Zooming to the Top 13 Years in a Row

Voted 2020 Best Places to Work in Healthcare in the U.S.

This booklet will provide you with general information about your benefits; it is not intended to replace Summary Plan Descriptions or official documentation about our benefits plans. Please review this booklet carefully, and contact the Human Resources staff below for further information or questions.

Sharareh Creel, Benefits Coordinator
924-8731 or sharareh.creel@womans.org

Julie Lear, Benefits and LOA Specialist
924-8140 or julie.lear@womans.org

Peter Lloyd, Benefits and Compensation Manager
924-8143 or peter.lloyd@womans.org

Benefits Fax
928-8850

On the cover: (L to R)
Claudia Ramirez-Duran, *LSU Clinic*; Derek Walker, *Environmental Services*; Jessica Smith, *Fitness Center*; Kerry Klein, *Information Systems*
Eric Suire, *Respiratory Therapy*; Tam LaBranche, *Pharmacy*; Meredith Gaudet, *Mother/Baby*
Tomeka Dunbar, *Materials Management*; Kera Sussmann, *Retail Pharmacy*
Paula O'Neill, *LSU Clinic*; Linda Hall, *Med-Surg/Oncology*; Nia'Ja Mack, *Woman's Gynecologic Oncology Clinic*; Julie Craven, *Imaging*

Table of Contents

Woman's Health Plan Benefits . . . 2
Who is Eligible? . . . 2
Important Terms . . . 3
Health Plan Schedule of Benefits . . . 4
Health Plan Premiums . . . 8
Meritain . . . 9
Aetna National PPO Network . . . 10
Teladoc . . . 11
Walk-in Clinics . . . 12
Healthy Merits . . . 13
Southern Scripts . . . 18
RxResults . . . 20
Pharmacy Plan Design . . . 21
Woman's Retail Pharmacy . . . 22
ActiveCare . . . 23
ActiveCare Diabetes Management . . . 23

Other Benefits . . . 24
Dental Plan Benefits . . . 24
Dental Plan Premiums . . . 24
Flexible Spending Accounts . . . 25
FSA Eligible Expenses . . . 26
FAQs About Your FSA . . . 27
Benny Benefits Debit Card . . . 28
Manage Your FSA Spending . . . 29
Always Care Vision Benefit . . . 30
Life Insurance and Accidental Death and Dismemberment (AD&D) . . . 32
Supplemental Life and AD&D . . . 33
Retirement Plans . . . 34
Transamerica . . . 37
Employee Assistance Program (EAP) . . . 38
Long Term Disability . . . 39
Employee Self Service . . . 40
How to Enroll . . . 41
Tuition Reimbursement . . . 42
Chubb Long-Term Care + Life Insurance Benefit . . . 43
Veterinary Pet Insurance (VPI) Program . . . 43
Accident Insurance . . . 43
Critical Illness Insurance . . . 44
Whole Life Insurance . . . 44
Short Term Disability Insurance Program . . . 45
When Can I Change My Benefit Elections? . . . 46

Show Me the Numbers . . . 48

Ways to Save . . . 49

Employee Discounts . . . 50
Woman's Hospital Services . . . 50
Woman's Fitness Club . . . 50
Woman's Spa Services . . . 50
Woman's Center for Wellness . . . 50
Woman's Retail Shops . . . 50
Woman's Way Café . . . 50
Woman's Graphic Services . . . 51
Other Discounts . . . 51
BASIS Baton Rouge . . . 51

Required Notifications . . . 52
HC Reform Eligibility Guidelines . . . 52
Notice of Privacy Practices . . . 54
Newborns' and Mothers' Health Protection Act . . . 62
Women's Health and Cancer Rights Act . . . 63
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) . . . 64
Employee Rights and Responsibilities . . . 68

Payroll Calendar . . . 69

Notes . . . 70

More Contacts . . . 73

Human Resources . . . 73

Woman's Health Plan Benefits

Woman's health plan is self-funded, which means that claims are paid by Woman's. Meritain Health is our third party administrator (TPA). Meritain maintains eligibility, processes claims, and provides customer service to all covered participants. Aetna provides a Preferred Provider Organization (PPO) network for the health plan. The level of benefit Woman's will pay is based on where you receive your care. Using Aetna network providers will save you and Woman's money!

Who is Eligible?

Full time employees

The Affordable Care Act (ACA or Healthcare Reform) requires Applicable Large Employers (ALE) to offer affordable healthcare to a full-time employee who regularly works 30 hours per week or a part-time employee who regularly works 32 or more hours in a 14-day pay period. Woman's offers affordable health coverage (as defined by ACA) to our full-time employees. However, if a part-time or PRN employee meets the definition of a full-time employee under the ACA guidelines, they will also be eligible for the premium rates offered to full-time employees. This definition of full-time applies only to healthcare benefits. See the "HC Reform Eligibility Guidelines" on page 52.

Part time employees

Full time and part time employees' eligible dependents

Eligible dependents include:

- a covered employee's legally married spouse
- each eligible child until their 26th birthday

The term "child" means:

- a natural born child
- a stepchild
- an adopted child or a child placed for adoption (from the date of placement with the employee for the purpose of legal adoption)
- a child for whom the employee is the legal guardian, until the date the child no longer qualifies as an Eligible Dependent as defined under this Plan
- a child for whom a court has awarded custody of the child to the employee or the employee's spouse.

Proof of dependent eligibility is required (e.g., marriage certificate, birth certificate, adoption papers, legal guardianship paperwork).

There is no waiting period for new employees. You are eligible to participate in the plan immediately, and have 31 days to enroll. Coverage is effective on your date of hire.

Important Terms

What is a **co-pay**?

The portion of medical expense you will pay for each occurrence of physician, urgent care, outpatient mental health and chiropractic care office visits. The member pays the co-pay at the time of the visit.

What is a **deductible**?

The portion of medical expense you will pay each calendar year before the plan pays anything for certain expenses.

What is **co-insurance**?

The percentage of eligible expenses that you will pay after the annual deductible is met.

What is an **Out-Of-Pocket (OOP) maximum**?

The maximum amount you will pay for eligible expenses incurred during a calendar year before the covered percentage increases to 100% for the remainder of the calendar year. Co-pays, deductibles and co-insurances are applied toward the OOP maximum.

Health Plan Schedule of Benefits

	Participating Providers	Non-Participating Providers *Subject to Usual and Customary Charges*
Lifetime Maximum Benefit	Unlimited	
Calendar Year Maximum Benefit	Unlimited	
Calendar Year Deductible		
Single	$900	$1,800
Family	$1,800	$3,600
Calendar Year Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copays — combined with Prescription Drug Card)		
Single	$6,850	$13,700
Family	$13,700	$27,400

MEDICAL BENEFITS	Participating Providers	Non-Participating Providers *Subject to Usual and Customary Charges*
Allergy Services (all)	80% after Deductible	50% after Deductible
Ambulance Services (if Medically Necessary)	80% after Deductible	80% after Deductible
Air Ambulance Services	80% after Deductible	80% after Deductible Up to 300% of Medicare Allowable Rate (not subject to Usual and Customary Charge)
Aquatic Therapy*	80% after Deductible	50% after Deductible
**NOTE: Aquatic therapy is only covered at Woman's Center for Wellness if you live within a 100-mile radius. There is no coverage for aquatic therapy performed at any other Participating or Non-Participating provider unless the Covered Person resides more than 100 miles away from Woman's Center for Wellness.*		
Autologous Blood Donation Services	80% after Deductible	50% after Deductible
Cardiac Rehab (Outpatient)	80% after Deductible	50% after Deductible
Maximum Benefit per Illness — Phase 2 Only	36 sessions	
Chemotherapy (Outpatient) (includes those performed during an office visit and at Woman's Hospital)	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation		
Office visits totaling less than $500 per visit	$30 Copay, then 100%; Deductible waived	50% after Deductible
Office visits totaling $500 or more per visit	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
NOTE: If a Covered Person has an office visit and a manipulation or modality on the same day, 2 Copays will apply.		
Colonoscopy (routine and non-routine)	80% after Deductible	50% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100%; Deductible waived	50% after Deductible
During an office visit	Paid under Physician Office Visit benefit	50% after Deductible
At Woman's Hospital	100%; Deductible waived	N/A
Any facility other than Woman's Hospital when not performed during an office visit	80% after Deductible	50% after Deductible
MRI, MRA, CAT and PET Scans, EKGs (includes those performed during an office visit and at Woman's Hospital)	80% after Deductible	50% after Deductible

Health Plan Benefits *continued*

MEDICAL BENEFITS	Participating Providers	Non-Participating Providers *Subject to Usual and Customary Charges*
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible
Emergency Services — Emergency Medical Condition	$150 Copay, then Deductible, then 80%	Paid at the Participating Provider level of benefits
Emergency Room — Non-Emergency Medical Condition	$300 penalty, then $150 Copay, then Deductible, then 80%	$300 penalty, then $150 Copay, then Deductible, then 50%
Failure to Thrive	80% after Deductible	50% after Deductible
Genetic Testing for BRCA1 and BRC2	80% after Deductible	50% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Hearing Aids (covered Dependent Children only)	80% after Deductible	50% after Deductible
Home Health Care	80% after Deductible	50% after Deductible
Hospice Care	80% after Deductible	50% after Deductible
Hospice Bereavement Counseling (within 6 months of patient's death) Maximum Benefit — 15 visits per family	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
** A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.*		
NOTE: If you live within a 100-mile radius of Woman's Hospital, all deliveries MUST be performed by Woman's Hospital and the services will be paid at the Participating Provider level of benefits. There is NO coverage for deliveries performed by any other Participating Provider or Non-Participating Provider unless you live outside of the 100-mile radius.		
Infertility	70% after Deductible	Not Covered
Diagnostic Testing, X-ray and Lab Services	70% after Deductible	Not Covered
Maximum Benefit — Oocyte Retrievals and Assisted Reproductive Technology for Attempts to Conceive a First Child	3 retrievals	Not Covered
Maximum Benefit — Oocyte Retrievals and Assisted Reproductive Technology for the Attempts to Conceive a Subsequent Child	2 retrievals	Not Covered
NOTE: Infertility expenses are only covered at Fertility Answers. See Eligible Medical Expenses for details on specific limitations.		
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	Paid based on place of service	Same as any other Illness
Delivery	80% after Deductible	Not Covered
** See Preventive Services under Eligible Medical Expenses for limitations.*		
NOTE: If you live within a 100-mile radius of Woman's Hospital, all deliveries MUST be performed by Woman's Hospital and the services will be paid at the Participating Provider level of benefits. There is NO coverage for deliveries performed by any other Participating Provider or Non-Participating Provider unless you live outside of the 100-mile radius.		

Health Plan Benefits *continued*

MEDICAL BENEFITS	Participating Providers	Non-Participating Providers *Subject to Usual and Customary Charges*
Mental Disorders		
Inpatient	80% after Deductible	50% after Deductible
Outpatient	$30 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
MinuteClinic	$20 Copay, then 100%; Deductible waived	50% after Deductible
Morbid Obesity (non-surgical)	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 course of treatment	
Nutritional Counseling for Diabetics & Pre-Diabetics	100%, No Deductible	50% after Deductible
Calendar Year Maximum Benefit	6 visits	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Outpatient Therapies — (e.g., physical, speech, occupational)	80% after Deductible	50% after Deductible
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits: Office visits totaling less than $500 per visit	$30 Copay*, then 100%; Deductible waived	50% after Deductible
Office visits totaling $500 or more per visit	80% after Deductible	50% after Deductible
Office Surgery	100%; Deductible waived	50% after Deductible
Teladoc	$20 Copay, then 100%; Deductible waived	N/A
**Copay applies per visit regardless of what services are rendered.*		
Preventive Services and Routine Care		
Preventive Services — (includes the office visit and any other eligible item or service received at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care — (includes any routine care item or services not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Routine Eye Exam	$30 Copay; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Routine Physical for an Eligible Employee and Covered Spouse	100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Well-Woman Exam (Includes Pap Smear Retrieval)	100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
NOTE: If you live within a 100-mile radius of Woman's Hospital, all pap smear processing, mammograms, colonoscopies (under preventive services) and ultrasounds of the breast MUST be performed by Woman's Hospital and the services will be paid at 100%; Deductible waived. There is NO coverage for pap smear processing, mammograms, colonoscopies (under preventive services) and ultrasounds of the breast performed by any other Participating Provider or Non-Participating Provider unless you live outside of the 100-mile radius. Refer to Routine Care under Eligible Medical Expenses for additional information.		

Health Plan Benefits *continued*

MEDICAL BENEFITS	Participating Providers	Non-Participating Providers *Subject to Usual and Customary Charges*
Private Duty Nursing	80% after Deductible	50% after Deductible
Maximum Benefit	15 shifts per admission	
Radiation Therapy (Outpatient)	80% after Deductible	50% after Deductible
Rehabilitation Facility	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	365 days	
Respiratory (includes those performed during an office visit and at Woman's Hospital)	80% after Deductible	50% after Deductible
Second Surgical Opinion	80% after Deductible	50% after Deductible
Skilled Nursing Facility	80% after Deductible	50% after Deductible
Smoking Cessation	80%; Deductible waived	50%; Deductible waived
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Transplants	80% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
Lodging Daily Maximum Benefit	$50 per day per person ($100 per day maximum) per transplant*	Not Covered
Transportation and Lodging Maximum Benefit	$10,000 per transplant*	Not Covered
** Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.*		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility		
Office visits totaling less than $500 per visit	$30 Copay*, then 100%; Deductible waived	50% after Deductible
Office visits totaling $500 or more per visit	80% after Deductible	50% after Deductible
**Copay applies per visit regardless of what services are rendered.*		
All Other Eligible Medical Expenses	80% after Deductible	50% after Deductible

Health Plan Premiums

The employee contribution for coverage for the employee, their spouse and qualifying dependent(s) is paid through bi-weekly payroll deduction, on a before-tax basis.

Health Plan Contribution — No Discounts	Full-Time	Part-Time
Employee	$69	$142
2 Person	$160	$277
Family*	$275	$482

Health Plan Contribution — $10 Healthy Merits discount	Full-Time	Part-Time
Employee	$59	$132
2 Person	$150	$267
Family*	$265	$472

Health Plan Contribution — $15 Non-Smoker discount	Full-Time	Part-Time
Employee	$54	$127
2 Person	$145	$262
Family*	$260	$467

Health Plan Contribution — $10 Healthy Merits and $15 Non-Smoker discount	Full-Time	Part-Time
Employee	$44	$117
2 Person	$135	$252
Family*	$250	$457

** A Full-Time employee whose spouse is also an employee eligible for health insurance will receive an additional discount off of the family rate. Please contact the benefits staff for information.*

On Your Mark, Get Set, Go Meritain.com!

Did you know?

You have access to a variety of online tools and resources through www.meritain.com!

What you'll find on the Meritain Health Member Portal

Using the Meritain Health Member Portal, you have 24-hour access to a number of tools and resources that can help you manage your health benefits. Below are a few of the tools available on Meritain.com:

- Verify eligibility and benefits coverage
- Find the status of claims
- View your Explanation of Benefits (EOB) documents
- Review your benefit plan documents in their entirety
- View deductibles and out-of-pocket limits
- Check Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) balances, if applicable
- Submit Coordination of Benefits (COB) information
- Update user demographic information
- Request Letter of Coverage (LOC)
- Prescription plan coverage
- Update account settings

Access as easy as 1–2–3!

Step 1:

You should open your Web browser and go to www.meritain.com.

Step 2:

You'll need to register your account. Start by clicking *Register* and then clicking on the *Member* tab.

Your spouse and adult dependents will need to create their own accounts.

Step 3:

You'll need to fill in your:

- Group ID (you can find this on your ID Card).
- Member ID (you can find this on your ID Card, as well. You should enter it with no spaces or dashes).
- Date of birth.
- Name.
- ZIP code.

You will be prompted to enter an email address, create a username and password, and select a security question. Review the terms and conditions, and click *I agree to terms and conditions* and *Next*, or click *Cancel*.

The next time you log in, just use the same username and password from Step 3.

Your DocFind® Online Directory

Open Choice® PPO

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Open Choice PPO network. It's easy when you use the online DocFind directory from Aetna.* With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the DocFind directory anywhere you have Internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain/**.
2. Key in the type of provider or provider name, specialty, procedure or condition under *Who or what are you looking for?* and the desired geographical area under *Where?* Click *Search*.
3. Choose *Open Choice® PPO* under *Select a Plan*.

OR

4. Click on one of the options listed under *Provider Types*, *Conditions or Procedures*. You will be prompted to key in the desired geographical area and select your plan (as shown in step three).
5. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
6. Narrow your search results by using the filters under *Narrow Your Results*. Choices include *Hospital Affiliations*, *Group Affiliations*, *Languages*, *Gender and Specialty*.
7. For more search tips, you can click on *Search Tips and FAQs* on the home screen.

If you have questions while searching for a doctor or hospital, simply click on the *Contact DocFind* link. It's at the top of any DocFind page. You'll be able to send a quick comment or question.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at 1.800.343.3140 from 8:00 a.m.–9:00 p.m. ET, Monday through Friday.

If you need more information, we're here to help. Just call Meritain Health using the number on your member ID Card.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.*

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

www.meritain.com

©2015-2016 Meritain Health, Inc. All rights reserved.

Reach a doctor 24/7

The Teladoc® solution

Teladoc is the on-demand healthcare solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc

- Saves time and money
  - There is a $20 copay for this service
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

**Please note, there is no guarantee you will be prescribed medication.*

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board certified and state licensed.
- Specially trained in telemedicine.

There's more than one way to reach a doctor

By phone. Just call **1.800.362.2667.**

Online. Simply request a video consultation online at **www.MyDrConsult.com**.

On the go. You can download the Teladoc mobile app by visiting the App Store or Google Play.

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infection
- Rash/skin infections
- Sinus infections
- Stomachache/ diarrhea
- Urinary tract infections

Our members love Teladoc

"We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service."

Contact a Teladoc physician at 1.800.362.2667, or by visiting **www.MyDrConsult.com**.

© 2015 Teladoc, Inc. All rights reserved. Teladoc and the Teladoc logo are registered trademarks of Teladoc, Inc. and may not be used without written permission. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not rescribe DEA controlled substances, non therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. Teladoc phone consultations are available 24 hours, 7 days a week while video consultations are available during the hours of 7am to 9pm, 7 days a week.

Walk-in Clinics

Walk into good health—and savings

Our natural reaction when we're suddenly sick or injured is to go straight to the Emergency Room (ER). However, if it's simply a minor illness or injury, going to the ER might not be your best option.* In fact, quicker, more affordable and more convenient treatment can come from your local walk-in clinic.

Many walk-in clinics are open seven days a week, including nights and weekends. That makes them an easy and highly accessible option. You can use them when you need to see a doctor after business hours. Plus, when you go to one of the almost 650 Aetna-contracted clinics instead of your local ER, your savings can really add up!

National walk-in clinics in the Aetna network include MinuteClinic® through CVS. You can find your closest walk-in clinic by using the DocFind tool at: **http://www.aetna.com/docfind/custom/mymeritain/.**

** Call your primary care doctor first when faced with a non-life-threatening condition.*

Walk-in clinic services

You might think the ER is the only place equipped to handle your health issue. That's a common misunderstanding. Walk-in clinics not only offer care for minor illnesses and injuries, they also offer plenty of other services. Walk-in clinics can provide or treat:

- Routine allergies.
- Sprains.
- Diabetes screening.
- Heart screenings.
- Pregnancy tests.
- Ear infections.
- Strep throat.
- Colds and flu.
- School physicals.
- Athletes foot.
- Insect bites.
- Poison ivy.
- Well-baby exams.
- Vaccinations, and more!

MinuteClinic

MinuteClinic locations are located in certain CVS Pharmacies and specialize in family healthcare with no appointment needed. There is a $20 copay if you need to visit a MinuteClinic.

Urgent needs require urgent care

If you have more serious symptoms, the Aetna network also covers urgent care centers. This gives you a quick and affordable alternative to the ER. Urgent care centers are staffed with doctors to handle vital medical issues.

However, if your medical need is more than urgent—with symptoms like chest pain, trouble breathing, bad bleeding, or other serious or life-threatening symptoms—*go straight to your local ER*!

Questions? We're here to help. Just call us at the number located on the back of your ID Card.

www.meritain.com | © 2019–2020 Meritain Health, Inc. .

Healthy employees are happy employees, and happy employees mean happy patients! A wellness program is a logical extension of our mission to improve the health of women and infants. Each Fall, you will have the opportunity to qualify for participation in the wellness plan for the upcoming calendar year.

TAKE 3 EASY STEPS TO EARN REWARDS IN 2021

STEP 1 Complete a **biometric screening** (includes fasting blood work) in November, 2020.

STEP 2 Complete your **online health assessment (AgeGage)** by November 30, 2020.

STEP 3 Receive **paycheck premium credits** and earn points toward additional wellness incentives by participating in Qualifying Activities.

https://womanshospitalfoundation.wellright.com

Qualifying Activities	Description	Wellness Points You Can Earn	Maximum Points Per Year
SayAah	Complete an **annual preventive exam (SayAah challenge)** between November 1, 2019 and October 31, 2020.	200	200
Meet 3 of 5	Reach 3 of 5 targeted goals for Metabolic Syndrome risk reduction	200	200
Move It	Achieve 30 mins of activity for a minimum of 46 days per quarter. Track your activity digitally on the web portal or through the Healthy Merits App.	100	400
HealthyU	There are over 100 online courses on topics like physical activity, nutrition, sleep and lifestyle management. Much of the course content is presented in video form to make the learning experience more enjoyable.	100	200
Company Challenges	Participate in a company challenge.	100	200
Nurse Health Coaching	Engage with your nurse coach each quarter.	100	400
PhysicianFax	Share your biometric screening results with your physician.	100	100
Wellness Event	Complete a sanctioned wellness event.	100 per event	200
Weight Management	Participate in either Weight Watchers or Woman's Balance Program.	200	200

- By completing your biometric screening and online health assessment by the designated deadlines, you'll earn a ***$10 per pay period premium credit*** for calendar year 2021.
- You also have the opportunity to earn up to an ***additional $250*** based on the points you earn for the Qualifying Activities above.
- That's a total of ***$510 in potential savings*** each year!

Level	Total Points Earned	Reward
1	1-399	$150
2	400-699	$200
3	700-1000	$250

Note: You must complete the following to be eligible for wellness points and the premium credit in 2021: online health assessment in October-November 2020; biometric screening in November 2020.

The program is optional, and none of your individual health information will be shared.

Meritain Health administers the Healthy Merits program, which means all of your medical information remains in one place, and with a company you have confidence in. Your results and information are completely confidential.

If you have questions about Healthy Merits, please call 1-877-348-4533 or email healthymerits@meritain.com.

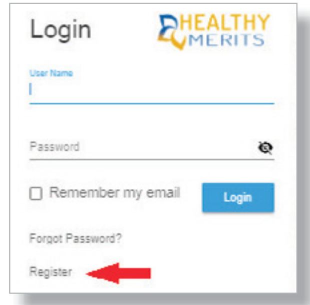
Wellness Portal Registration

Woman's Hospital Foundation

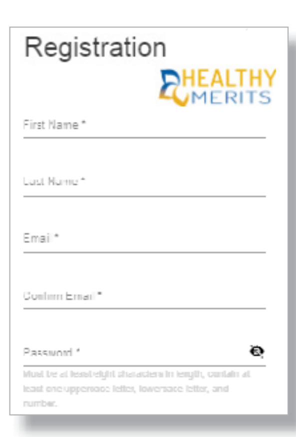
How to register for your Healthy Merits portal

To get started with your Healthy Merits wellness program, you must first register for your new Healthy Merits wellness portal. This portal gives you tools and resources to help guide you along your wellness journey.

1. Click on or copy and paste the below website: **https://womanshospitalfoundation.wellright.com**.
2. Click on *Register.*



3. Enter your information as it is appears on your Meritain Health® medical ID Card. Your unique ID is your Member ID found on your ID Card.
4. Verify your address via the email you receive. **Please note:** After you register, you will receive an email asking you to verify your email address. Please be sure to check your spam/junk folder for this email. Your registration is not complete until you verify your address through this email.



From here, you'll be able to explore different Healthy Merits topics and earn incentives!

Wellness matters!

When you feel better, you can accomplish more and get more enjoyment out of doing the things you love.

Questions? Just call Healthy Merits Customer Service at 1.877.348.4533 or email healthymerits@meritain.com.

Advocates for Healthier Living

At Meritain Health, we care about your well-being! That's why we offer a number of tools and resources to help you on your wellness journey.

www.meritain.com | © 2019–2020 Meritain Health, Inc.

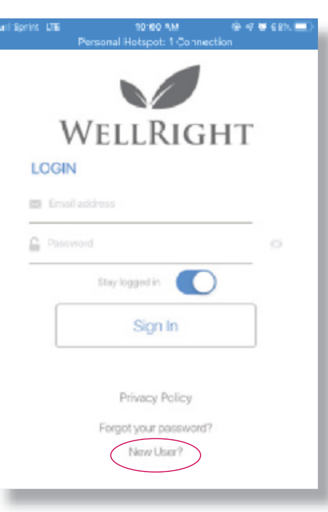
Wellness Portal Mobile App Registration

Woman's Hospital Foundation

How to register for your Healthy Merits portal with the mobile app

Healthy Merits gives you tools and resources for your wellness journey. To get started, you'll need to register for your wellness portal through the mobile app:

1. Download the WellRight app, available for both iOS and Android.
2. Open the app.
3. Click on *New User?*



4. Enter your company code *womanshospitalfoundation* in the pop-up box.
5. Enter your name, email, unique ID (this is your member ID found on your ID Card) and date of birth.
6. Verify your address via the email you receive. **Please note:** After you register, you will receive an email asking you to verify your email address. Please be sure to check your spam/junk folder for this email. Your registration is not complete until you verify your address through this email.

You're done! Now you can explore, participate and earn incentives! You can also view activities, challenges, and your incentive status online at **https://womanshospital.wellright.com**. You can log in to the website using the same email and password you used to register on the app.

Questions? Just call Healthy Merits Customer Service at 1.877.348.4533 or email healthymerits@meritain.com.

Advocates for Healthier Living

At Meritain Health®, we care about your well-being! That's why we offer a number of tools and resources to help you on your wellness journey.

www.meritain.com | © 2019–2020 Meritain Health, Inc.

Quest Diagnostics Metabolic Syndrome Testing

Woman's Hospital Foundation

Changes are coming! There is a new biometric screening vendor this year. Quest Diagnostics will be performing full comprehensive venipuncture panels. You will receive your results within 24–48 hours after the online screening at **https://womanshospitalfoundation.wellright.com** and will receive a packet in the mail within 10–14 business days.

Your health score will vary slightly from the past (with Interactive Health). See the table below for the new scoring chart using metabolic syndrome risk factors. Achieving three out of the five metrics in the chart will allow you to lower your health risks. You will earn two wellness points for achieving this requirement! Please allow four to six weeks for your results to show as completed.

Quest Diagnostics Metabolic Syndrome Risk Factors		
	Blood Pressure	<130 mmHg / <85 mmHg
	HDL Cholesterol	≥40 mg md/dL males ≥50 md/dL females
	Glucose	<100 mg/dL
	Triglycerides	< 150 mg/dL
	Waist Circumference	≤ 40 inches males ≤ 35 inches females

Notice Regarding Wellness Program

Healthy Merits is a voluntary wellness program available to all full-time and part-time employees participating in the Woman's Hospital Health Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "Age Gage" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a 35 panel blood test. You are not required to complete the Age Gage or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a $10 premium credit for completing the Age Gage, participating in the blood test and having a routine wellness exam. Although you are not required to complete the Age Gage or participate in the biometric screening, only employees who do so will receive the $10 premium credit.

Additional incentives of up to $250 may be available for employees who participate in certain health-related activities (e.g. activity-based and educational challenges) or achieve certain health outcomes such as reaching your Interactive Health Index goal of 200 points (IHI score). If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Human Resources Benefits Team at ext. 8140 or 8731.

The information from your Age Gage and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching, smoking cessation, etc. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Woman's Hospital may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Merits will never disclose any of your personal information either publicly or to Woman's, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, a doctor, and/or a health coach in order to provide you with services under the wellness program. These individuals are not employed by Woman's Hospital.

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 225-924-8643.

Southern Scripts

Pharmacy Plan

Our pharmacy benefits provider, Southern Scripts, works in conjunction with Rx Results to keep healthcare costs down for you and the Health Plan. The RxResults program uses the following components to manage drug costs prior auth, step therapy and exclusions.

In addition to using the lowest-cost, most effective drugs to treat certain conditions, the plan offers lower copays for generic and preferred medications. Compound medications and name-brand non-preferred drugs are covered, but you will pay a higher copay for these more costly medications. You can save even more by taking advantage of the new Variable Copay Benefit and by using the Woman's Retail Pharmacy.

To find the right pharmacy for you:

First Choice and Retail Pharmacies:

For the most convenient option, visit the Woman's Retail Pharmacy for your prescription needs. You may also present your member ID card when filling a prescription at any major retail chain or independent pharmacy; if your pharmacy is not yet in Southern Scripts' network have your pharmacist call the number on your card to enroll. Visit our pharmacy locator tool to find a pharmacy: www.southernscripts.net/members.php. Our preferred network, First Choice, will help you reduce prescription costs by providing the best discounts.
Note: Walgreens and Costco are not currently preferred network providers.

Specialty Pharmacies:

Certain medications used to treat serious or complex health conditions are provided by top quality specialty pharmacies. Use the pharmacy locator tool www.southernscripts.net/members.php to find a specialty pharmacy near you.

Variable Copays

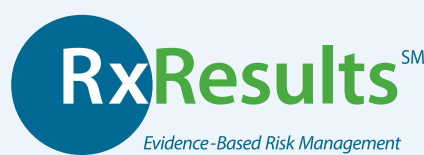
This benefit uses coupons provided by drug manufacturers to greatly reduce costs for eligible medications. Your copay may be drastically reduced at participating pharmacies for qualifying medications. Over 2000 medications qualify for the variable copay savings.

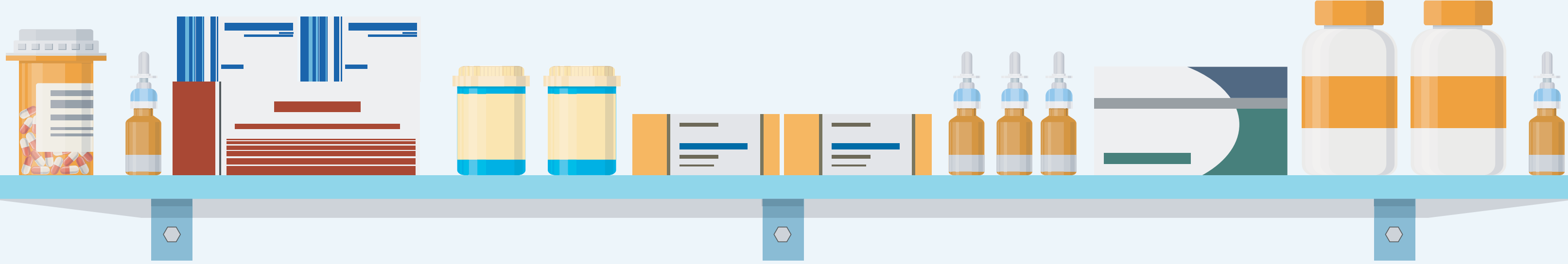
How it Works

The Variable Copay Program uses coupons provided by the manufacturer to greatly reduce the cost for eligible medications. To take advantage of this benefit, you must fill your prescription at the Woman's Retail Pharmacy or by mail order through a participating CRx preferred network pharmacy. The preferred network pharmacies provide free, automated shipping and refills.

If your medication has a variable copay opportunity, and you try to fill your medications at a retail pharmacy other than the Woman's Retail Pharmacy, the pharmacy will get a rejection message stating "Variable Copay Opportunity Available". Please call 1-800-710-9341. This does not mean your medication is not covered and instead means your medication is eligible for a manufacturer coupon that will reduce the cost to you.

Should you have any problem getting your medications filled, please call 1-800-710-9341 and a Customer Care Specialist will assist you in filling your prescription.





RxResults

RxResults will work in conjunction with Southern Scripts (our pharmacy benefit manager) to deliver an evidence-based prescription drug program. Changes to the prescription plan are based on recommendations and assistance from RxResults, LLC. The program is designed to help keep healthcare costs down for you and the Health Plan while conforming to national guidelines and/or best practices with respect to drugs used to treat certain medical conditions. The following programs are integrated into our pharmacy benefit program:

- **Reference Pricing**
  The plan uses this initiative when there are one or more similarly effective and lower cost drugs in a drug category. When these occur, the benefit plan will only pay the amount it would pay for the lower-cost drugs and patients will pay the difference in cost between the higher-cost drug and the lower-cost alternatives in the form of a higher co-payment. Patients have an opportunity to reduce their co-payment expenses by switching to an alternative drug product. In most cases, this discussion can occur with a phone call to your physician's office and does not require an office visit to have your prescription changed.
- **Prior Authorization**
  The plan uses this initiative when it is recommended that qualified personnel review a patient's medical situation or medication history prior to benefit coverage of a particular drug.
- **Step Therapy**
  The plan uses this initiative to require that a patient first try one or more drug products before the plan will provide benefit coverage for another drug.
- **Exclusions**
  The plan uses this initiative when there are other lower-cost drug products that are considered equally effective.

For questions, please call RxResults Member Services:

- Toll free at 1-844-853-9400
- Monday – Friday
- 7 a.m. – 7 p.m. central time

Prescriptions

Pharmacy Plan Design

$100 PMPY (Per Member Per Year) brand only annual drug deductible applies prior to co-pays. Deductible does not apply to generics.

Member Copayment Structure(s)						
	1-30 Day Supply		31-60 Day Supply		61-90 Day Supply	
	Member Copay	Member Coinsurance	Member Copay	Member Coinsurance	Member Copay	Member Coinsurance
IN-HOUSE PHARMACY						
Generic	$15	X	$30	X	$30	X
Preferred	$55	X	$110	X	$110	X
Compound	$70	X	X	X	X	X
Non-Preferred	$70	X	$140	X	$140	X
FIRST CHOICE & MAIL ORDER			**MAIL ORDER**			
Generic	$20	X	$40	X	$40	X
Preferred	$60	X	$120	X	$120	X
Compound	$75	X	X	X	X	X
Non-Preferred	$75	X	$150	X	$150	X
RETAIL-NON-FIRST CHOICE						
Generic	$30	X	Non-First Choice is limited up to 30-day supply			
Preferred	$70	X				
Compound	$85	X				
Non-Preferred	$85	X				
SPECIALTY						
Generic	$200	X	***All specialty medications are limited up to 30-day supply, specialty formulary and specialty network only** **Non-First Choice is limited up to 30 DS**			
Preferred	$200	X	*"If members are eligible to receive a subsidy through a manufacturer copay program, the copayment under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program."*			
Non-Preferred	$200	X	For rebate purposes, there are standard plan design requirements for rebates: The Plan Design must consist of a three-tier copay structure with the first tier comprised of Generic Drugs, the second tier comprised of Preferred Brand Drugs, and the third tier comprised of Non-Preferred Brand Drugs with a copayment differential between Preferred and Non-Preferred Brand Drugs of $20.00. For Plan Design, if a different Copay Structure is elected, then the ability to qualify for rebates will be impacted.			
Injectables Those not considered Specialty Drugs and does not include insulin	Retail 20%; Mail 20%					
Fertility Drugs	Retail 30%; Mail 30%					

Members receiving a brand name drug for which there is a generic equivalent available will pay the difference between the brand and generic plus the applicable brand copay.

Woman's Retail Pharmacy

Woman's onsite retail pharmacy is located on the first floor of the Support Services Building by the employee entrance. The pharmacy has contracted with most major prescription plans. It is a First Choice pharmacy for health plan participants, and offers variable copays (see page 19 for details). Employees and their families, discharged patients and the general public are able to fill prescriptions at the Retail Pharmacy. Prescriptions can be transferred to Woman's from other pharmacies. New prescriptions can be dropped off, sent electronically from your provider, or called in from the physician's office. It's a fast, friendly, and convenient way to get your prescriptions. You can also receive a 90 day prescription at the cost of a 2 month copay by filling it at the Woman's Retail Pharmacy. Check out their OTC meds as well!

Open Monday through Friday from 7:00 am to 5:30 pm.

- **Phone: 225-924-8199**
- **Fax: 225-928-8844**

DIABETES MANAGEMENT MADE EASY

REAL-TIME VISIBILITY

24/7 SUPPORT

IMPROVED OUTCOMES

How does it work?

Whether receiving a routine checkup or a diabetes specific treatment, if the underlying diagnosis is diabetes, it will be identified in the health claim. These claims are used to identify those living with diabetes.

An initial kit with testing supplies is shipped directly to the member's door.

ActiveCare reaches out to the member helping them walk through their new device and program.

Every time a member tests, the reading is sent and stored at ActiveCare. Members can go on-line at anytime to view their readings, set goals, create alerts and even share information with their physician or family members.

QUESTIONS? CALL 877-862-5553

ActiveCare™
a BioTelemetry company

TC-R&D-ACCTM-ART-262 Rev. 0 | © 2019, BioTel Care®, a BioTelemetry company.

Dental Plan Benefits

Calendar year deductible:	$75
Maximum calendar year family deductible:	$225
Maximum individual benefit per calendar year (not including orthodontic services):	$1,500
Maximum family benefit per calendar year (not including orthodontic services):	$4,500

Type of Service	Percentage Payable	Does Deductible Apply?	Does Waiting Period Apply?	Maximum Benefit
Preventative	100%	No	No	Subject to maximum dental benefit per calendar year
Anesthesia	80%	Yes	No	No maximum benefit
Basic Restorative Services	80%	Yes	No	Subject to maximum dental benefit per calendar year
Nonsurgical TMJ	80%	Yes	No	$2,000 individual lifetime benefit; subject to maximum dental benefit per calendar year
Periodontic Services	80%	Yes	No	$1,500 individual lifetime benefit; subject to maximum dental benefit per calendar year
Major Restorative Services	50%	Yes	Yes	Subject to maximum dental benefit per calendar year
Orthodontic	50%	Yes	Yes	$1,500 individual lifetime benefit

There is no dental provider list, you may use any dentist of your choice. Covered charges are subject to reasonable and customary allowances. You must be a plan participant for 12 months before you or your dependents are eligible to receive benefits for major restorative and orthodontic services.

Dental Plan Premiums

The employee contribution for coverage for the employee, their spouse and qualifying dependent(s) is paid through bi-weekly payroll deduction, on a before-tax basis.

Dental Plan Biweekly Contribution	Full-Time	Part-Time
Employee	$12	$15
2 Person	$23	$27
Family*	$35	$45

Flexible Spending Accounts

Woman's Hospital offers two types of spending accounts:

Health Care FSA

Health Care Flexible Spending Account

A Health Care FSA is designed to help you pay for eligible health and dental expenses not covered by your health plan.

DCAP

Dependent Care Flexible Spending Account

A DCAP is designed to allow you to pay for dependent care expense that you incur due to employment on a pre-tax basis.

You choose how much you want to contribute to the spending account(s), and that portion is deducted from your paycheck on a pre-tax basis, reducing your taxable income. Contributions are use-it-or lose it, based on IRS regulations.

The Maximum Annual Contributions*

Health Care FSA — $2,750 in 2021

DCAP — $5,000 in 2021 (or $2,500 if you're married and filing separate tax returns)

** Annual maximums are subject to change.*

Health Care FSA reimbursement is based on your annual election. When you incur expenses that are eligible for reimbursement, there are several ways to access the money in your Health Care FSA:

- Complete a claim form, attach applicable documentation, and fax or mail it to Meritain Health.
- Enroll in "Automatic Rollover." When a claim for non-prescription expenses (office visit copays, health and dental expenses that are applied to your deductible and co-insurance) are processed by Meritain Health, the claim is automatically rolled over to the Flexible Spending Account to reimburse you for eligible expenses (no claim form is necessary).
- Use your Benny Card to pay for prescriptions at the pharmacy and as payment for mail ordered prescriptions (no claim form is necessary).
- Log into www.mymeritain.com to view your claims, check your balance, and submit claims for payment anytime you choose.

Meritain Health processes FSA claims each week on Thursday. You have the option of direct deposit, or your check can be mailed to your home address. An explanation of payment which includes the amount of your balance is on the check stub.

If you don't use all of the money you contribute to your Health Care FSA in a calendar year, the IRS allows you to rollover up to $550 in unused funds to the following calendar year. The amount that rolls over does not decrease the amount you can contribute for the next year.

DCAP reimbursement is based on the balance you have in your account. You must complete a claim form, attach applicable documentation, and fax to (763) 852-5004, or mail it to Meritain Health.

There is no rollover option for the **DCAP**.

Call Human Resources at extension 8140 for more details.

Your Healthcare Flexible Spending Account (FSA)

Eligible expenses

Dental
X-rays
Dentures and bridges
Exams and teeth cleaning
Extractions and fillings
Gum treatment
Oral surgery
Orthodontia and braces

Vision
Eyeglasses and contact lenses
Laser eye surgeries
Prescription sunglasses
Radial keratotomy/LASIK

Hearing
Hearing devices and batteries
Hearing examinations

Lab exams/tests
Blood tests and metabolism tests
Body scans
Cardiographs
Laboratory fees
X-rays

Medical equipment/supplies
Crutches and wheel chairs
Hospital beds
Medic alert bracelet or necklace
Nebulizers
Prosthesis
Syringes
Wigs*

Medical procedures/services
Acupuncture
Ambulance
Hospital services
Infertility treatment*
Physical exams
Service animals
Vaccinations and immunizations

Medication
Insulin
Prescription drugs
Weight loss drugs*

Obstetrics
OB/GYN exams
OB/GYN prepaid maternity fees (Reimbursable after date of birth)
Pre and postnatal treatments

Practitioners
Allergist
Chiropractor
Dermatologist
Homeopath or naturopath*
Osteopath
Physician
Psychiatrist or psychologist

Therapy
Alcohol and drug addiction
Counseling (not marital, financial or career)
Massage*
Occupational
Physician, including licensed medical professional
Speech
Weight loss programs*

Healthcare FSA non-eligible expenses

Contact lens or eyeglass insurance or discount programs
Cosmetic surgery/procedures
Diaper service
Personal trainer
Insurance premiums and interest
Long-term care premiums
Marriage counseling
Maternity clothes
Teeth bleaching or whitening
Vitamins or nutritional supplements*

Important note

OTC medications and drugs without a doctor's prescription are not reimbursable through the healthcare FSA. The prescription requirement only applies to OTC items that contain a medicine or drug (i.e., cold medicines, aspirins, acid controllers, allergy and sinus drugs, etc.).

Please note: Expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Letter of Medical Necessity from your healthcare provider to qualify for reimbursement. This is not a complete listing. For more information, please visit www.irs.gov.

FAQs About Your Dependent Care Flexible Spending Account (FSA)

What is a Dependent Care FSA?

Your Dependent Care FSA is a tax-effective, money-saving option that will help you pay for the dependent care services necessary to enable you to work. With a Dependent Care FSA, pre-tax dollars can be set aside for day care type expenses for eligible children or adults.

Please note: future or projected expenses cannot be reimbursed from your Dependent Care FSA until services have been rendered.

What are the requirements for enrolling in a Dependent Care FSA?

In order to participate in a Dependent Care FSA, you must meet the following criteria:

- Work-related expense: Your child/dependent care expense must be incurred to allow you and your spouse, if married, to work or look for work. Unpaid volunteer work or volunteer work for a nominal salary does not qualify.

There are two exceptions to this requirement:

- Your spouse attends school full time. In order to be considered a full-time student, your spouse must be enrolled at a school during at least some part of each of five calendar months of the calendar year, not necessarily consecutive, for the number of hours considered to be a full-time course of study. A student who attends school only at night is not a full-time student.
- Your spouse is physically or mentally unable to care for himself/herself.

- Care provider: You must have made payments for child/dependent care to someone you or your spouse could not claim as a dependent; and if the person you made payments to was your child, he/she must have been 19 or older by the end of the year.
- Qualified dependent: The main purpose of your day care expense must be for the well-being and protection of a qualifying person.

A qualifying person is:

- A dependent under the age of 13 for whom you can claim as an exemption; or
- A dependent who is unable to care for himself/ herself and for whom you can claim an exemption (or could claim an exemption except the person had a gross income exceeding the exemption amount).

The dependent must also regularly spend at least eight hours a day in your home.

How much can I contribute each year?

For dependent care, the IRS allows a contribution of up to $5,000 per calendar year, or $2,500 if you are married and filing separate tax returns.

Your New Flexible Spending Account Benefits Card

What is a benefits debit card?

Your new benefits debit card is a special-purpose MasterCard® that gives you an easy, automatic way to pay for qualified healthcare expenses. You can electronically access the pre-tax dollars set aside in your Flexible Spending Account (FSA).

How does my debit card work?

It works like a MasterCard, with the value of your FSA contribution stored on it. When you have a qualified, eligible expense at a business that accepts MasterCard debit cards, you can simply use your benefits debit card. The amount of the qualified purchases will be deducted—automatically—from your account, and the pre-tax dollars will be electronically transferred to the provider/merchant for payment.

Is this just like other MasterCards?

No. Your benefits debit card is a special-purpose MasterCard that can be used only for qualified healthcare/benefits expenses. It can't be used, for example, at gas stations or restaurants. There are no monthly bills and no interest.

Where can I use my debit card?

Your card can be used to pay for eligible goods and services at providers/merchants that offer these goods or services and accept MasterCard. IRS regulations allow benefits debit card holders to use their cards in discount stores and supermarkets that are able to identify FSA-eligible items at checkout. If a card holder tries to use his or her card in a discount store or supermarket that doesn't offer this feature, the card may be declined.

As a result of healthcare reform, the list of participating discount stores and supermarkets may have changed. Be sure to visit www.sig-is.org for a current list of participating stores.

Manage Your Flex/CDHP Spending from the Palm of Your Hand

Intuitive. Simple. Convenient.

Want to manage your Flex/CDHP benefits spending from anywhere? There's an app for that!

Now you can easily and securely access your benefit accounts, submit claims and upload receipts at any time. Using your smart phone or mobile device, you have quick access to common Flex/CDHP account tasks. And with an easy-to-use design, our app gives you a quick view of your financial and account information.

Get reimbursed quickly

Using the member portal app, you can quickly file your claim with a receipt and request distribution from your Flex/CDHP account. You'll be able to get the payment process started right from your phone, wherever you are—and get your money faster.

To get your temporary mobile app credentials:

1. Log in to **http://account.www.meritain.com**.
2. Click the green *Go* button in the box titled *Flex/CDHP Accounts* to access the Flex/CDHP Portal.
3. Click the *Tools & Support* tab on the Flex/CDHP Portal homepage and select D*ownload Mobile App* to access your temporary mobile app credentials.
4. Use the temporary credentials to log into the mobile app, which can be downloaded from the App Store or Google Play.

Access the app from your smart phone or mobile device

The member portal app is available for iOS and Android™ processing systems, as well as mobile devices. This includes iPhone®, iPad®, iPod touch® and Android smart phones and tablets.

Never lose a receipt again

With the member portal app, you can snap a photo of your receipt to submit with a new claim, or add to an existing one. You'll be able to capture a receipt the moment a transaction happens. That's peace of mind with the touch of a button.

Check balances on the go

Wondering whether you can pay for an elective procedure or a mounting bill? You can quickly check your account to view your current balance—without waiting to get home to your computer. The app features summarized financial information and charts. Everything you need is right at your fingertips.

Stay up to speed

Using your app, you can set your account to send you text notifications. Plus, you'll be alerted of claims that require receipts. So you can rest easy that when you need to take action, you won't be left in the dark.

If you have any questions or need more information, we can help. Just call Meritain Health Customer Service at **1.800.566.9305.**

www.meritain.com | © 2019–2020 Meritain Health, Inc. All rights reserved.

Always Care Vision Benefit

Selection of Providers:
You have access to our national network of independent eye care professionals and large optical retail chains (including Walmart, Sam's Club, Costco*, Pearle Vision, Target, Sears, JCPenney and Visionworks). You may choose different providers for the vision exam and materials purchases. Visit www.AlwaysCareBenefits.com or call 888-400-9304 for a list of participating providers.

Covered Benefits:
Exam: Each member is entitled to a comprehensive vision exam. A exam co-pay applies and is outlined in the grid below.

Materials:
Each member may purchase eyewear in the form of an eyeglass frame and lenses or contact lenses with this plan. Purchases are subject to benefit frequencies and co-pays. Plan features include:

- *Frame Benefit:* Members may choose any frame within a provider's collection, subject to the retail frame allowance listed below. If the cost is greater than the plan's benefits, the member is responsible for the difference.
- *Eyeglass Lens Benefit:* Members always receive new lenses of the highest quality and craftsmanship. Standard plastic (CR-39 Plastic Material) single vision, bifocal and trifocal lenses are generally covered in full and plan allowances are listed below for specialty lenses. If the cost is greater than the plan's benefits, the member is responsible for the difference.
- *Contact Lens Benefit:* Members electing contact lenses instead of glasses may choose to apply the contact lens retail allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, the member is responsible for the difference. The contact allowance will apply to the retail cost of contact lenses and to any professional fitting fee charged by the provider.
- *Laser Vision Correction:* Members receive a discount on Lasik or PRK prices with participating surgery providers across the country (not an insured benefit).

Benefit Frequencies	
Examination	Once Every 12 Months
Eyeglass Lenses	Once Every 12 Months
Frames	Once Every 12 Months
Contact Lenses	Once Every 12 Months

Bi-weekly Rates*	
Employee Only	$2.82
Employee + Spouse	$5.44
Employee + Child(ren)	$5.78
Employee + Family	$8.06

** Rates valid from 1/1/2021 to 12/31/2021.*

Vision Care Services	All Participating Providers	Out-of-Network Allowance
Exam	$10 co-pay	Up to $35
Materials	$25 co-pay $0 co-pay on Contact Lenses	
Standard Plastic Lenses:		
Single Vision	Covered by co-pay	Up to $25
Bifocal	Covered by co-pay	Up to $40
Trifocal	Covered by co-pay	Up to $50
Lenticular	$80 allowance	Up to $50
Progressive	$70 allowance	Up to $40
Lens Options:		
Standard Scratch Resistance Coating	Covered in full at Wal-Mart, Sam's Club and Value-Added providers only	N/A
Polycarbonate Lenses for children to age 19 only	Covered at Wal-Mart and Sam's Club only	N/A
Frames: Members choose from any frame available at provider locations.	$120 allowance ($94 at Wal-Mart, Sam's Club and Costco*****)	Up to $50
Contact Lenses:** (Includes fit***, follow-up and materials)	**$0 co-pay**	
Elective	Up to $120 allowance	Up to $100
Medically Necessary	Covered	Up to $210

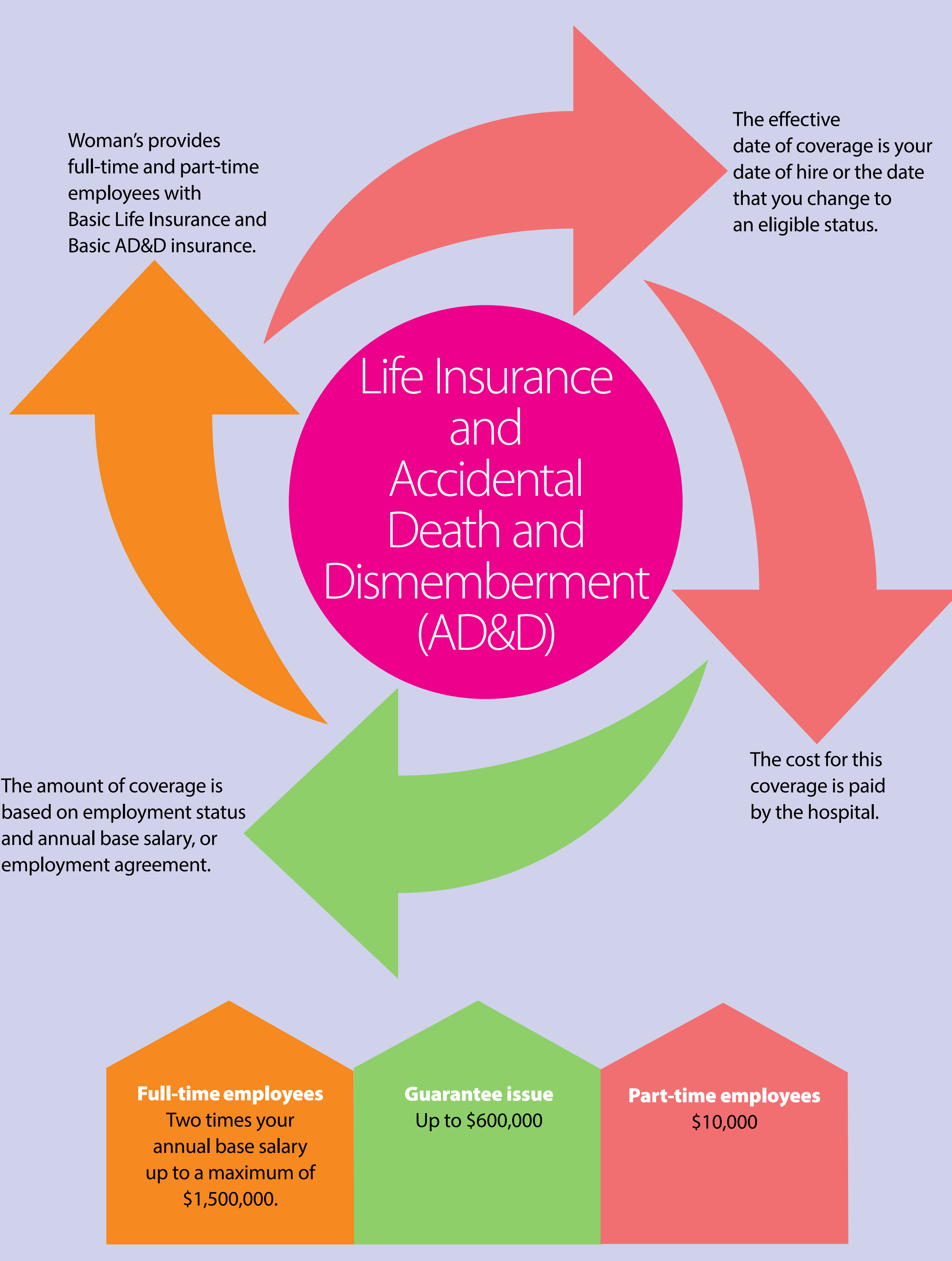
** Special payment and reimbursement terms apply for material purchases at Costco.*

*** Contact lenses are in lieu of eyeglass lenses and frames.*

**** Some providers, such as Walmart, may charge for a contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.*

Always Hearing℠ Savings Plan
- Available at no cost to all AlwaysCare Members
- Material discounts of between 30%-60% on all major name brand hearing instruments and accessories
- Battery program discounts up to 40% off retail pricing

To access call 888-400-9304



To download Life Insurance Enrollment and Beneficiary forms, visit the Intranet:
HR/Benefits/2021 Benefits

Supplemental Life and AD&D

Employee Eligibility
Full-time and part-time employees may purchase additional life insurance.

Family Eligibility
Coverage is available for your spouse and your unmarried children from live birth up to age 26 as long as you elect coverage on yourself.

Employees may purchase coverage amounts

Employee	Spouse
Minimum of $10,000 up to a maximum of 8 times base annual earnings up to $1,500,000 (Basic and Supplemental Life combined) maximum	Minimum of $5,000 up to a maximum of 50% of the employee coverage (or $250,000 whichever is less)
Benefit reduces to 65% of the original amount at age 70	Benefit reduces to 65% of the original amount at age 70
Benefit reduces to 50% of the original amount at age 75	Benefit reduces to 50% of the original amount at age 75
Up to $150,000 guaranteed issue	Up to $50,000 guarantee issue

Supplemental Life Rates

Employee
Biweekly payroll deduction per $1,000 unit of coverage. Coverage is in increments of $10,000.

Spouse
Biweekly payroll deduction per $1,000 unit of coverage. Coverage is in increments of $5,000.

Age	Employee	Spouse
<25	$0.02	$0.02
25 to 29	$0.02	$0.02
30 to 34	$0.03	$0.03
35 to 39	$0.04	$0.04
40 to 44	$0.05	$0.05
45 to 49	$0.06	$0.06
50 to 54	$0.10	$0.10
55 to 59	$0.18	$0.18
60 to 64	$0.27	$0.27
65 to 69	$0.52	$0.52
70+	$0.84	$0.84

Children: Biweekly payroll deduction
Life for Children: $10,000 = $0.74

This is a summary of benefits. For a complete description of benefits and limitations please refer to the Certificate of Coverage.

Supplemental AD&D Rates

Employee and Spouse: $.017 per $1,000 in coverage
Children: $10,000 = $0.09

Supplemental AD&D Coverage must be the same amount as the life insurance coverage up to a maximum of $250,000.

Retirement Plans

Retirement

The 403(b) Retirement Savings Plan

All employees are eligible to participate in the retirement plan on their date of hire. You may join the plan at any time.

Plan Highlights	You May Withdraw Funds From Your Plan at the Following Times
You may choose to make pre-tax salary contributions up to the maximum allowed by law.	Retirement at normal retirement age of 65
The 2021 annual IRS dollar limit is $19,500. Annual maximums are subject to change.	Termination of employment
Starting in the year you will attain age 50, you may make an additional catch-up contribution.	Financial hardship as defined in the plan
The annual IRS maximum catch-up contribution is $6,500. Annual maximums are subject to change.	Attainment of age 59½
You are always 100% vested in your contributions to this plan.	Disability
You may borrow from this plan, using your account as security.	Death
You may increase, decrease or stop your contributions at any time.	In-service withdrawal of all or a portion of contributions you have rolled into the plan at any time

To enroll, call Transamerica at 888-676-5512, or go to https://secure.transamerica.com

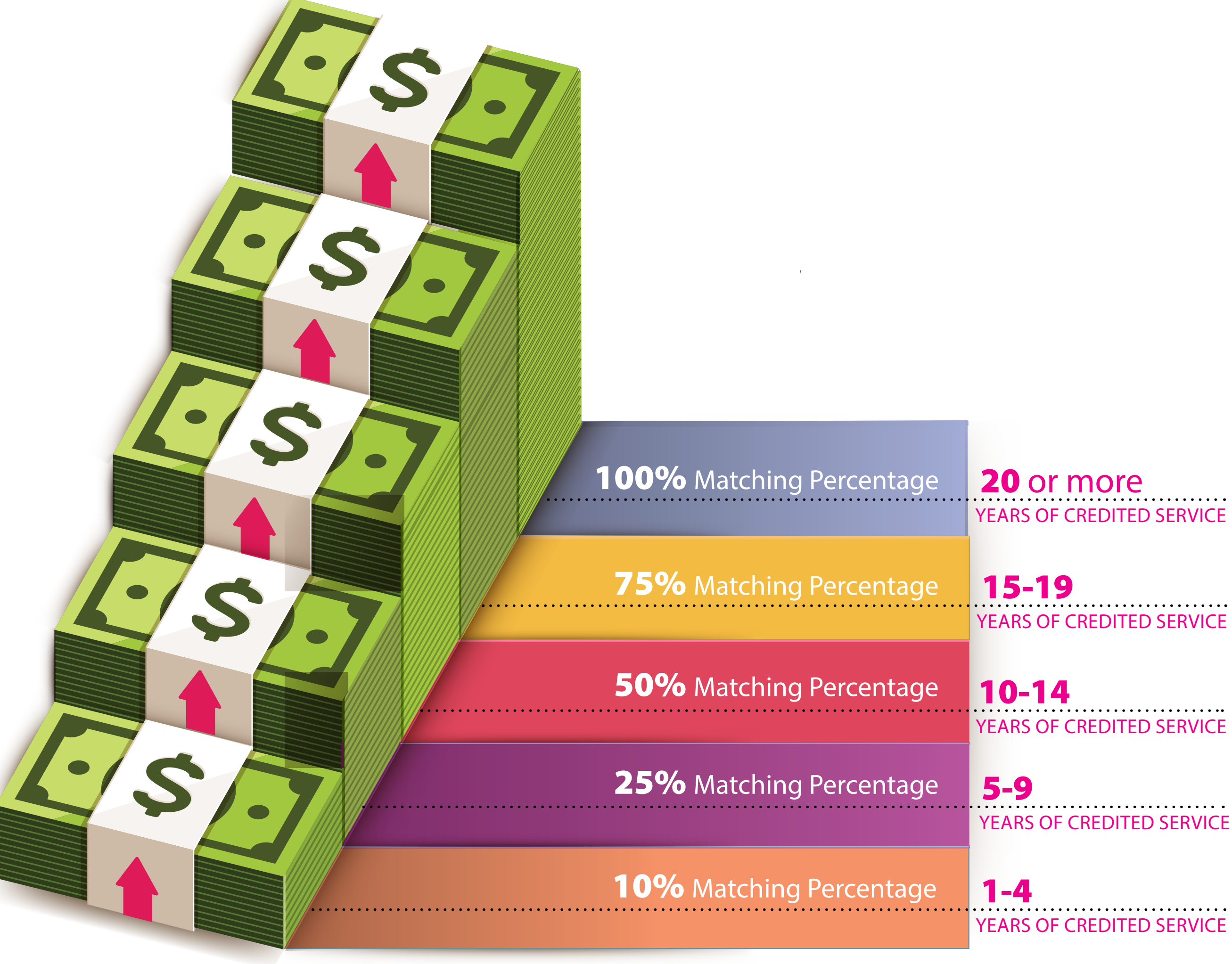
The 401(a) Employer Contribution Plan

You earn a year of credited service for each year you are paid 1000 eligible hours. You are 100% vested in the Employer Contribution Plan after completing three years of service with 1000 eligible hours.

The Employer Matching Contribution

To encourage you to save for retirement, Woman's Hospital will match eligible employees' 403(b) contributions each pay period on the first 10% of compensation you contribute to the 403(b) Retirement Savings Plan. The match is tiered, based on years of credited service. Your benefit increases to the next higher tier on April 1st after the calendar year in which you reach a milestone year.

Full time and part time employees are eligible to start receiving employer matching contributions after completing one year of service with 1,000 eligible hours and are age 21 or older. After meeting the eligibility requirements, you enter the Plan at the beginning of the next quarter.



The Employer Non-Elective Contribution

The Employer Non-Elective Contribution Plan is no longer available to new participants. Employees who were participants in the Plan as of 12/31/12 will continue to receive contributions to the plan, as long as they meet the annual eligibility requirements.

To receive a contribution, you must be paid 1000 eligible hours, and be employed on the last day of the calendar year, unless employment ends due to retirement, disability, or death. Contributions are based on years of credited service, and will be deposited in participant accounts after the end of the plan year.

The Employer Non-Elective Contribution	
Years of Credited Service	Contribution Percentage
1 – 4 years	1.25%
5 – 9 years	2.00%
10 – 14 years	2.75%
15 – 19 years	3.50%
20 – 24 years	4.25%
25 – 29 years	4.75%
30 or more years	5.25%

Woman's Hospital Foundation 403(b) Retirement Savings Plan

Taking control of your retirement journey should be simple. That's why your Transamerica account is built for easy access on any device.

SET UP YOUR ONLINE ACCOUNT
transamerica.com/portal/home

GETTING STARTED

- Click **Create an account** in the top-right corner.
- On the next page, you'll be prompted to enter your Social Security number and go through a verification process.
- If you've already set up your online account, click **Log In** in the top-right corner

COMPLETING YOUR PROFILE

- Add an email address to your account so you can be notified of suspicious account activity
- Consider adding an alternate email address for another line of communication

ONCE YOU'RE IN

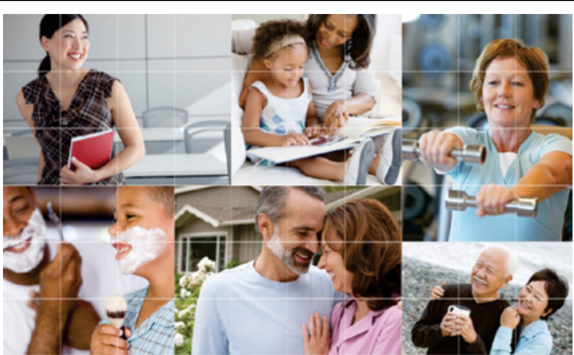
From the left-hand menu, scroll over the tabs — **Home, Review, Manage, Are You *OnTrack*®**, and **Resource Center** — and select an option from the drop-down lists.

Here, you can take control of your retirement and plan for your financial future.

- Check Account Balance
- Use our *OnTrack*® tool to help you create and easily modify your retirement income strategy
- Transfer between funds
- Review investment performance
- Manage contributions and fund allocations
- Name or change a beneficiary
- Fill out the form to start the transfer of your outside retirement assets to your plan
- Review loan status and payoff details

Review the fees and expenses you pay, including any charges associated with transferring your account, to see if consolidating your accounts could help reduce your costs. Be sure to consider whether such a transfer changes any features or benefits that may be important to you.

LifeWorks. Advice you can count on.



Find out how the LifeWorks program can help you, every day.

Whether you're trying to balance work and family life, caring for an older relative or coping with a personal issue, the LifeWorks program offers **free, confidential help** with personal and work-related issues whenever you need it, 24/7. You can call toll-free to speak with a professional LifeWorks consultant, or you can visit LifeWorks.com to find the help and resources you need. From help with a relationship to handling stressful times at work, LifeWorks can help you with almost any issue, including:

Life
- Stress and overload
- Addiction and recovery
- Relationships
- Depression
- Grief and loss
- Divorce and separation
- Finding time for you
- Work life balance
- Finding a counselor or therapist
- Legal issues

Family
- Parenting
- Adoption
- Discipline and safety
- Teenagers
- Single parenting
- Blended families
- Planning for college
- Financial aid
- Caring for seniors
- Caregiver resources

Money
- Budgeting
- Debt management
- Credit and collections
- Saving and investing
- Basic tax planning
- Buying a car
- Home buying and renting
- Saving for college
- Bankruptcy
- Estate planning and wills

Work
- Time management
- Career development
- Getting along at work
- Communication
- Job stress and burnout
- Relocation
- Networking
- Retirement planning
- Managing people
- Handling change at work

Health
- Exercise
- Healthy eating
- Managing stress
- Getting enough sleep
- Quitting tobacco
- Heart health
- Navigating the health care system
- Living with a disability
- Aging well
- Safety

Call anytime at 877-234-5151 or visit www.lifeworks.com (user id: womans; password: womans). Para información sobre este programa en español, visite en-línea en www.lifeworks.com (id de usuario: womans; clave: womans) o llame al 888-732-9020.

CERIDIAN

Employee Assistance Program (EAP)

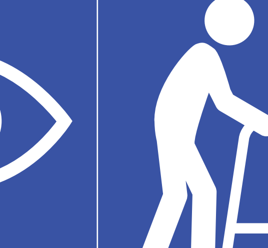
The Employee Assistance Program (EAP) is a service provided by Ceridian. The program is called LifeWorks, and is available to all employees and their eligible dependents. LifeWorks is completely funded by Woman's and is available 24 hours a day, 7 days a week. Woman's pays for up to 3 consultations per family member, per category, per year (up to a maximum of 15 visits per year for all categories combined). The interactive website offers great information on all sorts of topics. You can read articles, download books, listen to a podcast, contact a consultant, and much more. Contact Human Resources at 8140 or 8731 for more details.

Long Term Disability

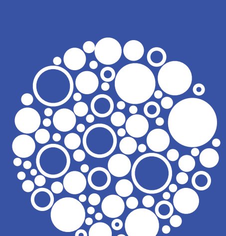
Long term disability benefit applies to full-time employees only. Full-time employees are automatically enrolled.

Woman's pays 100% of the cost of this program.

This policy will pay up to 60% of your pre-disability earnings after you have been continuously disabled for 90 days or more, and are under the care of a physician.



The maximum monthly benefit is $10,000, and will continue as long as you are disabled, until you reach Social Security Normal Retirement Age or reach the maximum benefit period.



Refer to the Group Disability Summary Description Plan on the Intranet: *Departments/HR/Benefits for more details.*

Value Added Benefits with Cigna Long Term Disability:

- **Life Assistance Program (LAP)** – Access to licensed Cigna clinicians 24/7 for phone consultations, 3 free in-person counseling sessions, referrals to community resources, legal and financial services, as well online resources for work/life challenges.
- **CignaWillCenter.com** – Online access to state specific legal documentation for wills and powers of attorney, and valuable resources for estate and funeral planning.
- **Identity Theft** – provides identity theft prevention and resolution services, including access to personal case managers to who provide assistance and guidance as well as education and tools to help prevent identity theft in the future.
- **Healthy Rewards** – Provides discounts on a variety of health and wellness products and services.
- **My Secure Advantage** – offers customers with approved disability claims (and their household members) access to expert "money coaching" for all types of financial challenges.

More information can be found on the Intranet:
HR/Benefits/2021 Benefits
Or contact Human Resources at 8731 or 8140 for more details

Employee Self Service

The Employee Self Service portal is your direct link

- View and enroll in core benefits programs
- Update your personal information
- View and print your paycheck information and W-2
- View your PTO and ELB balances
- Change your benefit elections due to a Qualifying Event
- View and change your tax withholdings
- View job postings, Hospital policies, discount information and important news
- View and change your direct deposit information
- Sign up for First Alert notifications

First time users

- Double-click the ESS icon on your desktop, or click the ESS link at the top of the Intranet home page
- Enter your employee ID number as the User name
- Enter the last four digits of your SSN as the password
- Change your password. Must contain:
  - 1 uppercase letter
  - 1 lowercase letter
  - 1 number
  - 1 special character
- Answer 3 security questions

Return users

Forgot your password?
Click on "Forgot your password?" located under the "Log in" button.

Home access

http:N11.ultipro.com or enter through www.womans.org.

How to Enroll in the Health and/or Dental Plan

1. Sign onto Employee Self Service (ESS) within 31 days of your hire date
2. Click on Menu
3. Under the Myself tab
4. Go to Life Events
5. Click I Am a New Employee

Select Your Benefits

If you decide not to enroll in the Woman's Health Plan, or many of the benefits plans described in this booklet within 31 days of your hire date or change to an eligible status, you will not be able to enroll until Open Enrollment, unless you experience a "Qualifying Life Event." You are able to enroll, make changes or cancel certain benefits within 31 days of a qualifying event.

For further information, see *"When Can I Change My Benefit Elections?"* on page 46 or call Human Resources at extension 8140.

Tuition Reimbursement

Are you thinking of going back to school or taking a class to further your career goals? Woman's may help pay for your tuition. If you are a full-time or part-time employee you may be eligible for a reimbursement of your educational expenses each semester. *(See HR Policy #256 for full details.)*

Reimbursement is based on the grade achieved and will be paid, up to the maximum benefit allowable, as follows:

Grade	Reimbursement
A, B or Pass (pass/fail)	100%
C	75%
D or below	0%
Fail (pass/fail)	0%

Full-time employee
limited to $2,500 per calendar year

Part-time employee
limited to $1,500 per calendar year

An application and fee bill must be submitted prior to the start of each semester. Funds are limited. Applications are processed on a first come, first served basis.

The application can be found on the Intranet:
Departments/HR/Forms/Tuition

Voluntary Benefits

Chubb Long-Term Care + Life Insurance Benefit

This benefit will help pay for services to care for you when you can no longer perform everyday activities on your own. These activities can range from help at home with meal preparation and housekeeping to personal care services like bathing, dressing, eating and moving around. Care is typically received at home, in a nursing home or in an assisted living facility which is a home-like setting that offers safety and security.

As we age, the likelihood of needing LTC increases and the cost of home care can exceed $40,000/year. Your health insurance, disability benefit and Medicare do not cover most LTC costs. Also, LTC isn't just for the elderly. An accident or prolonged illness means the need for LTC services can happen to anyone at any age.

How it Works

One policy with two benefits — life insurance coverage for your family and LTC benefits if you need them.

As Life Insurance, the benefit protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long-Term Care, if you become chronically ill, your policy will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

Employees can choose a life insurance amount between $25,000 - $150,000, then your LTC Benefit payout is 4% each month and your total LTC benefit pays up to 75 months.

Please note this benefit will not replace your existing life insurance — you can be enrolled in both plans. The Chubb plan helps protect you with a long-term care event.

Learn More & Enroll

Go to https://www.getltci.com/womans to learn more and login to view your plan rates before enrolling. Have a question? Talk to an expert at (844) 349-8308.

Veterinary Pet Insurance (VPI) Program

- Full-time and part-time employees are eligible to participate
- Reimbursements are paid directly to pet owners for a comprehensive list of veterinary services.
- Choice of any veterinarian — no pre-authorization required.
- Coverage for spaying, neutering, and confinement of your pet at a veterinarian's premises or hospital.
- Choose the coverage that's right for your pet and your budget.
- Additional discounts are available when you enroll multiple pets.

For questions about the VPI program or to enroll, please call 877-PETS-VPI.

Accident Insurance

- Full-time and part-time employees are eligible to participate
- Supplements your medical insurance by helping you pay out-of-pocket costs – such as deductibles, co-pays, coinsurance and other non-medical expenses incurred from an accidental injury.
- Employee and family members are insured for covered accidents, 24 hours a day, 7 days a week.
- Plan pays benefits in addition to medical plan reimbursements and Workers' Compensation.

For questions, information on portability, or to enroll, please call The Farmington Company at 800-621-0067.

Voluntary Benefits *continued*

Critical Illness Insurance

- Full-time and part-time employees are eligible to participate
- Lump-sum benefits are paid directly to the insured following the diagnosis of each eligible critical illness.
- Dependent children are covered at 25% of the primary insured's coverage amount at no additional charge.
- Eligible conditions include heart attack, stroke, end-stage renal failure, major organ transplant, cancer, etc.
- Annual $50 health screening benefit (employee and spouse only).
- Rates will not increase due to change in age, health, or individual claim.
- Simplified underwriting — answer only a few health questions.

For questions, information on portability, or to enroll, please call The Farmington Company at 800-621-0067.

Whole Life Insurance

- Full-time and part-time employees are eligible to participate
- Provides a life insurance policy and builds cash value.
- Benefits will not change and premiums will not increase over time.
- You may purchase coverage for eligible family members even if you do not purchase a policy for yourself.

For questions, information on portability, or to enroll, please call The Farmington Company at 800-621-0067.

Short Term Disability Insurance Program

- Full-time employees are eligible to participate.
- Provides income replacement for illnesses and off-the-job injuries.
- The maximum period of coverage is 3 months.
- The maximum benefit amount is $5,000 per month, not to exceed 60% of pre-disability weekly income.
- Pregnancy is covered the same as any other illness.
- Benefits will commence on the fifteenth day of disability. You will have to use PTO and/or ELB to receive pay for the first 14 days of your disability.
- *Pre-Existing Limitations Apply* — You will not be paid for any disability that results from a pre-existing condition that you sought medical care for or were treated for in the 12 months prior to the effective date of coverage.

For questions, information on portability, or to enroll, please contact The Farmington Company at 1-800-621-0067.

Monthly Income Range	Monthly Benefit	Age 17-49	Age 50-69
$501-$666	$400	$11.01	$12.87
$834-$1,000	$600	$16.51	$19.29
$1,167-$1,333	$800	$22.02	$25.70
$1,501-$1,666	$1,000	$27.52	$32.11
$1,834-$2,000	$1,200	$33.02	$38.53
$2,167-$2,333	$1,400	$38.53	$44.94
$2,501-$2,666	$1,600	$44.03	$51.40
$2,834-$3,000	$1,800	$49.53	$57.81
$3,167-$3,333	$2,000	$55.04	$64.22
$4,001-$4,166	$2,500	$68.77	$80.26
$4,834-$5,000	$3,000	$82.51	$96.33

Benefits Summary

When Can I Change My Benefit Elections?

You may enroll in the benefits plans offered by Woman's within 31 days of your date of employment or date of eligibility. Once elections are made, they may not be changed unless a qualifying event occurs, or during Open Enrollment. If you experience a "change in status," you must experience a gain or loss of eligibility, and your enrollment change must be consistent with that gain or loss. Proof of dependent eligibility is required.

Event	When You Can Change Coverage	Benefits Affected	Effective Date
New hire or rehire	You may elect coverage within 31 days of your date of hire or rehire.	Health, Dental, Health FSA, DCAP, Life, LTD, STD, Critical Illness, Accident, Vision, Pet	Date of hire or rehire
Change from FT to PT status	You may delete coverage within 31 days of your change of status date.	Health, Dental, DCAP, Life, Critical Illness, Accident, Vision, Pet. LTD and STD automatically cancel.	Status change date
Change from PT to FT status	You may elect or change coverage within 31 days of your change of status date.	Health, Dental, DCAP, Life, LTD, STD, Critical Illness, Accident, Vision, Pet.	Status change date
Change from PRN to FT status	You may elect coverage within 31 days of your change of status date.	Health, Dental, Health FSA, DCAP, Life, LTD, STD, Critical Illness, Accident, Vision, Pet	Status change date
Change from PRN to PT status	You may elect coverage within 31 days of your change of status date.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision, Pet	Status change date
Birth, adoption or adoptive placement of a child	You may elect, change or delete coverage within 31 days of the birth, adoption or adoptive placement.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision, Pet	Date of birth, adoption or adoptive placement
Marriage	You may elect or change coverage within 31 days of your marriage.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision, Pet	Date of marriage
Divorce	You may elect or change coverage within 31 days of date of divorce. Coverage on spouse ends. Notify HR within 31 days of the date of divorce. If you do not have a QMCSO, you may not change your dependent children's coverage.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision	Coverage will continue for your spouse until the last day of the month after divorce. COBRA is available if notice is given within 60 days.
QMCSO requiring you to cover the children	You may elect or change coverage within 31 days of the QMCSO.	Health, Dental, Health FSA	Coverage will be effective on the date of the QMCSO.
QMCSO requiring another plan to cover the children	You may cancel their coverage within 31 days of the QMCSO.	Health, Dental, Health FSA	Coverage will be effective on the date of the QMCSO.
Death of spouse or qualified dependent	Notify HR within 31 days of the death of a spouse or qualified dependent.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision	Benefits will end on the date of death.

Event	When You Can Change Coverage	Benefits Affected	Effective Date
Child reaches dependent age limit	Your child's coverage ends. Notify HR within 31 days of the child's 26th birthday.	Health, Dental, Life, Vision	Midnight on the last day of the month in which the child turns 26. COBRA is available if notice is given within 60 days.
Family Medical Leave of Absence (FMLA)	You may cancel your coverage within 31 days of the beginning of your FMLA.	Health, Dental, Health FSA, DCAP, Life, STD, Critical Illness, Accident, Vision, Pet	The first day of the month after your FMLA begins.
Return to work from FMLA	You may elect to re-instate the coverage you cancelled when you started your FMLA, within 31 days of your return to work.	Health, Dental, Health FSA, DCAP, Life, STD, Critical Illness, Accident, Vision, Pet	The date that you return to work from FMLA.
Change in employment status of the spouse and/or dependent children	You may elect, change or delete coverage within 31 days of the date of the employment status change. This change must result in a gain or loss of eligibility for the employee, spouse, or dependents.	Health, Dental, Health FSA, DCAP, Life, Critical Illness, Accident, Vision, Pet	Benefits can begin as early as the date of the change. Benefits will end on the last day of the month in which the change occurred.
A significant change in cost or coverage options	You may elect, change or delete coverage within the enrollment period.	Health, Dental, DCAP, Life, LTD, STD, Critical Illness, Accident, Vision, Pet	Election can only be made in advance, and it must be consistent with the cost or coverage change. Will coordinate with previous plan based on gain or loss of coverage.
Medicare or Medicaid Entitlement	You may cancel coverage within 31 days of the date of Medicare or Medicaid entitlement.	Health, Dental	The date of Medicare or Medicaid entitlement
Medicare or Medicaid Termination	You may elect coverage within 31 days of the date of Medicare or Medicaid entitlement termination.	Health, Dental	The date of Medicare or Medicaid entitlement termination.
Open Enrollment	You may elect, change or delete coverage during the Woman's Hospital open enrollment period, or the enrollment period of your spouse's employer.	Health, Dental, Health FSA, DCAP, Life, STD, Critical Illness, Accident, Vision, Pet	Effective January 1, following open enrollment. We will coordinate the effective date with your spouse's employer.
Termination of employment with Woman's	All coverage will be cancelled automatically.	Health, Dental, Health FSA, DCAP, Life, LTD, STD, Critical Illness, Accident, Vision, Pet	The end of the month after employment ends. COBRA is available if notice is given within 60 days.
Reduction in hours of service	When an employee is expected to work fewer than 30 hrs/week due to reduction in hours.	Health	Effective date of enrollment in new policy.
Enrollment in a Qualified Health Plan	Within 31 days of enrollment in a QHP.	Health	Effective date of enrollment in new policy.

Show Me the Numbers

Woman's offers a wide array of benefits to help employees and their families meet their needs. Woman's spent the following amounts on benefits over the last three fiscal years.

Benefit	FY 2018	FY 2019	FY 2020
Health	$13,841,174	$15,056,285	$16,047,833
Dental	$1,175,272	$1,221,890	$1,005,219
Pharmacy	$3,116,262	$3,251,108	$3,575,908
Retirement Matching Contribution	$3,787,805	$3,934,672	$4,055,158
Retirement Non-Elective Contribution	$2,438,918	$2,483,628	$2,471,048
Long Term Disability	$337,517	$334,266	$331,987
Life Insurance	$145,777	$158,473	$169,414
Employee Assistance Plan	$27,806	$28,497	$25,956
Tuition Reimbursement	$158,049	$118,554	$125,222
Employee Discounts on WH Services	$1,789,772	$1,880,886	$2,108,421
Totals	**$26,818,352**	**$28,468,259**	**$29,916,166**

Ways to Save

Utilize an After Hours Clinic or CVS Minute Clinic for treatment of minor illnesses and injuries.
(see page 12)

Choose an After Hours Clinic, Teladoc, CVS Minute Clinic or Urgent Care Clinic versus the Emergency Department.
(see pages 11 and 12)

Purchase generic medications when possible.

Take advantage of Woman's Retail Pharmacy.

Utilize the free consultations through the Employee Assistance Program (EAP) for family, personal and work related issues.

Get regular preventive care checkups.

Tell your OB/GYN to send your Pap-smear to Woman's for processing.

Don't forget about all of Woman's discounted services

- **Lab work**
  - for the entire family
- **Radiology/ Imaging Services**
  - MRI
  - Nuclear Med
  - Mammography
- **Physical Therapy**
- **Occupational Therapy**
- **Audiology**
- **Hearing Aids**
- **Speech Therapy**
- **Behavioral Health Clinic**
- **Colonoscopy**
- **Endocrinology & Weight Management Clinic**
- **Sleep Studies**

Woman's Hospital Services

Woman's offers a 20% discount on hospital services to full-time and part-time employees and their eligible dependents. Also, onsite staff development educational offerings are completely FREE to employees.

Woman's Fitness Club

Woman's Fitness Club offers a 50% discount on memberships for employees and spouses. Payroll deduction is available for memberships, programs and personal training fees. One, six and twelve month memberships are available. For more information, call 225-924-8114.

Woman's Spa Services

Woman's Spa offers a 10% discount on spa services, including massage therapy, facial treatments, manicures, pedicures, tinting and waxing, and spray tanning services. Dermalogica, Skinceuticals Skin Care Products and Jane Iredale Cosmetics are available as well. For more information on Spa Services, please call 225-924-8388.

Woman's Center for Wellness

Woman's Center for Wellness offers services for men, women, children and infants. Services include occupational therapy, physical therapy, speech therapy, warm water therapy, mammography, nutritional counseling, hearing services, hearing aid sales, swimmers ear molds, hunter's ear molds and ear molds for earphones. For more information, call 225-924-8450.

Woman's Retail Shops

Check out the great selection of unique gifts available in the Woman's Retail Shops. The shops offer two convenient locations (one in the Physician Office Building and one in the Main Hospital), friendly service, a 10% discount on most items, and 15% on scrubs. Plus, payroll deduction is available! ($200 limit per pay period on scrubs.)

Woman's Way Café

The Café offers a wide variety of dishes. Enjoy the Choice Matters dishes and the salad bar. Or, check out the Café Classics, Pacific Rim and Deli Depot, the brick-fired pizza oven, any of the Grab-n-Geaux items, and / or a little something from the Sweet Sensations, and you'll receive a 15% discount. Swipe your ID badge for fast, easy charging, that will be deducted from your next paycheck. ($160 limit per pay period.)

Expect a transformation.

Learn sustainable lifestyle changes in 12 weeks in a group or individual setting with a focus on real foods, fitness for life and overall healthy habits.

- Weekly weigh-ins are mandatory for Woman's discount.
- Payroll deduction available.

Fitness
Nutrition
Spa Services
Therapy

For more information:
Call **225-924-8313** or visit **womans.org/balance**

Woman's Graphic Services

Woman's Graphic Services offers a 10% discount on exceptional quality printing, such as invitations for a party, personalized holiday cards or banners. Call Graphic Services at 225-924-8497.

BASIS Baton Rouge

Did you know that Woman's employees and medical staff get priority enrollment at BASIS Baton Rouge – the public charter school on Woman's campus? BASIS is the No. 1 charter school operator in the country, and the Baton Rouge school currently serves grades Kindergarten – 6th grade (K-7th for the 2021-2022 school year). For more information please contact:
BASIS Baton Rouge, 7550 McCall Drive, Baton Rouge 70817
P (225) 308-7450, basisbatonrouge.org

Take advantage of these other great discounts

Fitness Centers
Calloways and Burn Boot Camp

Financial Institutions
Bayou Federal Credit Union and NOLA Lending Group

Computers
Dell, CDW Healthcare

Premier Employee Discounts
AT&T, Sprint, Verizon, Guard Well, Moving Services, Orkin, NPA and PPG Industries

Apartment Living/ Hotel Accommodations
Cityscape at Essen Apartments, Live Oak Apartments, The Gates at CitiPlace Apartments, Tapestry Bocage and Long Farm Apartments, Wyndham Garden Hotel on Bluebonnet, Courtyard & Residence Inn by Marriott on Siegen Lane and Woodsprings Suites

Automotive Discounts
Acura Advantage Benefits Program, TEAM Automotive Group, Enterprise Rent-A-Car, Simple Simon, Chabill's Tire & Auto Service

Other Discounts
Camp Bow Wow and Home Buddies, Taekwondo Plus, Farrell-Calhoun, Office Depot, and Logan Farms of Louisiana

For the most current information on discounts and promotions, visit the Intranet under Departments/HR/Employee Discounts. Discounts are subject to change without notice.

Important Information

HC Reform Eligibility Guidelines

Employee Medical Eligibility

An individual whom the Employer classifies as a full-time employee of the Employer and is regularly scheduled to work thirty (30) or more Hours of Service per week, or an individual whom the Employer classifies as a Part-Time Employee of the Employer and is regularly scheduled to work thirty-two (32) or more Hours of Service in a fourteen (14) day pay period (a "Part-Time Employee"), will be eligible to enroll for coverage under this Plan (an "eligible Employee").

An individual is not eligible for coverage if the Employer classifies the individual as a temporary or a Seasonal Employee, a contract employee, an independent contractor or an employee of an independent contractor, or as included in a unit of employees covered by a collective bargaining agreement, unless the agreement, by a specific reference to the Plan, provides for coverage under the Plan.

The above groups of individuals are eligible for coverage or are excluded from coverage under this Plan based on the Employer's classification even if the Internal Revenue Service or any other agency, an arbitrator, or a court determines that the Employer's classification was incorrect or reclassifies that individual as an employee for employment tax purposes or for any other purpose.

An eligible Employee's Eligibility Date is the first day he or she is an eligible Employee as a Full-Time Employee or a Part-time Employee (as described in the previous paragraph).

Determining Full-Time Employee Status for Ongoing Employees: In determining whether an Ongoing Employee is classified as a Full-Time Employee the Employer has set forth a Standard Measurement Period of twelve (12) months followed by a Standard Stability Period of twelve (12) months. If during the Standard Measurement Period, the Ongoing Employee is determined to be a Full-Time Employee, the Plan will have a ninety (90) day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process. Coverage will be effective on the first of the Employee's Stability Period.

Determining Full-Time Employee Status for New Variable Hour, Seasonal, or Part-Time Employees: In determining whether a New Variable Hour, Seasonal, or Part-Time Employee will be considered as a Full-Time Employee during the Initial Stability Period the Employer has set forth an Initial Measurement Period of twelve (12) months followed by an Initial Stability Period of twelve (12) months. If during the Initial Measurement Period, the Employee is determined to be a Full-Time Employee, the Plan will have a thirty (30) day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process.

Coverage will be effective on the first day of the Employee's Stability Period. Notwithstanding any other provision to the contrary, the combined length of the initial Measurement Period and the Administrative Period for a New Employee who is a Part-Time or Variable Hour or Seasonal Employee may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one Hour of Service with the Employer.

Material Change in Position or Employment Status for New Variable Hour, Seasonal, or Part-time Employee: An Employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least (30) Hours of Service per week for the Employer will be treated as a Full-Time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents beginning on the earlier of:

(1) The fourth full calendar month following the change in employment status; or

(2) The first day of the Initial Stability Period (but only if the Employee averaged as least 30 Hours of Service per week during the Initial Measurement Period).

Notice of Privacy Practices

Woman's Health & Dental Plan

Woman's Flexible Spending Account Plan

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 Privacy Notice describes how the group health benefits under the Woman's Hospital Foundation Health & Dental Plan and Woman's Hospital Foundation Health Care Flexible Spending Account Plan (the "Plans," "we," or "us") may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information the Plans create or receive about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services or the payment for health care. We limit the collection and disclosure of protected health information to that which is the minimum necessary to accomplish the purpose of the use, disclosure, or request and to meet legal requirements. If the practices described in this notice meet your expectations, there is nothing you need to do. If you have any questions about this notice, please contact our Privacy Contact at the address at the end of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Privacy Notice. We may change the terms of this notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will send you a revised notice should we make any significant changes to our privacy practices. You may request a copy of the notice at any time by writing to our Privacy Contact at the address at the end of this notice.

1. Uses and Disclosures of Protected Health Information for Treatment, Payment or Health Care Operations

We collect a variety of personal information to administer your group health coverage. This information includes medical services bills, medical record information, and past and present medical information. You may provide some of this information in your enrollment form, claims and correspondence (such as address, phone number, Social Security number, prior health coverage, marital status, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions and communication with you, affiliates, employers, schools, insurance agents, insurers, and health care providers. We retain this information after your coverage under the Plans ends.

Treatment: The Plans do not render treatment. However, we may use and disclose your protected health information to a physician or other health care provider to treat you and to otherwise coordinate or manage your health care and any related services. For example, we may disclose your protected health information to a doctor or hospital that provides care to you to manage or coordinate payment for those services and supplies.

Payment: Your protected health information will be used, as needed, to enroll you in the Plans, to process claims for payment of health care services and any appeals that may arise in connection with a claim denial. This may include certain functions we may perform before we approve or pay for the health care services, such as making a determination of eligibility or coverage under the Plans, reviewing services you receive or will receive for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to us to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information for underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and securing or placing a contract of reinsurance relating to claims for health care (including stop loss insurance and excess risk insurance). The Plans are prohibited from using or disclosing protected health information that is genetic information of an individual for underwriting purposes.

We will share your protected health information with Woman's Hospital Foundation, the Plan sponsor, and with third party "business associates" that perform various activities (e.g., claims processing or administration, data analysis, processing or administration, utilization review, and repricing), including auditors, accountants and attorneys. Our disclosure will be subject to the privacy requirements in the Plan documents. We may disclose summary health information to the Plan sponsor for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plans, or modifying, amending, or terminating the Plans. We may disclose to the Plan sponsor information on whether you are participating in the Plans or are enrolled in or have disenrolled from the Plans. We will not obtain, retain, or disclose your genetic information or records relating to any sexually transmitted disease, including HIV / AIDS, alcohol or drug abuse treatment, substance abuse testing, or mental health except as permitted or required under Louisiana law.

- We will respond to your request for access or an accounting within 30 business days from the date your request is received.
- We will inform you of the nature and substance of such recorded personal information.
- We will give you a list of the persons to whom it has disclosed such personal information within two years prior to the request for access, if that information is recorded.

- We will respond to your written request to correct, amend, or delete any recorded personal information about you within our possession within 30 business days from the date your request is received or notify you of our refusal to make the correction, amendment or deletion, the reasons for the refusal, and your right to a statement of disagreement.

Whenever an arrangement between a business associate and the Plans involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Disclosures to Your Personal Representative: We may disclose your protected health information to a personal representative(s) you designate. A person who has the authority to make health care decisions on your behalf under applicable law will be your personal representative. A parent, guardian or other person acting in loco parentis generally will be the personal representative of an unemancipated minor, except with respect to health care services the unemancipated minor can obtain without the consent of the parent, guardian or other person acting in loco parentis.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

The Plans will obtain an authorization for any use or disclosure of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by the individual. The Plans will obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of a face-to-face communication made by the Plans to the individual or a promotional gift from the Plans of nominal value. If the marketing involves direct or indirect financial remuneration to the Plans from a third party, the authorization will state that such remuneration is involved. The Plans will obtain an authorization for any disclosure of protected health information that is a sale of protected health information. Such authorization will state that the disclosure will result in remuneration to the Plan. Other uses and disclosures of your protected health information not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law as described in this notice. You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following situations. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care or payment for your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or track products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as the FDA may require.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, and (5) if a crime occurs on our premises.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that 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. We may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Specialized Government Functions: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the Department of Veterans Affairs to determine your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military. We may also disclose your protected health information to authorized federal officials to conduct national security and intelligence activities, including to provide protective services to the President or others who are legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Required Uses and Disclosures: We must disclose your protected health information to you on your request and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the federal privacy requirements.

2. Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. However we will agree to the restriction if (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the protected health information pertains solely to a health care item or service for which the individual, or person other than the Plans on behalf of the individual, has paid the health care provider in full. In other cases, if we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to your requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by submitting a written request to the Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
For example, you may ask us to contact you only at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We may ask you to state that the information to which our request relates could endanger you. You must make this request in writing to our Privacy Officer.

You have the right to inspect and copy your protected health information.
The provider (e.g., doctor, dentist, hospital, pharmacy or other care giver) that generated the original records will have information that is the most complete. However, you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for us used, in whole or in part, by or for us to make decisions about your claims. You must make any request to review your protected health information in writing to the Privacy Officer. We may impose a reasonable cost-based fee for providing you copies, which may include the cost of supplies, labor and postage.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to a law that prohibits access to protected health information. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.

You may have the right to request that we amend your protected health information.
This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. For example, we may not be able to correct inaccuracies in information others provided to us. We also may determine that the information is accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information during the six years before your request.
This right applies to disclosures, if any, that were made for purposes other than treatment, payment or health care operations as described in this Privacy Notice. It excludes disclosures we may have made to you, pursuant to your authorization, incident to a use or disclosure that is otherwise permitted to family members or friends involved in your care or payment for your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a time frame that is shorter than during the six years before your request. Your right to receive this information is subject to certain exceptions, restrictions and limitations. The exception above for treatment, payment or health care operations may not apply to certain disclosures through an electronic health record of any protected health information we maintain in an electronic health record in which case you would have a right to receive an accounting of disclosures of such information during only the three years prior to the date on which your request the accounting. We will charge you for the cost of providing more than one list during a 12-month period.

You have the right to obtain a paper copy of this notice from us, on request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to Woman's (refer to contact information below)or to the Secretary of Health and Human Services if you believe we violated your privacy rights. You may file a complaint with our Privacy Officer. Your complaint must be submitted in writing. We will not retaliate against you for filing a complaint. Our Privacy Contact can answer your questions or provide you further information about the complaint process.

The Plan's Privacy Officer is the Vice President Employee/Wellness Services of Woman's, 100 Woman's Way, Baton Rouge, Louisiana 70817, 225-924-8643.

This updated notice was published and became effective on September 1, 2013.

(Rev. 10/2015)

Newborns' and Mothers' Health Protection Act

Fact Sheet

U.S. Department of Labor
Employee Benefits Security Administration

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions** (FAQs) About the Newborns' and Mothers' Health Protection Act.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act, signed into law on October 21, 1998, provides protection for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

In compliance with this Act, the Woman's Hospital Health Plan will cover:

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

This coverage will be subject to the same annual deductibles and copayments that apply to your other plan benefits. Please review your Summary Plan Description for details on the plan's deductible and coinsurance requirements.

Important: Please share this information with your spouse if she is also covered under this plan.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: *http://myalhipp.com/*
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: *http://myakhipp.com/*
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: *http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx*

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website: *https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx*
Phone: 916-440-5676

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

Health First Colorado Website: *https://www.healthfirstcolorado.com/*
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: *https://www.colorado.gov/pacific/hcpf/child-health-plan-plus*
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): *https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program*
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: *https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html*
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: *https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp*
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: *http://www.in.gov/fssa/hip/*
Phone: 1-877-438-4479
All other Medicaid
Website: *https://www.in.gov/medicaid/*
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: *https://dhs.iowa.gov/ime/members*
Medicaid Phone: 1-800-338-8366
Hawki Website: *http://dhs.iowa.gov/Hawki*
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: *http://www.kdheks.gov/hcf/default.htm*
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: *https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx*
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: *https://kidshealth.ky.gov/Pages/index.aspx*
Phone: 1-877-524-4718
Kentucky Medicaid Website: *https://chfs.ky.gov*

LOUISIANA – Medicaid

Website: *www.medicaid.la.gov* or *www.ldh.la.gov/lahipp*
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: *https://www.maine.gov/dhhs/ofi/applications-forms*
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: *https://www.maine.gov/dhhs/ofi/applications-forms*
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: *http://www.mass.gov/eohhs/gov/departments/masshealth/*
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: *https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp*
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: *http://www.dss.mo.gov/mhd/participants/pages/hipp.htm*
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.govMontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: *http://www.ACCESSNebraska.ne.gov*
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: *http://dhcfp.nv.govMedicaid*
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: *https://www.dhhs.nh.gov/oii/hipp.htm*
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: *http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/Medicaid*
Phone: 609-631-2392
CHIP Website: *http://www.njfamilycare.org/index.html*
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: *https://medicaid.ncdhhs.gov/*
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: *http://www.insureoklahoma.org*
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: *https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx*
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: *http://www.eohhs.ri.gov/*
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: *https://www.scdhhs.gov*
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: *http://dss.sd.gov*
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: *http://gethipptexas.com/*
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: *https://medicaid.utah.gov/*
CHIP Website: *http://health.utah.gov/chip*
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: *http://www.greenmountaincare.org/*
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: *https://www.coverva.org/hipp/*
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: *https://www.hca.wa.gov/*
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: *http://mywvhipp.com/*
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: *https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm*
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: *https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/*
Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Employee Rights and Responsibilities

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

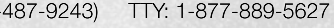
ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE



www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Woman's 2021 BIWEEKLY PAY CALENDAR

January

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	**8**	9
10	11	12	13	14	15	16
17	18	19	20	21	**22**	23
24/31	25	26	27	28	29	30

February

S	M	T	W	T	F	S
	1	2	3	4	**5**	6
7	8	9	10	11	12	13
14	15	16	17	18	**19**	20
21	22	23	24	25	26	27
28						

March

S	M	T	W	T	F	S
	1	2	3	4	**5**	6
7	8	9	10	11	12	13
14	15	16	17	18	**19**	20
21	22	23	24	25	26	27
28	29	30	31			

April

S	M	T	W	T	F	S
				1	**2**	3
4	5	6	7	8	9	10
11	12	13	14	15	**16**	17
18	19	20	21	22	23	24
25	26	27	28	29	**30**	

May

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	**14**	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	**28**	29

June

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	**11**	12
13	14	15	16	17	18	19
20	21	22	23	24	**25**	26
27	28	29	30			

July

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	**9**	10
11	12	13	14	15	16	17
18	19	20	21	22	**23**	24
25	26	27	28	29	30	31

August

S	M	T	W	T	F	S
1	2	3	4	5	**6**	7
8	9	10	11	12	13	14
15	16	17	18	19	**20**	21
22	23	24	25	26	27	28
29	30	31				

September

S	M	T	W	T	F	S
			1	2	**3**	4
5	6	7	8	9	10	11
12	13	14	15	16	**17**	18
19	20	21	22	23	24	25
26	27	28	29	30		

October

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	**15**	16
17	18	19	20	21	22	23
24/31	25	26	27	28	**29**	30

November

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	**12**	13
14	15	16	17	18	19	20
21	22	23	24	25	**26**	27
28	29	30				

December

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	**10**	11
12	13	14	15	16	17	18
19	20	21	22	23	**24**	25
26	27	28	29	30	31	

Notes

Notes

Employee Health Clinic
225-924-8144

Fitness Club and Spa Services
225-924-8300

Therapy Center
225-924-8450

Payroll
225-924-8440
Fax: 225-928-8855

Woman's Retail Pharmacy
225-924-8199
Fax: 225-928-8844

ActiveCare
877-862-5553
www.activecare.com

Aetna National PPO Network
800-925-2272
www.aetna.com/docfind/custom/mymeritain

AlwaysCare Vision Benefits
888-400-9304
www.alwayscarebenefits.com

Bayou Federal Credit Union
225-924-8470 (Onsite)
225-925-8800 (Main branch)
www.bayoufcu.org

Chubb (Long Term Care)
844-349-8308

Human Resources

Sharareh Creel, Benefits Coordinator
225-924-8731
sharareh.creel@womans.org

Julie Lear, Benefits and LOA Specialist
225-924-8140
julie.lear@womans.org

Peter Lloyd, Benefits and Compensation Manager
225-924-8143
peter.lloyd@womans.org

HR Benefits Fax: 225-928-8850

Ceridian (Employee Assistance Program)
877-234-5151
www.lifeworks.com
User ID & password: womans

The Farmington Company
800-621-0067
www.farmingtonco.com

Healthy Merits
877-348-4533
https://womanshospitalfoundation.wellright.com

Meritain Health (Flex Spending Account)
800-566-9305
Claim Fax: 763-852-5004
www.mymeritain.com

Meritain Health
800-925-2272 or
800-566-9311
Claim Fax: 763-852-5057
www.mymeritain.com

RxResults
844-853-9400

Southern Scripts
1.800.710.9341
www.southernscripts.net

Transamerica (Retirement Plan)
888-676-5512 – Enrollment
800-755-5801 – Active Participants
https://secure.transamerica.com

VPI
877-PETS-VPI

Woman's **Mission**

To improve the health of women and infants.

100 Woman's Way | 225-924-8655 | A nonprofit organization | **womans.org**
Woman's is an Equal Opportunity Employer | Accredited by the Joint Commission