\$2,000	<b>Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss</b>	
At least 10 square inches, but less than 20 square inches	2nd degree – \$0 3rd degree – \$2,500	<b>Intensive care admission</b> (same as above)	\$3,000	Loss of both hands or both feet; or	\$15,000
At least 20 square inches, but less than 35 square inches	2nd degree – \$0 3rd degree – \$5,000	<b>Hospital confinement</b> (per day up to 365 days)	\$400	Loss of one hand and one foot; or	\$15,000
35 or more square inches of the body surface	2nd degree – \$1,000 3rd degree – \$10,000	<b>Intensive care confinement</b> (per day up to 15 days)	\$800	Loss of one hand or one foot;	\$7,500
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit	<b>Medical imaging test</b> (once per accident)	\$300	Loss of two or more fingers, toes, or any combination; or	\$1,500
<b>Skin graft for any other accidental traumatic loss of skin</b>		<b>Outpatient surgery facility service</b> (once per accident)	\$100	Loss of one finger or toe	\$750
At least 10 square inches, but less than 20 square inches	\$150	<b>Pain management</b> (epidural, once per accident)	\$100	<b>Catastrophic Accident Dismemberment† - once per lifetime, not payable with catastrophic loss</b> Loss of both hands or both feet; or loss of one hand and one foot	
At least 20 square inches, but less than 35 square inches	\$250	<b>Treatment and Other Services</b>		Employee (prior to age 65)	\$100,000
35 or more square inches of the body surface	\$500	<b>Surgery Benefit</b>		Spouse and Child	\$50,000
<b>Concussion</b>		Open abdominal, thoracic	\$1,500	Employee (age 65-69)	\$50,000
<b>Coma</b>		Exploratory (without repair)	\$150	Spouse and Child	\$25,000
<b>Ruptured Disc</b>		<b>Hernia Repair</b>	\$150	Employee (70+ years old)	\$25,000
<b>Knee Cartilage</b>		<b>Physician Follow-Up Visit</b> (3 visits per accident)		Spouse and Child	\$12,500
Torn with surgical repair	\$750	Primary care physician	\$150	<b>Accidental loss — paralysis, sight, hearing and speech</b> Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Exploratory surgery or cartilage shaved, only	\$150	Specialist	\$150	Permanent paralysis; or	\$15,000
<b>Laceration</b>		Urgent care facility	\$150	Loss of sight of both eyes; or	\$15,000
<b>Tendon/ligament and rotator cuff</b>		<b>Chiropractic visit</b> (up to 3 visits per calendar year)	\$50	Loss of sight of one eye; or	\$7,500
Surgical repair of one	\$800	<b>Therapy Services</b> (up to 10 per accident)		Loss of hearing in one ear	\$7,500
Surgical repair of two or more	\$1,200	Occupational therapy	\$100	<b>Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment</b> Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Exploratory surgery without repair	\$150	Speech therapy	\$100	Employee (prior to age 65)	\$100,000
<b>Dental Work Emergency</b>		Physical therapy	\$100	Spouse and Child	\$50,000
Extraction	\$100	<b>Prosthetic device or artificial limb</b>		Employee (age 65-69)	\$50,000
Crown	\$300	One	\$750	Spouse and Child	\$25,000
<b>Eye Injury</b>		More than One	\$1,500	Employee (70+ years old)	\$25,000
		<b>Appliance</b> (once per accident)	\$100	Spouse and Child	\$12,500
		<b>Blood, plasma and platelets</b>	\$400	†Catastrophic accidental benefit — payable after fulfilling a 365 day elimination period.	
		<b>Travel due to accident</b> Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip	\$0.40 per mile		



## Administered by Unum

### Who is eligible?

You are eligible for the Hospital Indemnity plan through Unum if you are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 24 hours per week each week and you are performing the material and substantial duties of your regular occupation. Employee must purchase coverage for themselves in order to purchase spouse or child coverage.

### What is covered?

With the high costs of healthcare, one trip to the hospital could mean a substantial setback from the out-of-pocket costs that aren't covered by a standard medical plan. Hospital Indemnity helps covered employees and their families cope with financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

### Why is this coverage so valuable?

- Money is paid directly to you. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- The benefit is compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire.
- **The benefit provides enhanced hospital benefits of 100% when you use hospitals owned, operated or controlled by Baptist Health. This enhanced benefit applies to Hospital Admission, Hospital Daily Stay and Short Stay.**

### Annual BeWell Benefit:

\$50 each year per covered family member for getting a covered BeWell screening test.

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

Your Bi-Weekly Premium	
You	\$12.03
You and your spouse	\$21.43
You and your children	\$17.41
Family	\$26.81



Scan QR code for more information about Unum coverage on the Virtual Benefits Fair.

# Whole Life Insurance with Long-Term Rider Care

## Administered by Unum

### How does it work?

You can keep Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. The benefit amount stays the same, too — it doesn't decrease as you get older. That means you get protection during your working years and into retirement.

Whole Life Insurance also earns interest, or "cash value," at a guaranteed rate of 4.5%. You can borrow from that cash value, or you can buy a smaller, paid-up policy — with no more premiums due.

### What's included?

#### A "Living" Benefit

You can request an early payout of your policy's death benefit (up to \$150,000 maximum) if you're expected to live 12 months or less. It would reduce the benefit that's paid when you die.

#### Long-Term Care Rider

Long-Term Care Insurance will help protect your savings from being drained by this expensive care. Most important, this coverage allows you to use the benefit whether you receive care at home, or in a long-term care facility, an adult day care, or a nursing home.

#### Advantages of the Long-Term Care Rider

- For long-term care facility, nursing home care or assisted living facility, provides a benefit that is the lesser of:
  - 6% of the death benefit, less any policy debt at the end of the waiting period; your actual monthly expenses; or
  - \$3,000
- For home health care or adult day care, this benefit provides a maximum monthly benefit that is the lesser of:
  - 4% of the death benefit, less any policy debt at the end of the waiting period;
  - Your actual monthly expenses; or
  - \$1,500
- Benefits are payable once you have been receiving long-term care for 90 days.

### Why should I buy coverage now?

- It's more affordable when you're younger. Once you've bought coverage, your cost stays the same as long as you keep it.
- The cost is conveniently deducted from your paycheck.
- Whole life gives you valuable protection in addition to any term life insurance you might have. Term Life is like renting a house; employees use the protection for a set period of time.
- Whole Life is like owning a house; employees keep the benefit for a LIFETIME.
- This product complements your existing employer-paid group term life; valuable protection for your working years and benefits that carry into retirement.
- Term Life and Whole Life provide comprehensive LIFE INSURANCE.

### Who is eligible?

You are eligible for the Whole Life Policy if you are under the age of 80 years old. The Long-Term Care Rider is available up to age 70. You must be actively at work at the time of application and regularly scheduled to work at least 24 hours per week.

### Coverage options available

- Employee: \$10,000, \$25,000, \$50,000 or \$100,000
- Spouse: \$10,000 or \$25,000
- Children: \$10,000 or \$25,000
- Guarantee Issue coverage for Employee & Children
- Contingent Guarantee Issue Coverage for Spouse  
Within the past 12 months, has the spouse been admitted to a hospital or missed five or more consecutive days of work for any reason other than vacation, cold, flu, pregnancy, accidents, allergies, back or knee disorder?
- Premiums do not increase with age.
- Premium for the Whole Life policy is waived whenever the insured is receiving benefits under the base LTC Rider.

To enroll in the Unum Whole Life coverage, go to  
Workday> Benefits> Unum Voluntary Benefit Enrollment



Scan QR code for more information about Unum coverage on the Virtual Benefits Fair.



## Administered by Nationwide

### Who is eligible?

You are eligible to purchase Pet Insurance if you are regularly scheduled to work at least 24 hours every week.

### What do the plans cover?

All plans are administered by Nationwide Insurance. We offer two plans that you can pick from for your pet(s):

- **My Pet Protection with Wellness** – This plan covers accidents & injuries, illnesses, cancer, X-rays, surgery and hereditary coverage, along with wellness exams, vaccinations, spay/neuter and much more!
- **My Pet Protection** – This plan covers accidents & injuries, cancer, X-rays, surgery and hereditary coverage.

Both plans feature a \$250 annual deductible with a \$7,500 maximum annual benefit. For either plan, you can visit any licensed veterinarian, anywhere in the world!

### How do the plans work?

Depending on the plan selected, you're covered for virtually everything from everyday pet health care to unexpected veterinary bills – all starting at less than \$1 a day.

Nationwide offers medical and wellness plans for dogs, cats, birds, and exotic pets. They provide simple claim filing and convenient 24/7 online account access.

Members also have free, 24/7 access to a veterinary professional through Vet Helpline (a \$150 value!) for any pet question. Pre-existing conditions are not covered. If you have multiple pets, you will need to purchase a policy for each pet.

Two easy ways to enroll in Nationwide Pet Insurance:

1. Go to [petinsurance.com/baptist-health](https://petinsurance.com/baptist-health).
2. Call 877.738.7874. Mention you are a Baptist Health employee to receive the discount on your policy.



Scan QR code for more information about Nationwide coverage on the Virtual Benefits Fair.



## Administered by Allstate Identity Protection

### Who is eligible?

You are eligible to purchase Identity Theft protection if you are regularly scheduled to work at least 24 hours every week.

### What do these plans cover?

The Identity Theft plan is administered by Allstate Identity Protection. The Allstate Identity Protection Pro covers:

- Identity and credit monitoring
- Tri-bureau credit alerts
- Unlimited credit reports from TransUnion
- Dark web monitoring
- Financial transaction monitoring
- Social media reputation monitoring
- Accounts secured with two-factor authentication
- 24/7 Privacy Advocate remediation
- \$1 million identity theft insurance policy
- 401(k) and HSA stolen fund reimbursement
- Tax fraud refund advances

### DID YOU KNOW?

- Every 2 seconds an identity is stolen
- 1.3 million people were identity theft victims in 2015
- \$15 billion dollars was stolen from fraud victims in 2015
- It takes an average of 165 hours to restore an identity

InfoArmor has joined The Allstate Corporation and is now called Allstate Identity Protection. The name has changed, but the service has not. You are in good hands with Allstate Identity Protection.

### How do these plans work?

- 1. Enroll**  
Access to your full Allstate Identity Protection coverage capabilities begins on your effective date.
- 2. We monitor**  
Our advanced technology looks for suspicious activity associated with your personal profile.
- 3. We alert**  
We alert you to any activity associated with your account.
- 4. We restore**  
In the event of identity theft, we fully manage the process of recovering your identity, credit, and sense of security so the impact to your life is minimal.
- 5. We reimburse**  
Our \$1 million identity theft insurance policy covers the costs associated with reinstating your identity.†

#### Allstate Identity Protection Pro Costs (bi-weekly)

Employee Only	\$3.67
Family	\$6.44

#### Allstate Identity Protection Pro Plus Costs (bi-weekly)

Employee Only	\$4.59
Family	\$8.28

## QUESTIONS?

Contact 1.800.789.2720 or visit [www.myaip.com](http://www.myaip.com).

†Identity theft insurance underwritten by insurance company subsidiaries or affiliates of Assurant. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.



Scan QR code for more information about ID Theft coverage on the Virtual Benefits Fair.



## Allstate Identity Protection Pro Employee Benefit Checklist

	Allstate Identity Protection Pro	Allstate Identity Protection Pro Plus
<b>Identity Monitoring</b>		
NEW Allstate Digital Footprint		✓
Auto-on monitoring	✓	✓
Rapid alerts	✓	✓
High-risk transaction monitoring	✓	✓
Social media reputation monitoring	✓	✓
Sex offender registry	✓	✓
Credit and debit card monitoring	✓	✓
Bank account transaction monitoring	✓	✓
401(k) and HSA account monitoring	✓	✓
Student loan activity alerts	✓	✓
Financial transaction monitoring	✓	✓
Lost wallet protection	✓	✓
Digital exposure reports	✓	✓
Dark web monitoring	✓	✓
Human-sourced intelligence	✓	✓
Compromised credentials	✓	✓
Data breach notifications	✓	✓
Deceased family member coverage	✓	✓
Mobile app with full functionality	✓	✓
Social media account takeover		✓
NEW IP address monitoring		✓

†Identity theft insurance underwritten by insurance company subsidiaries or affiliates of Assurant. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Allstate Identity Protect Pro and Allstate Identity Protect Pro Plus are offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

	Allstate Identity Protection Pro	Allstate Identity Protection Pro Plus
<b>Credit</b>		
TransUnion credit monitoring	✓	✓
Credit score tracking	✓	✓
Unlimited TransUnion credit reports and scores		✓
Credit freeze assistance		✓
Tri-bureau credit monitoring		✓
Credit lock (adult and child)		✓
Annual tri-bureau report and score		✓
Credit report disputes		✓
<b>Remediation</b>		
Full-service, 24/7 remediation support	✓	✓
\$1 million insurance policy†	✓	✓
Stolen fund reimbursement†		✓
Credit report disputes		✓
Tax fraud refund advance†		✓
401(k) and HSA reimbursement†		✓
Tap-to-call from mobile app		✓

### Allstate Identity Protection Pro vs. Allstate Identity Protection Pro Plus: What's the difference?

Allstate Identity Protection Pro Plus comes with our new proprietary tool, the Allstate Digital Footprint, which allows users to see who has their data. Allstate Identity Protection Pro Plus also provides 401(k) and HSA stolen fund reimbursement and tax fraud refund advances.†

IP address monitoring — exclusive to Allstate Identity Protection Pro Plus — makes it easier to detect and inform employees if they're compromised. Our data shows satisfaction and engagement are highest when participants are enrolled in Allstate Identity Protection Pro Plus.



## Administered by Fiducius

Your financial wellness matters to us! We now offer the voluntary Loan Relief™ benefit from Fiducius, so you can take control of your student loans, put more money in your pocket and focus on what really matters to you. Integrated student loan benefits work to provide Baptist Health employees with financial well-being.

### Could Fiducius Loan Relief™ benefit be a good option for you?

Do you, your spouse or other family members have student loans? Trying to understand all the possible ways to better manage them can be a daunting task. With their financial planning approach, the student loan Advisors at Fiducius help you navigate and determine your best option, including forgiveness, refinancing and consolidation.

### It's Easy to Get Started with the Loan Relief™ Benefit

Let the student loan financial planning experts at Fiducius get to work for you:

- Assess: Learn about your personal financial situation and goals
- Advise: Identify the best option to solve your student loan issue
- Relieve: Provide a customized Student Loan Financial Wellness Plan

The custom plan is yours at no cost. Then, decide to hire Fiducius (fees apply), or pursue the plan on your own. It's up to you.

**VISIT** <https://baptisthealth.myfiducius.com/register>. Register with code BAPH1 & learn how much you could save.

**QUESTIONS OR TROUBLE WITH LOGIN?**  
Call 513.645.5400, email or visit the Fiducius website for more information and success stories.





## Administered by Fidelity

### Thrift Plan

#### Who is eligible?

All employees are eligible to contribute pre-tax dollars to the Thrift Plan. You are eligible for matching contributions after one year and 1,000 hours of service.

#### What do I need to do?

The Thrift Plan is voluntary; however, you are automatically enrolled beginning with your first paycheck after 60 days of employment. Your automatic contribution will be three percent of your paycheck. Newly hired employees not wishing to participate must contact Fidelity to opt out. If you previously worked for Baptist Health, enrollment is not automatic. You will need to contact Fidelity to start your Thrift Plan enrollment.

#### Why should I participate in the plan?

The Thrift Plan lets you save and invest a portion of your regular salary on a pre-tax basis. That means you save on income taxes while you save for your future. In addition, once you've completed a year of service and worked 1,000 hours, Baptist Health will begin matching \$0.50 of every dollar you contribute, up to six percent of your pay; plan limits apply. You become vested in the matching contributions based on your years of service:

Vesting Schedule	
Years of Service	Percentage Vested
< 2 years	0%
= 2 but < 3 years	25%
= 3 but < 4 years	50%
= 4 but < 5 years	75%
5 years +	100%

You may choose from a wide range of investment options. If you do not make a choice, you will automatically be invested in the applicable Vanguard Target Retirement Income Fund Investor Shares based on your age. That means your savings have the potential to grow substantially over the years.

The Thrift Plan includes a Roth feature, which offers the potential to earn income tax-free growth and tax-free withdrawals (provided certain requirements are met).

#### When can I get the money I save?

You are entitled to your vested Thrift Plan account when you retire. You are also entitled to your own savings, plus the vested portion of the Baptist Health contributions, if you leave Baptist Health before retirement. You will receive additional information, including limitations and restrictions, when you enroll.

#### How do I review my account information?

You may call 800.343.0860, or go online to [www.Fidelity.com/atwork](http://www.Fidelity.com/atwork).

You do not have to re-enroll in your retirement benefits; however, Open Enrollment is an ideal time to review your contribution amount and investment choices. You may change your Thrift Plan deductions anytime during the year.

For more information on this additional savings option, please log on to NetBenefits at [www.netbenefits.com/baptist](http://www.netbenefits.com/baptist) and go to Plan Information and Documents to review the Roth fact sheet. For more information, call Fidelity Investments at 800.343.0860.

#### Student Loan Planning Assistance Tool

Tools/services with Fidelity are available to assist employees with making smart choices to manage student debt and outstanding loans. These tools will guide employees on repayment options, including public student loan forgiveness, options for refinancing and consolidation of student debt.

For more information, visit [www.Fidelity.com](http://www.Fidelity.com)



Scan QR code for more information about Fidelity coverage on the Virtual Benefits Fair.



## Get the right support for your precious delivery.

If you're thinking about having a baby or have one on the way, Optum® is here to provide information and support—throughout your pregnancy and after giving birth.

When you enroll in the program, you'll have access to our exclusive mobile application personalized to your delivery date as well as a maternity nurse. The nurse is available to help answer your questions and help you with things like:

- Choosing a doctor or nurse-midwife, and help you with finding a pediatrician or other specialist
- Information to help you take care of yourself and your baby— even if your pregnancy is considered high-risk
- Support to help you manage your health— physically and emotionally — before and after your baby is born

## Special care at a special time.

Having a baby that needs extra care can be scary and stressful. But Neonatal Resource Services is here to provide information and support.

When you enroll in the program, you'll be able to work with one of our neonatal nurses, who will answer your questions and help you with things like:

- Working with the NICU to provide information and support
- Making a plan for bringing baby home, and lining up home services and equipment
- Putting you in touch with local services and resources

This may be a challenging time, but we want you to know we're here to help you. **Get started today.**



Get started today by calling **1.877.201.5328** or visit **Myoptum.phs.com** where you can download the Optum® Health Beginnings app.



## CO-INSURANCE

The percent of eligible charges that the employee pays.

## CO-PAYMENT (COPAY)

The fixed amount paid by you, your spouse, or a covered dependent at the time services are received from a network provider. Copays do not apply to deductibles – copays apply to your maximum out-of-pocket amount.

## DEDUCTIBLE

The fixed amount you must pay out of pocket each calendar year before the plan begins to pay for covered healthcare expenses.

## ELECTION PERIOD

New hires have 30 days from their date of hire to elect current year benefits.

Benefits will be active on the first day of the month following or the coincident event date.

## EMBEDDED DEDUCTIBLE

An embedded deductible combines individual and family deductibles. Provides “individual protection” by allowing each covered member the opportunity to meet the individual deductible and receive co-insurance benefits prior to the family deductible being met.

## GUARANTEE ISSUE

The amount of coverage pre-approved by the insurance company regardless of your or another covered person’s health status.

## MEDICAL EMERGENCY

A sudden, serious, unexpected, and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration (i.e., irreparable damage) resulting in a threat to the insured person’s life or body part.

## NETWORK BENEFITS

The benefits applicable for the covered services of a healthcare provider “in-network” (i.e., a preferred provider in the health plan’s network).

## OUT-OF-POCKET MAXIMUM

The most a covered person is required to pay in deductibles, copays and co-insurance in a calendar year for covered healthcare expenses.

## OUT-OF-NETWORK BENEFITS

The benefits available by a non-network provider.

## PRE-AUTHORIZATION

Approval required before you or another covered person receives certain services. Please refer to the summary plan description for additional information on what services require pre-authorization. Summary plan descriptions are available on the HR Portal under the benefits section.

## HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

A health plan that provides significant benefits and satisfies minimum deductibles and out-of-pocket maximums. No benefits can be paid by an HDHP until the annual deductible is met.

## HEALTH SAVINGS ACCOUNT

Tax-advantaged medical savings account available to individuals who are enrolled in high deductible health plans. HSA funds may be used to pay for qualified medical expenses that are not covered under the HDHP.

## LIMITED FSA

Allows reimbursement of qualifying out-of-pocket dental and vision expenses. This option is for employees who are covered on the High Deductible Health Plan.

## AFFILIATES

### Tier 1

- a. All Baptist Tax ID #s for Facilities and Professional Providers
- b. Plus all Anthem Hospitals/Facilities/Professional Providers for pediatric claims ONLY up to age 18 (this is based on patient’s date of birth at time of claim)
- c. And specific Affiliated list of non-Baptist providers to apply the tier 1 benefit.
- d. And all MOHS surgical procedures, all Cataract and Glaucoma procedures, apply tier 1.

**Tier 2** - Anthem’s Hospital/Facility and Professional Provider Network



## **PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of 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](mailto:CustomerService@MyAKHIPP.com)  
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

### **ARKANSAS – Medicaid**

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

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

Health First 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

### **FLORIDA – Medicaid**

Website: <http://flmedicaidprecovery.com/hipp/>  
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: <http://www.indianamedicaid.com>  
Phone: 1-800-403-0864

### **IOWA – Medicaid**

Website: <http://dhs.iowa.gov/Hawki>  
Phone: 1-800-257-8563

### **KANSAS – Medicaid**

Website: <http://www.kdheks.gov/hcf/>  
Phone: 1-785-296-3512

### **KENTUCKY – Medicaid**

Website: <https://chfs.ky.gov>  
Phone: 1-800-635-2570

### **LOUISIANA – Medicaid**

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>  
Phone: 1-888-695-2447

### **MAINE – Medicaid**

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>  
Phone: 1-800-442-6003  
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/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>  
Phone: 1-800-657-3739

## MISSOURI – Medicaid

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

## MONTANA – Medicaid

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

## NEBRASKA – Medicaid

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

## 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.njfamilycare.org/index.html>  
CHIP Phone: 1-800-701-0710

## NEW YORK – Medicaid

Website: [https://www.health.ny.gov/health\\_care/medicaid/](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: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>  
Phone: 1-800-692-7462

## RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>  
Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

## NEVADA – Medicaid

Medicaid Website: <https://dhcnp.nv.gov>  
Medicaid Phone: 1-800-992-0900

## SOUTH CAROLINA – Medicaid

Website: <http://dss.sd.gov>  
Phone: 1-888-828-0059

## 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

Medicaid Website: [http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
Medicaid Phone: 1-800-432-5924  
CHIP Website: [http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
CHIP Phone: 1-855-242-8282

## WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>  
Phone: 1-800-562-3022 ext. 15473

## 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/publications/p1/p10095.pdf>  
Phone: 1-800-362-3002

## WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>  
Phone: 307-777-7531

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](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

## **PAPERWORK REDUCTION ACT STATEMENT**

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

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

## **NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependent's coverage. However, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing toward the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

## **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

On October 21, 1998 Congress passed the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include: Reconstruction of the breast upon which the mastectomy has been performed, Surgery/reconstruction of the other breast to produce a symmetrical appearance, Prostheses, and Physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not: interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

## **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

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

## **HIPAA PRIVACY NOTICE**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information that your company plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

## **HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI**

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request.



The minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

### **The following uses and disclosures of your PHI may be made by the Plan:**

**For Payment.** Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

**For Treatment.** Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

**For the Plan's Operations.** Your PHI may be used as part of the Plan's health care operations. Healthcare operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

- The PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- The PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

**For Appointment Reminders.** Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

**Disclosures to Plan Sponsor.** The Plan may disclose your health information to the Plan Sponsor for Plan administration functions that the Plan Sponsor provides to the Plan. The Plan Sponsor is required to maintain the confidentiality and security of your health information received from the Plan. The Plan Sponsor must also agree not to use or disclose your health information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor. The Plan Sponsor has amended the Plan documents to specifically allow disclosures of health information to the Plan Sponsor for Plan administration functions as required by HIPAA. The Plan may also disclose to the Plan Sponsor, in summary form, claims history and other similar information to perform functions such as obtaining premium bids or to modify the Plan. Such summary information does not disclose an individual's name or other identifying characteristics. The Plan may also disclose to the Plan Sponsor the fact that an individual is enrolled in, or disenrolled from, the Plan.

**Prohibition on use of Genetic Information for Underwriting Purposes.** The Plan is prohibited from using or disclosing Protected Health Information that consists of genetic information for underwriting purposes.

**When Required by Law.** The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

**For Workers' Compensation.** The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

**For Public Health Activities.** When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

**To Report Abuse, Neglect or Domestic Violence.** When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.



**For School Records.** The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

**For Public Health Oversight Activities.** The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

**For Judicial or Administrative Proceedings.** The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

**For Other Law Enforcement Purposes.** The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

**To a Coroner or Medical Examiner.** When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

**For Research.** The Plan may use or disclose PHI for research, subject to certain conditions.

**To Prevent or Lessen a Serious and Imminent Threat.** When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

**State Privacy Laws.** Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

**Right to Request Restrictions on PHI Uses and Disclosures.** You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

**Right to Inspect and Copy PHI.** You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

**Right to Amend.** You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.



**Right to Receive an Accounting of PHI Disclosures.** At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

**Right to Receive Confidential Communications.** You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

**Right to Receive a Paper Copy of This Notice Upon Request.** To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

**A Note About Personal Representatives.** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of your unsecured PHI.

**Your Right to File a Complaint.** You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

**Contact Information.** If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan.

**The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer.** The text contained in this Benefit Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefit Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact the Benefits Department.

## **MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE** **IMPORTANT NOTICE 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by Your Employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?** You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. 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 Employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents will be able to get this coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?** You should also know that if you drop or lose your current coverage with Your Employer 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 Your Options Under Medicare Prescription Drug Coverage.** More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://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).

## MEDICARE PART D NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

### IMPORTANT NOTICE FROM YOUR EMPLOYER 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 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by Your Employer is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Your Employer. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you become eligible.
3. You can keep your current coverage from Your Employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

**When Can You Join A Medicare Drug Plan?** You can join a Medicare drug plan when you become eligible for Medicare and each year from October 15 to December 7. However, if you decide to drop your current coverage with Your Employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Your Employer.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?** Since the coverage under Your Employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base benefit 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 benefit premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**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 Employer coverage will not be affected. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents will be able to get this coverage back.

**For More Information About This Notice Or Your Current Prescription Drug Coverage.** Contact the Your Employer Benefit Department.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Your Employer changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage.** More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For more information about Medicare prescription drug coverage:**

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

## **GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUATION COVERAGE RIGHTS UNDER COBRA)**

### **INTRODUCTION**

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

**What is COBRA continuation coverage?** COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefit (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefit (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee’s becoming entitled to Medicare benefit (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

**How is COBRA continuation coverage provided?** Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.



## **There are also ways in which this 18-month period of COBRA continuation coverage can be extended:**

**Disability extension of 18-month period of COBRA continuation coverage.** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**If you have questions:** Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep your Plan informed of address changes.** To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Plan contact information. Please contact your Human Resources Department.

## **NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE PART A:**

### **GENERAL INFORMATION | FORM APPROVED OMB NO. 1210-0149 (EXPIRES 6/30/2023)**

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

**What is the Health Insurance Marketplace?** The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2020 for coverage starting as early as January 1, 2021.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?** You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

**How Can I Get More Information?** For more information about your coverage offered by your employer, please check your summary plan description or Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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







**Corbin**



**La Grange**



**Lexington**



**Louisville**



**Madisonville**



**Paducah**



**Richmond**



**Floyd**



**Hardin**



**System Services**



This guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding "grandfathering" of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resources Department for further information.

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