

2020 EMPLOYEE BENEFITS

Eligibility ■ Medical ■ Dental ■ Vision ■
Life Insurance ■ Disability ■ Accident ■
Critical Illness ■ Cancer ■ Enrollment



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YOUR BENEFITS PROGRAM

It is with pleasure that we present you with this year's employee benefits guide for our 2020 benefits program. At City of Cookeville our most important asset is our people. That's why we offer you an exceptional benefits program with many options, designed to meet your needs and the needs of your family. In this booklet you will find summaries of the City of Cookeville's medical, dental, vision, disability, life, and additional voluntary plans such as critical illness, cancer, and accident.

This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

CLAIM QUESTIONS OR ISSUES

Having issues with a claim? Follow the steps below to get the help you need. It's important to always start by contacting your insurance company directly. If you still have issues after you've talked with your carrier, notify our Benefits Coordinator and we will work with our insurance broker, McGriff Insurance Services, to try and provide a resolution. McGriff Insurance has a team of account managers to assist you with any claims issues that you might be experiencing. If you have a problem or a question about a claim:

1

Call your insurance carrier's customer service department. Phone numbers can be found on your ID cards and on page 30 of this booklet.

2

If the carrier does not resolve your problem, contact your Benefits Coordinator: Kim Lacy at 931-520-5291 or email kab@cookeville-tn.gov

3

If you are still not satisfied after steps 1 and 2, your employer will contact our team at McGriff Insurance Services to help further assist you.



NEW PLANS & CARRIERS FOR 2020

You have the option of enrolling in some great new benefits with new insurance carriers for the 2020 plan year. The new plans and carriers include:

- » Short Term and Long Term Disability through Lincoln Financial
- » Employee Assistance Program (EAP) through Lincoln Financial
- » Critical Illness, Accident and Hospital Indemnity Insurance through The Hartford
- » Cancer & Specified Disease Insurance through Bay Bridge Administrators
- » Whole Life Insurance through Bankers Worksite

OTHER CHANGES FOR 2020

- On May 28, 2019 the IRS released Revenue Procedure 2019-25 to announce the inflation-adjusted limits for high deductible health plans (HDHPs) for 2020. Due to this change the City of Cookeville is required to increase the deductible on the HDHP to the new amounts below.
 - » Embedded Deductible HDHP: Individual deductible is increasing to \$2,800 and the family deductible is increasing to \$5,600.
- This year's enrollment is **ACTIVE** which means you **must** enroll in your benefits even if you're not making any changes from last year.
- We are very excited to announce that we have a **new online benefits enrollment website**. For the first time ever all of your benefits elections will be done online! That's why we're having an active enrollment.
- We understand that you may have questions on which plans best fit your needs so we have arranged to have professional benefit enrollers come onsite and meet with each benefit eligible employee, one on one, to answer any employee benefit related questions you may have. They will also help you complete your enrollment through the new benefits enrollment website.
- **Please note:**
 - » The benefit enrollers are not employed by nor do they represent any of the insurance carriers. Their role is to educate you on the benefit options you have available to you.
 - » The City of Cookeville does not endorse any of the employee benefit insurance plans that are offered to our employees for purchase on a voluntary basis. Your enrollment in any of these plans is on a voluntary basis and each employee must decide if they wish to elect or decline these coverages.

BENEFITS ELIGIBILITY

For all full-time, benefit eligible employees, benefits will take effect the first of the month following 30 days of full-time employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children under age 26, regardless of marital or student status, are eligible to enroll in medical, dental, vision, life, critical illness, accident, hospital indemnity and cancer insurance.
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Other dependents who may live with you, but are NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed above
- Ex-spouses
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

MAKING CHANGES TO YOUR BENEFITS

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change.

Open Enrollment generally occurs in the fall with plan changes effective from January 1st through December 31st of the following year.

To make benefit changes as a result of a Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify the Benefits Coordinator within 30 days of the date of the qualifying event
- Provide proof of your life status event
- Login to the Prepare Benefits Enrollment Portal to complete enrollment/change or contact the Benefits Coordinator for assistance.



The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

WELLNESS—BE YOUR BEST SELF!

The City of Cookeville is committed to providing resources to promote a healthy workforce. The physical, mental and emotional well-being of our employees is a main priority within our organization. We seek to improve individual wellness, and to make health and wellness a permanent staple in our employees' and their families' lives. In turn, we envision an environment with greater employee satisfaction, increased productivity, decreased absenteeism and lower health insurance premiums!

HOW DO I PARTICIPATE?

The City of Cookeville will again be partnering with Cookeville Regional Medical Center for the annual Wellness Fair. Employees are encouraged to participate in the Wellness Fair; however, participation is on a voluntary basis. The City of Cookeville will not deny access to health insurance or other benefits if an employee chooses not to participate in wellness. **For employees wanting to receive the medical premium wellness incentive you must attend one of the Wellness Fair meetings, complete a Lipid Profile, a Complete Chemistry Profile and complete a Personal Health Assessment online with BCBS.** You must also agree to allow CRMC to share your biometric results with BCBS. There is no charge to employees for any of the five tests below. Additional testing will be available to employees and their spouse at their own expense.

Employer Paid Wellness Tests	New Hire Quarterly Wellness Dates
Lipid Profile	December 10, 2019
Prostate Specific Antigen (PSA)	March 11, 2020
Flu Shot	June 10, 2020
3-D Mammogram	September 29—October 1, 2020
Complete Chemistry Profile	December 9, 2020

CRMC URGENT CARE CLINIC: As an employee of the City of Cookeville you and your eligible dependents are able to visit the CRMC Urgent Care Clinic for non-emergent care such as sick visits, sports physicals, and limited lab work/injections that are included in the contract between the City of Cookeville and CRMC. Any additional lab tests that may be ordered will be the responsibility of the employee to pay through payroll deduction. Children needing well-child exams or physicals with immunizations will need to seek treatment from their pediatrician. Dependent children will be seen for sick visits only.

HOW MUCH DOES IT COST? Employees and eligible dependents enrolled in either of the BCBST health insurance plans are charged \$20.00 per visit. This fee does not apply toward the annual insurance deductible. An employee who does not participate in the city health insurance program is charged \$60.00 per visit. These fees will be payroll deducted. Dependents of employees who are not covered under the BCBS health insurance are not authorized for treatment.

WHO IS AN ELIGIBLE DEPENDENT? An eligible dependent is defined as a spouse or child under the City of Cookeville BCBST health insurance plan. Employees must have listed the dependent on the Employee Personal Data sheet provided to the City of Cookeville Accounting department. If the dependent is not listed on this document, they will not be authorized to receive treatment. The employee does not have to accompany the dependent to the clinic. The dependent will be required to provide the last four digits of his or her social security number for identification (not the employee's). If the dependent is under the age of 18, a parent or legal guardian must accompany them.

MEDICAL BENEFITS PROVIDED THROUGH BLUECROSS BLUESHIELD OF TN

City of Cookeville is pleased to provide employees with access to two medical plan options through BlueCross BlueShield of Tennessee. Offering a competitive benefits package is important to us and we need your help! We ask that you continue to help us manage our medical costs by getting involved in your healthcare! You can impact the bottom line by:

- Using the ER only for true emergencies
- Taking advantage of generic prescriptions when available
- Utilizing the preventive care benefit
- Staying in-network whenever possible

Your Health Partner

BlueCross BlueShield of TN is not just a health plan. They are also a team of health care providers — including doctors, nurses, pharmacists, and specialists — all working together to provide the right care for you and your family. Employees have the option of electing a PPO plan or a High Deductible Health Plan (HDHP).

Benefits At A Glance: In-Network Benefits Listed

Option 1: PPO	Option 2: HDHP
Deductibles: \$1,000 per individual \$3,000 per family	Deductibles: \$2,800 per individual \$5,600 per family
Coinsurance: You pay 20% and BCBS pays 80% after deductible	Coinsurance: You pay 20% and BCBS pays 80% after deductible
Primary care physician visit: 20% coinsurance after deductible	Primary care physician visit: 20% coinsurance after deductible
Specialist visit: 20% coinsurance after deductible	Specialist visit: 20% coinsurance after deductible
ER Visit: \$100 copay + 20% after deductible	ER Visit: 20% coinsurance after deductible
Out-of-Pocket Maximum: \$2,500 per individual \$5,000 per family	Out-of-Pocket Maximum: \$5,000 per individual \$10,000 per family
Pharmacy Coverage: Tier 1 Generic: 30% Copay Tier 2 Preferred: 40% Copay Tier 3 Non-Preferred: 50% Copay Specialty: 50% Copay	*Pharmacy Coverage: Tier 1 Generic: \$10 Copay Preventive Drugs Tier 2 Preferred: \$35 Copay Preventive Drugs Tier 3 Non-Preferred: \$60 Copay Preventive Drugs Specialty: 20% after deductible

** Copays listed above apply only to medications listed on the BCBST Preventive Drug List. Medications not included on this list, but listed on the BCBST Preferred Formulary will be subject to the deductible and coinsurance.*

MEDICAL: OPTION 1 PPO¹

	Your Cost In-Network	Your Cost Out-of-Network
Annual Deductible		
Individual	\$1,000	\$2,000
Family	\$3,000	\$6,000
Out of Pocket Maximum		
Individual	\$2,500	\$7,500
Family	\$5,000	\$15,000
Coinsurance (Member pays)	20% after deductible	40% after deductible
Professional Services		
Primary Care Office Visits	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Preventive Care Services	Covered at 100%	40% after deductible
Hospital Services		
Facility Fee (Prior Authorization Required)	20% after deductible	40% after deductible
Physician/surgeon fees	20% after deductible	40% after deductible
Emergency Care Services		
Emergency Room	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible
Emergency Medical Transportation	20% after deductible	20% after deductible
Outpatient Surgery (Prior Authorization Req.)		
Facility Fee	20% after deductible	40% after deductible
Physician/surgery fee	20% after deductible	40% after deductible
Diagnostic Testing		
X-Ray, Blood work	20% after deductible	40% after deductible
Imaging (CT, PET scans, MRIs)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Services	20% after deductible	40% after deductible
Inpatient Services	20% after deductible	40% after deductible
Prescription Drugs	(Retail up to 30-day supply)	(Retail up to 30-day supply)
Tier 1 Generic	30% copay	40% after deductible
Tier 2 Preferred	40% copay	40% after deductible
Tier 3 Non-Preferred	50% copay	40% after deductible
Specialty	50% copay	Not covered
Medical Employee Premiums (24 payroll deductions)		
Tier	Employee Wellness	Employee Non-Wellness
Employee Only	\$35.00	\$53.60
Employee + One	\$98.50	\$117.10
Family	\$123.50	\$142.10

1. Medical Option 1 is a FSA eligible health plan. Refer to page 11 for more information.

MEDICAL: OPTION 2 HDHP¹

	Your Cost In-Network	Your Cost Out-of-Network
Annual Deductible		
Individual	\$2,800	\$5,600
Family	\$5,600	\$11,200
Out of Pocket Maximum		
Individual	\$5,000	\$15,000
Family	\$10,000	\$30,000
Coinsurance (Member pays)	20% after deductible	40% after deductible
Professional Services		
Primary Care Office Visits	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Preventive Care Services	Covered at 100%	40% after deductible
Hospital Services		
Facility Fee (Prior Authorization Required)	20% after deductible	40% after deductible
Physician/surgeon fees	20% after deductible	40% after deductible
Emergency Care Services		
Emergency Room	20% after deductible	20% after deductible
Emergency Medical Transportation	20% after deductible	20% after deductible
Outpatient Surgery (Prior Authorization Req.)		
Facility Fee	20% after deductible	40% after deductible
Physician/surgery fee	20% after deductible	40% after deductible
Diagnostic Testing		
X-Ray, Blood work	20% after deductible	40% after deductible
Imaging (CT, PET scans, MRIs)	20% after deductible	40% after deductible
Mental Health Services		
Outpatient Services	20% after deductible	40% after deductible
Inpatient Services	20% after deductible	40% after deductible
Prescription Drugs	(Retail up to 30-day supply)	(Retail up to 30-day supply)
Tier 1 Generic	\$10 copay preventive drug list	40% after deductible
Tier 2 Preferred	\$35 copay preventive drug list	40% after deductible
Tier 3 Non-Preferred	\$60 copay preventive drug list	40% after deductible
Specialty	20% after deductible	Not covered

Copays listed above apply only to medications listed on the BCBST Preventive Drug List. Medications not included on this list, but listed on the BCBST Preferred Formulary will be subject to deductible and coinsurance.

Medical Employee Premiums (24 payroll deductions)

Tier	Employee Wellness	Employee Non-Wellness
Employee Only	\$0	\$18.60
Employee + One	\$0	\$18.60
Family	\$0	\$18.60

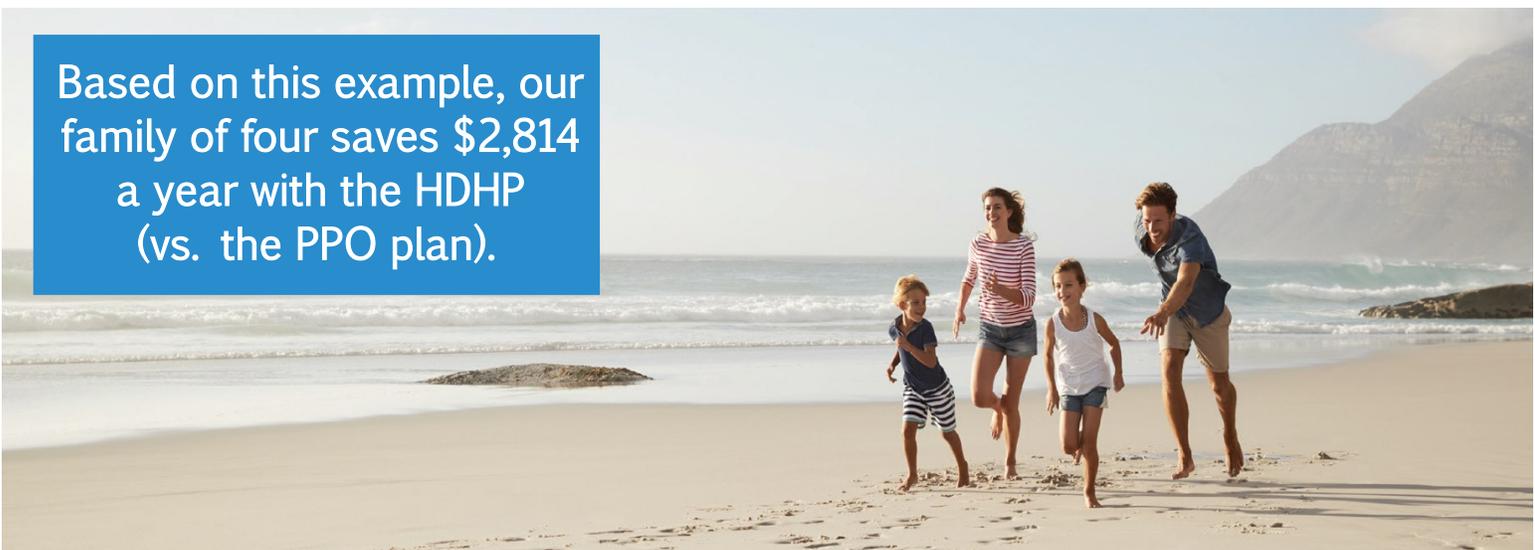
1. Medical Option 2 is a HSA compatible health plan. Refer to page 12 for more information.

MEDICAL PLAN COMPARISON

Thinking about which medical plan to select? Use this cost comparison scenario to help you decide. The example is based on a family of four who are moderate users of the health care, their annual health care costs (including premiums) and how their costs compare under both plans when they see **in-network** providers.

	Your Cost In-Network	
	MEDICAL OPTION 1: PPO	MEDICAL OPTION 2: HDHP
Preventive Care: Two adult annual physicals and two well-child annual exams	Paid at 100% by BCBS	Paid at 100% by BCBS
Two primary care doctor visits	\$250 (\$125 doctor fee per visit. ^{1,2})	\$250 (\$125 doctor fee per visit. ^{1,2})
One specialist doctor visit	\$200 (\$200 doctor fee per visit. ^{1,2})	\$200 (\$200 doctor fee per visit. ^{1,2})
Four pediatrician visits	\$500 (\$125 doctor fee per visit. ^{1,2})	\$500 (\$125 doctor fee per visit. ^{1,2})
Eight generic prescriptions for preventive medications filled through retail pharmacy	\$60 (30% copay per Rx; Estimated Rx cost of \$25 each)	\$80 (\$10 copay per Rx)
Four generic prescriptions filled at a retail pharmacy	\$30 (30% copay per Rx; Estimated Rx cost of \$25 each)	\$100 (\$25 per Rx ²)
Two preferred brand prescriptions filled at a retail pharmacy	\$40 (40% copay per Rx; Estimated Rx cost of \$50 each)	\$100 (\$50 per Rx ²)
TOTAL OUT-OF-POCKET COSTS	\$1,080 (\$950 applied toward deductible)	\$1,230 (applied toward deductible)
Employee Premium Contributions for the Year <i>(Assumes Wellness Premiums)</i>	\$2,964	\$0
TOTAL ANNUAL HEALTHCARE COST	\$4,044	\$1,230

Based on this example, our family of four saves \$2,814 a year with the HDHP (vs. the PPO plan).



¹Doctor fees vary. ²Assumes deductible has not been met. This example is for illustrative purposes only and is not inclusive, nor a guarantee of eligibility or payment. Please see City of Cookeville benefit plan documents for specifics regarding your plan. If any conflict arises between this example and City of Cookeville's plan documents, the terms of the plan documents will apply.

BLUECROSS BLUESHIELD OF TN MEMBERSHIP BENEFITS

Membership has its Benefits!

BlueCross BlueShield of Tennessee is more than just a provider of health plans. They offer a wealth of tools and programs at no additional cost that empower you to take an active role in your own health.

Virtual Visits-PhysicianNow

Get access to care 24/7 with PhysicianNow telehealth. A virtual visit lets you see a doctor from your mobile device or computer without an appointment. This service is available to any employee and their dependents that are covered under one of the BCBS of TN medical plans. The cost is \$20 per consult for members enrolled in Medical Option 1 and \$40 per consult for members enrolled in Medical Option 2.

BlueAccess

BlueAccess is an online, self-service center that provides you with access to your health plan information whenever you need it! You can access your claims history, find a doctor, estimate your treatment costs, order a new ID card and access your personal health history at any time.

BluePerks

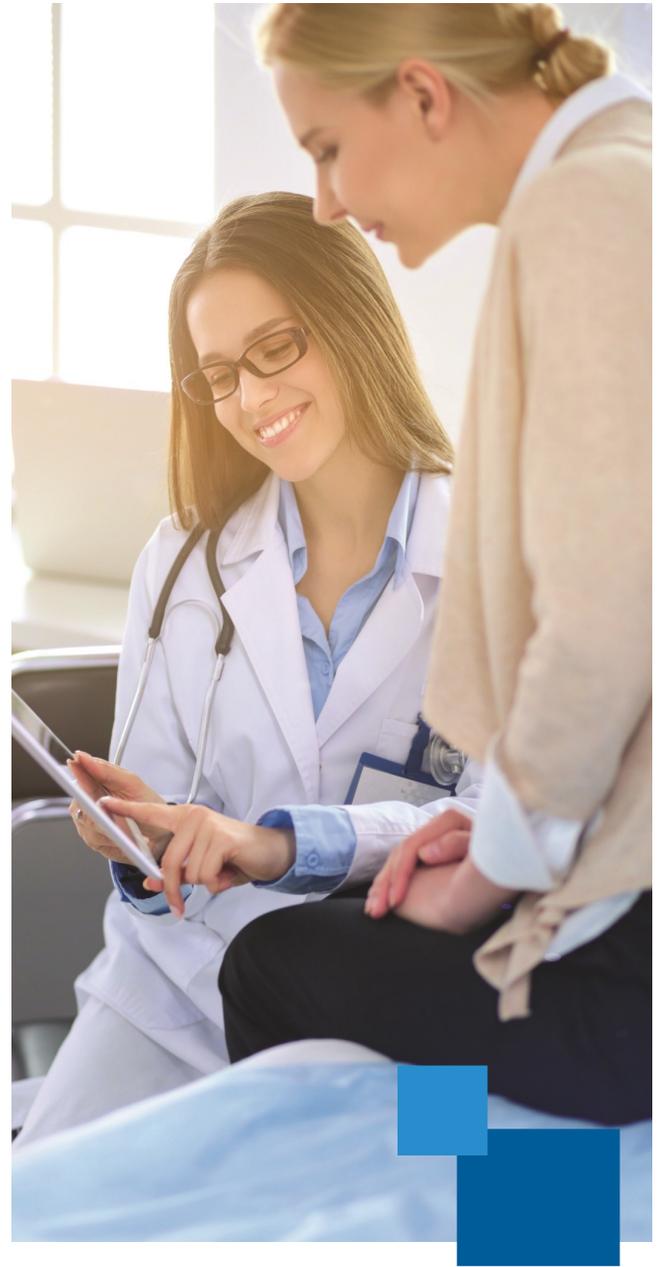
BluePerks is your gateway to dozens of deals and discounts that save you money and keep you healthy. Find savings on health care services related to vision, hearing aids, massage therapy, maternity and baby items, fitness apparel and gear, weight loss programs and much more!

ProtectMYID

BCBS has partnered with Experian to provide identity protection services as part of your medical plan at no additional cost to you! ProtectMYID provides credit monitoring, fraud protection and fraud resolution support to adults with eligible BlueCross medical coverage.

myBlue TN

You're constantly on the go, so you need a convenient way to keep up with your BlueCross health plan. With myBlue TN, you can find doctors or pharmacies, look up claims information, access a digital version of your member ID card and much more! Just download the myBlue TN app at the Apple App Store or the Google Play Store to get started!



Member Resources — BlueCross BlueShield of TN

Program	Website or Phone
Virtual Visits-PhysicianNow	www.bcbst.com/blueaccess and select My Health and Wellness
BlueAccess	www.bcbst.com/blueaccess
BluePerks	www.bcbst.com
ProtectMYID	www.bcbst.com/protectmyid or 1-866-926-9803
myBlue TN	App available at Apple App Store or Google Play Store

FLEXIBLE SPENDING ACCOUNT PROVIDED BY BLUECROSS BLUESHIELD OF TN

A Flexible Spending Account (FSA) is a plan made available to you through the City that allows you to set aside pre-tax dollars to pay for eligible expenses incurred when enrolled in the benefit. You may set aside a certain amount, up to an annual maximum of \$2,700, for un-reimbursed, qualified healthcare expenses.

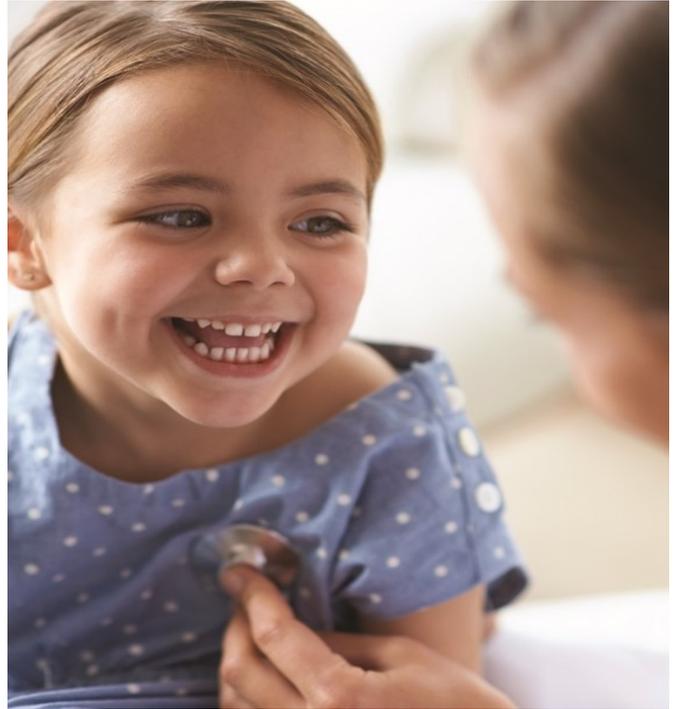
Limited Purpose Flexible Spending Account: This is an account available for anyone enrolled in Medical Option 2. Keep in mind, your HSA money should be used for any medical expenses. Funds from a Limited FSA can only be used for dental and vision expenses, not medical expenses. If you have an existing FSA and enroll in the HDHP medical option you will be allowed to enroll in the Limited FSA and can use your rollover FSA money for dental and vision expenses.

HOW IT WORKS

The FSA is offered through the City of Cookeville and is administered by BlueCross BlueShield of TN. When you choose to enroll in the Healthcare FSA, you determine the dollar amount you want to contribute based on your estimated expenses for the upcoming plan year. Your contributions will be deducted in equal amounts from each paycheck, *pre-tax*, throughout the Plan Year.

Your total annual Healthcare FSA contribution amount is available immediately at the start of the Plan Year. The pre-tax advantages of a FSA allows you to save up to 30% on your eligible healthcare expenses every year!

Be sure to calculate your expenses carefully, with the exception of a \$500 carryover on the healthcare FSA, any unused funds at the end of the Plan Year are forfeited.



HERE'S AN EXAMPLE OF HOW YOU CAN SAVE WITH A FSA

John looks at his family's health care needs for next year. He estimates they will spend at least \$2,650 for copays, deductible, out of pocket drug costs, eyeglasses for him and his wife, as well as braces for his daughter. Funding an FSA will help him pay for care with pre-tax dollars.

How John Saves	With an FSA (pre-tax dollars)	Without an FSA (after-tax dollars)
Annual earnings	\$30,000	\$30,000
Pre-tax contribution	\$2,650	
Taxable Income	\$27,350	\$30,000
Taxes*	\$6,837.50	\$7,500
Take-Home Pay	\$20,512.50	\$22,500
Health Care Costs		\$2,650
Spendable Income	\$20,512.50	\$19,850
John's savings	\$662.50	

*Based on a 25% tax rate (includes federal, state and Social Security/FICA)

Eligible Expenses

FSA funds may only be used for eligible expenses under your healthcare FSA. Some eligible expenses include:

- Medical/dental office visit copays
- Dental/orthodontic care services
- Eye exams and prescription glasses/lenses
- Prescriptions
- Vaccinations

A complete list can be found at www.irs.gov in IRS Publications 502 & 503.



HEALTH SAVINGS ACCOUNT

If you select Medical Option 2, the HDHP, you are eligible to open a Health Savings Account (HSA). An HSA allows you to set aside a portion of your salary to pay for eligible out-of-pocket health care expenses including copays, deductibles, coinsurance and more! Or you can let the funds in your HSA accumulate over time for future health care expenses.

HSA Advantages

- **Reduces Your Taxable Income** — The amount you elect to contribute to your HSA reduces your taxable income, meaning more money in your pocket!
- **Portability** — Your HSA is yours to keep even if you change jobs.
- **No Use-It-Or-Lose-It Rule** — Unused funds carry over from year-to-year and can build over time.
- **Control** — You determine how and when to use the funds.
- **Investment Opportunity** — HSA balances over a certain amount may be invested for future savings.
- **Retirement Savings** — Funds remaining in your account after you reach the age of 65 can be used for non-medical expenses with ordinary taxes paid, similar to a 401(k).

The IRS annual maximum contributions into your account:

- 2020 Single and Family Limits - \$3,550 and \$7,100
- Persons greater than age 55 may set aside an additional \$1,000 in catch-up contributions each year

HSA Limitations

- You must have the funds available in your account in order to spend them. You are able to save receipts and file a claim for reimbursement once the funds are available, provided the expenses are incurred after the account was open.
- Remember to always keep your detailed receipts to verify the eligibility of your purchase in case you are ever audited by the IRS. To check if an expense is HSA eligible, visit www.irs.gov.
- You may not open or contribute to an HSA if you have other first dollar coverage such as an HMO, PPO or Medicare.
- Although current law allows parents to add children up to age 26 to their health plan, the IRS only allows funds in an HSA to be used for expenses incurred by:
 - The plan participant and their legal spouse
 - All dependents claimed on your tax return
 - Any person that could be claimed as a dependent on a return except if:
 - that person filed a joint return,
 - had a gross income of \$4,050 or more; or,
 - the plan participant, or their spouse if filing jointly, could be claimed as a dependent on someone else's return.



DENTAL BENEFITS PROVIDED THROUGH BLUECROSS BLUESHIELD OF TN

Finding a Provider

BlueCross BlueShield’s online directory makes it easy to find in-network dentists. Just follow these easy steps to find an In—Network Provider:

- Visit www.bcbst.com
- Search for a network provider by location
- Call 800-565-9140



It’s About More Than a Pretty Smile

Our oral health affects our ability to speak, smell, taste, chew, and swallow. However, oral diseases, which can range from cavities to oral cancer, cause pain and disability for millions of people each year.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health! Recent studies have linked gum disease to damage elsewhere in the body such as oral infections, diabetes, heart disease, stroke, and preterm, low-weight births.



DENTAL BENEFITS

	In—Network Benefits
Annual Deductible	
Individual	\$0
Family	\$0
Maximum Annual Benefit	
■ (Per individual, per calendar year)	\$2,500 maximum per person
Preventive Services	
■ Oral Exams, Cleanings, X-rays, Fluoride Treatment, Sealants, Space Maintainers	Plan pays 80% of eligible charges
Basic Services	
■ Basic restorative, basic endodontics, basic periodontics, basic oral surgery	Plan pays 80% of eligible charges
■ Major Endodontics	
Major Services	
■ Major Restorative, Prosthodontics, Implants	Plan pays 50% of eligible charges
Orthodontia (Child up to age 19)	Plan pays 50% up to \$2,500 Lifetime Maximum
Network Dentists paid at the PPO fee schedule; non-network dentists paid 30% less than the PPO fee schedule.	

Dental Employee Premiums: (24 Payroll Deductions)

Employee Only	Employee + One	Family
\$0	\$10.67	\$19.76

VISION BENEFITS PROVIDED THROUGH BLUECROSS BLUESHIELD OF TN

BCBS of TN members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. The vision plan covers routine eye care, including eye exams and eyeglasses (lenses and frames) or contacts. With this plan you can see any provider you choose, but you will receive the most benefit when you choose providers that are within the VisionBlue network.

To find a provider call **800-565-9140** or visit www.bcbst.com

VISION BENEFITS	In-Network	Out-of-Network
Eye Examination - One Every 12 months	\$10 Copayment	Up to \$35 allowance
Vision Materials		
Standard Plastic Lenses - One Every 12 months Single Vision Bifocal	\$25 Copayment \$25 Copayment	Up to \$30 allowance Up to \$45 allowance
Lens Options: Standard Polycarbonate Standard Polycarbonate (Under age 19) UV Treatment	\$40 Additional Copayment \$0 Copayment \$15 Copayment	Not Covered Up to \$5 allowance Not Covered
Frames - One Every 24 months	\$0 Copayment up to \$120 allowance, 20% off balance over allowance	Up to \$60 allowance
Contacts (<i>in lieu of glasses + Frames</i>) - Every 12 months		
Contact Lenses Fit and Follow-Up Standard Premium	\$55 Copayment 10% off retail	Not Covered Not Covered
Conventional	\$0 Copay up to \$120 allowance, 15% off balance over allowance	Up to \$96 allowance
Disposable	\$0 Copay up to \$120 allowance	Up to \$96 allowance
Medically Necessary	Covered at 100%	Up to \$200
Vision Employee Premiums: (24 Payroll Deductions)		
Employee Only	Employee + One	Family
\$3.33	\$6.66	\$10.66

EMPLOYER PAID LIFE AND AD&D PROVIDED THROUGH LINCOLN FINANCIAL

NEW INSURANCE CARRIER! Life Insurance gives you the security of knowing you can provide an income to remaining family members in the event of a fatal illness or accident. The City of Cookeville provides a basic life and accidental death and dismemberment benefit (AD&D) for all eligible employees. This benefit is provided to you at no cost through Lincoln Financial.



The group term life plan is provided to you by the City of Cookeville on a guarantee issue basis, meaning you do not have to undergo individual underwriting to be covered under this policy!

Employer Paid Group Term Life Insurance and AD&D Benefit Highlights

<p>What Is Group Term Life Insurance?</p>	<p>Group Term Life Insurance is offered through the City of Cookeville and pays a benefit to your beneficiary if you pass away. The City of Cookeville also provides employees with eligible dependents a dependent life benefit at no cost.</p>
<p>Who Is Eligible For Life Insurance?</p>	<p>Employees: All regular full-time employees</p> <p>Spouses: All legally married spouses. If your spouse is also an eligible employee with the City of Cookeville, then your spouse is not eligible for coverage under the spouse rider/benefit. However, they would be covered under their own individual employer paid policy.</p> <p>Children: Children 14 days to age 26 are eligible for coverage.</p>
<p>What Amount Of Coverage Am I Eligible For?</p>	<p>Employees:</p> <p>CLASS 1: City Managers and Councilmen - \$50,000</p> <p>CLASS 2: Department Heads and 1st Level Supervisors - \$40,000</p> <p>CLASS 3: 2nd Level Supervisors, 3rd Level Supervisors and all other full-time employees earning \$20,000 or more annually - \$30,000</p> <p>CLASS 4: All other full-time employees earning \$10,000 but less than \$20,000 annually - \$20,000</p> <p>CLASS 5: All other full-time employees earning less than \$10,000 annually - \$10,000</p> <p>SPOUSE: \$2,000 of Basic Life Insurance</p> <p>CHILDREN: Age 14 days to 6 months—\$100 Age 6 months to age 26 years—\$1,000</p>
<p>What Does My Life Insurance Include?</p>	<ul style="list-style-type: none"> • Accelerated Death Benefit • Accidental Death and Dismemberment • Continuation of Coverage • Conversion • Portability • Waiver of Premium
<p>Will My Benefits Decrease As I Get Older?</p>	<p>Benefit amount will reduce to 67% of original coverage at age 70 and to 50% of original coverage at age 75.</p>

VOLUNTARY LIFE INSURANCE AND AD&D PROVIDED THROUGH UNUM

WHAT IF YOU ARE INTERESTED IN PURCHASING ADDITIONAL LIFE INSURANCE?

On the previous page we reviewed the employer paid life insurance benefit that is provided to you by the City of Cookeville at no cost. But what if that coverage isn't enough?



Life insurance isn't a fun thing to think about, and it may seem like an unnecessary expense. But, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you. As an eligible employee of the City of Cookeville, you have the option to purchase voluntary life insurance on you and your dependents at a low, group rate.

Voluntary Life and AD&D Benefit Highlights

Voluntary Term Life Benefit

Employee: Up to 5 times salary in increments of \$10,000. Not to exceed \$500,000.

Spouse: Up to 100% of the employee amount in increments of \$5,000. Not to exceed \$500,000. Benefits will be paid to the employee.

Child(ren): live birth to 6 months old: \$1,000

6 months to age 26: \$2,000 increments up to maximum of \$10,000.

Upon death, benefits would be paid to the employee. In order to purchase coverage on your child(ren), you must purchase coverage for yourself.

**Note: Disabled children over the maximum child age limits may be eligible for benefits. Please contact your Benefits Coordinator for more information.*

Accidental Death & Dismemberment (AD&D)

Employee: Up to 5 times salary in increments of \$10,000. Not to exceed \$500,000. You may purchase AD&D coverage for yourself regardless of whether you purchase Life coverage.

Spouse: Up to 100% of employee amount in increments of \$5,000. Not to exceed \$500,000. Benefits will be paid to the employee.

Child: Up to 100% of the employee coverage amount in increments of \$2,000. Not to exceed \$10,000. The maximum death benefit for a child between the ages of live birth and 6 months is \$1,000. Benefit will be paid to the employee.

In order to purchase AD&D coverage for your spouse and/or child, you must purchase AD&D coverage for yourself.

Age Reduction Schedule

Benefits reduce to 67% of original amount at age 70 and 50% of original amount at age 75.

VOLUNTARY TERM LIFE PREMIUM CALCULATION

Age	Employee Life Monthly Premium Per \$10,000 benefit	Spouse Life Monthly Premium per \$5,000 benefit	Child Life Monthly Premium per \$2,000 benefit
Under Age 29	\$0.48	\$0.240	\$0.34
30-34	\$0.67	\$0.335	
35-39	\$0.89	\$0.445	
40-44	\$1.06	\$0.530	
45-49	\$1.67	\$0.835	
50-54	\$2.51	\$1.255	
55-59	\$4.75	\$2.375	
60-64	\$6.27	\$3.135	
65-69	\$8.08	\$4.040	
70-74	\$14.25	\$7.125	
75+	\$28.50	\$14.250	

Voluntary AD&D Monthly Premiums

Employees:	Spouse:	Child(ren):
\$0.30 per \$10,000 benefit	\$0.15 per \$5,000 benefit	\$0.06 per \$2,000 benefit

How to Calculate Your Monthly Premium

	COVERAGE AMOUNT	INCREMENT	RATE	MONTHLY COST
EMPLOYEE	\$	÷ \$10,000	x \$	= \$
SPOUSE	\$	÷ \$5,000	x \$	= \$
CHILD(REN)	\$	÷ \$2,000	x \$	= \$

**Note: A spouse's premium is based on the employee's age, not the age of the spouse. Employees electing child coverage will only pay the premium for one child no matter how many are covered on the plan.*

GROUP WHOLE LIFE INSURANCE PROVIDED THROUGH BANKERS WORKSITE

NEW BENEFIT!

Group Whole Life Insurance Protection from BankersWorksite® offers coverage that not only extends your own financial protection when faced with an unexpected event, but also offers guaranteed benefits to help the ones you love continue to live their lives while helping to keep their financial health intact.



Term Life vs. Whole Life—What is the Difference?

Product	Employer Paid Group Term Life	Voluntary Term Life	Group Whole Life
Premium Type	Employer Paid	Employee Paid	Employee Paid
Benefit Reductions	Guaranteed benefit reduction at specific age	Guaranteed benefit reduction at specific age	No reduction in benefits
Protection Period	While employed	While employed	Through entire working period and retirement
Practical Application	Salary replacement	Family protection (education, mortgage, etc.)	Final expenses, medical expenses for terminally ill

About Your Benefits:

- Employee: \$10,000 to \$100,000 benefit in \$10,000 increments
- Guaranteed Issue up to \$100,000 of coverage with no health questions
- Available to employees age 18-70

Optional Dependent Benefits

- Spouse: \$5,000 to \$30,000 benefit, not to exceed 100% of the employee's elected amount
- Spouse coverage is provided through a Term Life Rider
- Available to spouses age 18-50
- Child Term Rider: \$10,000 covers child(ren) age 15 days through age 25

Policy Benefits

- Guaranteed Death Benefit
- Guaranteed Level Premiums
- Guarantee Cash Value
- Guaranteed Living Benefits
- Policy is portable
- Waiver of Premium for Disability Rider
- Accelerated Death Benefit Rider for Terminal Illness
- Lump Sum Accelerated Death Benefit for Chronic Illness Rider
- Immediate Claims Payment

How it Works

Maximize Death Benefit
You lead a full life and don't need any long term care.

Total Death Benefit*
\$100,000

Maximize Living Benefits
You lead a full life and need an assisted living lifestyle and/or nursing home care.

Total Living Benefits*
\$100,000

Split Your Benefits
You lead a full life and need home healthcare.

Death Benefit	Chronic Illness
\$52,000	\$48,000
Total Death & Living Benefit* \$100,000	

* This is an example for illustrative purposes only. Actual policy amounts and payments will depend on benefits purchased, death and living benefits.

Please refer to the Prepare Benefits Enrollment Portal for pricing.

View your coverage, your way.

Accessing your benefits using MyCoverage has never been easier. MyCoverage is an easy-to-use website that allows you 24/7 access to coverage and benefit information. Plus you can check claim status, update your profile and more.

mycoverage.bankersworksite.com

SHORT-TERM DISABILITY INSURANCE PROVIDED THROUGH LINCOLN FINANCIAL

NEW BENEFIT! The Lincoln short-term disability insurance plan provides a cash benefit, paid directly to you, when you are out of work due to injury, illness, surgery or recovery from childbirth. This plan offers affordable group rates for City of Cookeville employees and offers a fast, no-hassle claims process!



Short-Term Disability

Benefit Amount	\$100 minimum benefit per week, in \$100 increments
Maximum Benefit	\$2,000 weekly maximum not to exceed 60% of salary
Maximum Payment Period	Up to 13 weeks
Elimination Period	14 days for accidents and sickness
Minimum Work Hours Per Week	Must be actively working a minimum of 37.5 hours per week
Pre-Existing Conditions	If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start day, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

SHORT-TERM DISABILITY PREMIUM CALCULATION

Calculate your short-term disability semi-monthly premium in three easy steps:

1. Multiply your weekly salary (up to \$3,333) by 0.6. If your weekly salary exceeds \$3,333, multiply \$3,333 by 0.6.	<p>Weekly Salary X 0.6 = Maximum Limit</p> <p>\$ _____ X 0.6 = \$ _____</p>
2. Select a coverage amount in \$100 increments that does not exceed the maximum limit.	<p>Selected Coverage Amount: \$ _____</p>
3. Multiply your selected coverage amount by your age-range premium rate from the table below.	<p>Coverage Amount X Premium Rate = <u>Semi-Monthly Premium</u></p> <p>_____ = \$ _____</p>

Age Range	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-99
Premium Rate	0.01950	0.01950	0.01950	0.01950	0.02100	0.02550	0.03050	0.04000	0.05000	0.05550	0.06800	0.06800

LONG-TERM DISABILITY INSURANCE PROVIDED THROUGH LINCOLN FINANCIAL

NEW BENEFIT! The Lincoln long-term disability insurance plan provides a cash benefit, paid directly to you, if you are out of work for 90 days or more due to an injury, illness or surgery. This plan offers affordable group rates for City of Cookeville employees and includes *EmployeeConnect* services, which gives you and your family confidential access to counselors as well as personal, legal and financial advice.



Long-Term Disability

Benefit Amount	60% of your monthly salary, limited to \$6,000 benefit per month, or 70% of salary if certain conditions are met. <i>See progressive income benefit below for more details.</i>
Maximum Payment Period	Later of age 65 or Social Security Normal Retirement Age
Elimination Period	90 days
Minimum Work Hours Per Week	Must be actively working a minimum of 37.5 hours per week
Pre-Existing Conditions	If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start day, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Understanding Your Long-Term Disability Benefits

- **Progressive Income Benefit:** Pays an additional 10% benefit, increasing your benefit maximum to 70% of monthly earnings, if an employee has a loss of two or more activities of daily living or cognitive impairment. Activities of daily living include bathing, dressing, toileting, transferring, continence and eating.
- **Definition of Disability:** For the first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, your plan includes an ‘any gainful occupation’ definition of disability which reduces the disability benefit if the employee is able to earn 66 2/3% of pre-disability earnings.
- **Earnings Definition:** Benefit amounts are based on an employee’s base pay and exclude commissions, bonuses or overtime pay.
- **Trial Work Days:** The amount of time an employee can return to work during the elimination period without having to start a new elimination period. Your plan includes 180 trial work days.
- **Special Limitations:** Benefits are limited to 24 months for mental illness, substance abuse and specified illnesses.
- **Partial Disability Benefits:** If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.

LONG-TERM DISABILITY PREMIUM CALCULATION

Your estimated semi-monthly premium is determined by multiplying your monthly salary amount (up to \$10,000) by your age-range premium rate. If your monthly salary exceeds \$10,000, multiply \$10,000 by your premium rate.

$$\text{Monthly Salary} \times \text{Premium Rate} = \text{Semi-Monthly Premium}$$

\$ _____ X _____ = \$ _____

Age Range	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70--99
Premium Rate	0.00075	0.00125	0.00205	0.00315	0.00440	0.00570	0.00725	0.00610	0.00475	0.00415	0.00415	0.00415

EMPLOYEE ASSISTANCE PROGRAM: *EMPLOYEECONNECT*

PROVIDED THROUGH LINCOLN FINANCIAL

New Benefit! Life has its share of ups and downs—and sometimes you may need a little guidance through the “downs.” *EmployeeConnect* services, offers an array of confidential services to help you and your loved ones meet the challenges that life, work and relationships can bring.

- **Unlimited 24/7 Assistance**– You can access the following services anytime, online or with a toll-free call.
 - » Information, resources, and referrals on family matters, such as child and elder care; kennels and pet care; event and vacation planning; moving and relations; car buying; college planning and more!
 - » Legal information and referrals for situations requiring expertise in family law, estate planning, landlord/tenant relations, consumer and civil law, and more
 - » Guidance with financial matters, including household budgeting, and short-and long-term planning
- **In-person guidance**– Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect* you get:
 - » In-person help for short-term issues (up to four sessions with a counselor per person, per issue, per year)
 - » In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and subsequent meetings at a reduced fee
- **Online resources**– *EmployeeConnect* offers a wide range of information and resources that you can research and access on your own just by visiting www.GuidanceResources.com. There you will find: articles and tutorials, streaming videos and interactive tools—including financial calculators, budgeting spreadsheets and a language translator

Take advantage of the *EmployeeConnect* program by visiting www.GuidanceResources.com or call 888-628-4824.

LIFEKEYS & TRAVEL CONNECT SERVICES



PROVIDED THROUGH LINCOLN FINANCIAL

NEW BENEFITS! LifeKeys: No matter how well you plan your life, you can be sure a few unforeseen challenges will arise. When they do, it's reassuring to know that help and support are close at hand—thanks to LifeKeys® services from Lincoln Financial. If you are enrolled in the employer paid life insurance, this program provides access to a wide array of services to help you and your loved ones through life's ups and downs—and prepare you for whatever lies ahead.

LIFEKEYS SERVICES INCLUDE:

- **Online will preparation:** Having a will is important because it allows you to designate who will receive your property and assets when you die. Without one, your state determines how your estate is distributed. EstateGuidance® will preparation is a quick and easy way to create and execute a will.
- **Information on important life matters:** You have access to GuidanceResources® Online, where you'll find articles, tutorials, videos, and "Ask the Expert" advice on a wide range of topics—including legal, financial, family and career. It's a way to stay "in the know" on important matters that impact both your personal and professional life.
- **Protection against identity theft:** Identity theft is widespread, and everyone is vulnerable. LifeKeys includes an online resource for the information you need to recognize and prevent identity theft—and restore your good name.
- **Guidance and support for your beneficiaries:** The LifeKeys comprehensive program offers resources to help your loved ones address a range of common concerns. Services include grief counseling, advice on financial and legal matters, and help coping with the occasional challenges of day-to-day life.

TravelConnect: This service is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home. Whether traveling for business or leisure, if you are enrolled in the employer paid life insurance, you and your loved ones can count on *TravelConnect* for responsive and caring support—24 hours a day, 7 days a week.

You can count on TravelConnect services to:

- **Coordinate and provide transportation:** TravelConnect will coordinate and provide transportation from an initial medical facility that cannot adequately treat the patient due to their condition.
- **Coordinate travel and airfare for your dependent children.** This includes the services, transportation expenses and accommodations of a qualified escort.
- **Medical care, and travel services recovery:** Assistant services include, but are not limited to:
 - » Medical record requests
 - » Intermediary services
 - » Recovering lost or stolen documents or luggage
 - » Medical and dental referrals
 - » Language Translation
 - » Corrective lenses and medical device replacement
 - » Arrangements for a deceased traveler

For a complete list of TravelConnect services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

VOLUNTARY BENEFITS PROVIDED THROUGH THE HARTFORD & BAYBRIDGE

NEW BENEFITS AND NEW CARRIERS! Voluntary benefits can help offset costs caused by sudden illness, accidents, cancer, or hospital confinements. They can also cover some non-medical expenses that your current insurance might not cover.

MEETING YOUR NEEDS

Life can be unpredictable and full of surprises. Sometimes your circumstances change and you need coverage that can help meet your needs. With access to a Critical Illness, Hospital Indemnity, Accident and Cancer plan you can rest easy knowing your future is a little more secure.

BUDGET FRIENDLY

Sometimes, receiving proper healthcare can be difficult if money is tight. Our voluntary benefit options can provide valuable coverage at an affordable price. Voluntary insurance can help alleviate worry and help keep your finances strong.

PUTTING YOU FIRST

The quality of your health shouldn't be undermined by unaffordable care. Voluntary benefits are designed to supplement any insurance you may already have and can help offset medical expenses not paid by other coverage you may have.

ADVANTAGES TO YOU:

- Some plans are guarantee issue
- Benefits paid directly to you
- Benefits paid in addition to any other coverage
- Individual or family coverage
- Affordable premiums
- Wellness benefits available



ACCIDENT INSURANCE PROVIDED THROUGH THE HARTFORD

NEW PLAN OPTIONS AND NEW CARRIER!

Accident Coverage provides cash benefits for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an accidental injury occur. No one plans to have an accident, but it can happen anytime, anywhere! Accident coverage through The Hartford can help pick up where other insurance leaves off. The information below is a brief summary of benefits. Please refer to the Hartford Accident benefit summary for more covered treatments, plan limit maximums and benefit exclusions.



- Guaranteed Issue coverage; no medical exams or tests to take
- Coverage available to yourself and your family
- Coverage is portable, meaning if you were to leave employment at City of Cookeville you have the option to continue this coverage directly with The Hartford
- Two Accident plan options to choose from

ACCIDENT BENEFITS	Option 1	Option 2
Initial Physician Office Visit	\$75	\$100
Accident Follow Up Visit	\$75	\$100
Emergency Room Visit	\$150	\$200
Urgent Care Center	\$75	\$100
Air/Ground Ambulance	\$900 / \$300	\$1,200 / \$400
Hospital Admission	\$1,000	\$1,500
Daily Hospital Confinement	\$200 per day up to 365 days per lifetime (Total daily and ICU)	\$300 per day up to 365 days per lifetime (Total daily and ICU)
Daily ICU Confinement	\$400 per day up to 30 days per accident	\$600 per day up to 30 days per accident
Diagnostic Exam	\$200 once per accident within 90 days	\$300 once per accident within 90 days
X-Ray	\$50 once per accident within 90 days	\$75 once per accident within 90 days
Fractures	Up to \$6,000	Up to \$9,000
Laceration	Up to \$600	Up to \$600
Burns (2nd/3rd Degree)	Up to \$10,000	Up to \$15,000
Accidental Death Benefit	Employee: \$30,000 Spouse: 50% of employee's benefit Child(ren): 25% of employee's benefit	Employee: \$50,000 Spouse: 50% of employee's benefit Child(ren): 25% of employee's benefit

Accident Employee Premiums: (24 Payroll Deductions)

Plan Option	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Option 1	\$4.87	\$7.68	\$8.30	\$13.00
Option 2	\$7.27	\$11.45	\$12.42	\$19.44

CRITICAL ILLNESS PROVIDED THROUGH THE HARTFORD

NEW PLAN AND NEW CARRIER!

A serious medical event such as a heart attack or stroke could leave you in a period of financial difficulty. Even if you have medical insurance, there are typically uncovered expenses to consider such as deductibles, copayments, travel expenses to and from treatment centers and loss of wages or salary. Critical Illness insurance from The Hartford pays you a cash benefit for covered illnesses and treatments. This benefit also includes a \$50 wellness benefit payable once per calendar year for each insured person who has an approved health screening test performed.



- Lump sum benefit paid directly to you
- Guaranteed Issue Amount: \$20,000 for employees. All spouse and child(ren) amounts are guarantee issue.
- Coverage is portable

Critical Illness Plan Design

Coverage Amount

Employee Coverage Amount	\$10,000 or \$20,000
Spouse Coverage Amount	50% of the employee's coverage amount
Child(ren) Coverage Amount	\$5,000

Covered Illnesses

Cancer Conditions

Invasive Cancer*, Benign Brain Tumor*	100% of coverage amount
Non-invasive Cancer	25% of the coverage amount

Vascular Conditions

Heart Attack*, Heart Transplant*, Stroke*	100% of the coverage amount
Aneurysm, Angioplasty/Stent; Coronary Artery Bypass Graft	25% of the coverage amount

Other Specified Category

Coma*, End Stage Renal Failure, Loss of Hearing, Loss of Speech, Loss of Vision, Major Organ Transplant*, Paralysis	100% of the coverage amount
Bone Marrow Transplant	25% of the coverage amount

Neurological Category

Advanced Multiple Sclerosis, Advanced Parkinson's, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	100% of the coverage amount
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Child Conditions

Cerebral Palsy, Congenital Heart Disease, Cystic Fibrosis, Muscular Dystrophy, Spina Bifida	100% of the coverage amount
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CRITICAL ILLNESS CONTINUED PROVIDED THROUGH THE HARTFORD

Critical Illness Plan Design Continued

Additional Plan Features

Recurrence- pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount
Health Screening Benefit	\$50 once per covered person per year
Coverage Maximum: Primary Insured and Spouse Child(ren)	500% of coverage amount 300% of coverage amount
Pre-Existing Condition Limitation	None
Benefit Separation Period	Non-Related Illness: None Related Illness: 30 days

Critical Illness Premiums: (24 Payroll Deductions) Non-Tobacco User

NON-TOBACCO USER													
Benefit Amount	Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
\$10,000	Employee Only	\$1.96	\$1.96	\$2.71	\$2.71	\$4.97	\$4.97	\$9.15	\$9.15	\$17.99	\$17.99	\$33.41	\$33.41
	Employee & Spouse	\$3.16	\$3.16	\$4.27	\$4.27	\$7.74	\$7.74	\$14.22	\$14.22	\$27.84	\$27.84	\$51.34	\$51.34
	Employee & Child(ren)	\$3.66	\$3.66	\$4.02	\$4.02	\$6.07	\$6.07	\$10.19	\$10.19	\$19.02	\$19.02	\$34.44	\$34.44
	Employee & Family	\$5.13	\$5.13	\$5.79	\$5.79	\$9.02	\$9.02	\$15.43	\$15.43	\$29.04	\$29.04	\$52.54	\$52.54
\$20,000	Employee Only	\$3.45	\$3.45	\$4.91	\$4.91	\$9.39	\$9.39	\$17.72	\$17.72	\$35.40	\$35.40	\$66.24	\$66.24
	Employee & Spouse	\$5.38	\$5.38	\$7.54	\$7.54	\$14.37	\$14.37	\$27.28	\$27.28	\$54.53	\$54.53	\$101.52	\$101.52
	Employee & Child(ren)	\$5.14	\$5.14	\$6.22	\$6.22	\$10.49	\$10.49	\$18.76	\$18.76	\$36.43	\$36.43	\$67.27	\$67.27
	Employee & Family	\$7.35	\$7.35	\$9.07	\$9.07	\$15.65	\$15.65	\$28.50	\$28.50	\$55.73	\$55.73	\$102.72	\$102.72

Critical Illness Premiums: (24 Payroll Deductions) Tobacco User

TOBACCO USER													
Benefit Amount	Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
\$10,000	Employee Only	\$2.15	\$2.15	\$3.38	\$3.38	\$7.66	\$7.66	\$16.70	\$16.70	\$37.02	\$37.02	\$64.93	\$64.93
	Employee & Spouse	\$3.45	\$3.45	\$5.31	\$5.31	\$11.95	\$11.95	\$25.94	\$25.94	\$57.22	\$57.22	\$100.26	\$100.26
	Employee & Child(ren)	\$3.84	\$3.84	\$4.69	\$4.69	\$8.76	\$8.76	\$17.74	\$17.74	\$38.05	\$38.05	\$65.96	\$65.96
	Employee & Family	\$5.42	\$5.42	\$6.84	\$6.84	\$13.23	\$13.23	\$27.15	\$27.15	\$58.42	\$58.42	\$101.46	\$101.46
\$20,000	Employee Only	\$3.82	\$3.82	\$6.25	\$6.25	\$14.75	\$14.75	\$32.81	\$32.81	\$73.47	\$73.47	\$129.28	\$129.28
	Employee & Spouse	\$5.96	\$5.96	\$9.63	\$9.63	\$22.79	\$22.79	\$50.72	\$50.72	\$113.29	\$113.29	\$199.36	\$199.36
	Employee & Child(ren)	\$5.51	\$5.51	\$7.56	\$7.56	\$15.85	\$15.85	\$33.86	\$33.86	\$74.50	\$74.50	\$130.31	\$130.31
	Employee & Family	\$7.93	\$7.93	\$11.16	\$11.16	\$24.07	\$24.07	\$51.94	\$51.94	\$114.49	\$114.49	\$200.56	\$200.56

HOSPITAL INDEMNITY INSURANCE PROVIDED THROUGH THE HARTFORD

NEW PLAN! Hospital Indemnity Insurance coverage through Hartford provides:

- A cash benefit paid if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury.
- Benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover such as medical copays and deductibles, or benefits can be used for any non-medical expenses such as the mortgage, groceries and utilities
- Simple enrollment with no health or medical questions to answer
- Plan is portable so you have the ability to take the coverage with you if you change jobs



Hospital Indemnity Benefit Summary

First Day Hospital Confinement	\$1,000 payable once per year
Daily Hospital Confinement (Day 2+)	\$150 per day up to 90 days per year
Daily ICU Confinement (Day 1+)	\$300 per day up to 10 days per year
Coverage Type	On and off-job (24 hour coverage)
Child(ren) Age Limits	To age 26

Hospital Indemnity Employee Premiums: (24 Payroll Deductions)

Employee Only	Employee + Spouse	Employee + Child(ren)	Family
\$8.99	\$18.61	\$17.09	\$27.93



ABILITY ASSIST® & HEALTHCHAMPION PROVIDED THROUGH THE HARTFORD

NEW BENEFIT! Included for members that are enrolled in any of The Hartford Voluntary Plans!

Life presents complex challenges and getting support should be easy! If the unexpected happens, you should have simple solutions to help cope with the stress and life changes that may result. That's why The Hartford's Ability Assist® Counseling Services, offered by ComPsych®, can play such an important role.

Ability Assist Counseling Services	
Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your dependents may face. It is staffed by Guidance Experts– highly trained master's level clinicians– who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include:
	<ul style="list-style-type: none"> • Job pressures • Relationship/marital conflicts • Stress, anxiety and depression • Work/school disagreements • Substance abuse • Child and elder care referral services
Financial Information and Resources	Provides unlimited telephonic support for the complicated financial decisions you or your dependents may face. Speak by phone with a Certified Public Accountant and Certified Financial Planners on a wide range of financial issues. Topics may include:
	<ul style="list-style-type: none"> • Managing a budget • Retirement • Getting out of debt • Tax questions • Saving for college
Legal Support and Resources	Offers unlimited telephonic assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your dependents. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include:
	<ul style="list-style-type: none"> • Debt and bankruptcy • Guardianship • Buying a home • Power of attorney • Divorce
Health and Benefit Services	HealthChampion is a service that supports you through all aspects of your health care issues. HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include:
	<ul style="list-style-type: none"> • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/test/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan providers • An easy-to-understand explanation of your benefits • Cost estimation for covered and non-covered treatments • Guidance on claims and billing issues • Fee payment/ plan negotiation

CANCER & SPECIFIED DISEASE INSURANCE PROVIDED THROUGH BAYBRIDGE

Protect your income with cancer insurance! Hopefully, you and your family will never face cancer. But if you do, Bay Bridge Administrators (Underwritten by MetLife) can help! Employees have the option between two Cancer and ICU plans. You must elect cancer coverage in order to elect the ICU benefit. This benefit does have a pre-existing condition limitation. During the first 12 months of a covered person's insurance, losses incurred for pre-existing conditions are not covered. However, after this 12 month period benefits for such conditions will be payable unless specifically excluded from coverage.

The information below is a brief summary of coverage. Please refer to your BayBridge Cancer Brochure for more plan details.



CANCER BENEFITS	Cancer Plan: Option 1	Cancer Plan: Option 2
First Diagnosis Benefit	\$2,500	\$2,500
Wellness Benefit	\$50 per covered person, per year	\$100 per year
Hospital Confinement	\$100 per day	\$200 per day
ICU Confinement	See optional ICU benefit below	See optional ICU benefit below
Surgical	Up to \$1,500	Up to \$3,000
Radiation/Chemotherapy	\$200 per day	\$500 per day
Colony Stimulating Factors	\$500 per month	\$500 per month
Cancer Plan Employee Premiums: (24 Payroll Deductions)		
Employee Only	\$6.15	\$10.17
Family	\$12.95	\$21.57
ICU BENEFITS	ICU Plan: Option 1	ICU Plan: Option 2
Optional Intensive Care Rider	\$325 per day	\$625 per day
ICU Plan Employee Premiums: (24 Payroll Deductions)		
Employee Only	\$1.36	\$2.61
Family	\$2.83	\$5.44

BENEFITS RESOURCES

Coverage & Carrier	Group #	Contact Information
Medical: BlueCross BlueShield of TN	106949	Customer Service: 800-565-9140 Website: www.bcbst.com
PhysiciansNow	106949	Phone: 888-283-6691 Website: www.bcbst.com/blueaccess
Dental and Vision BlueCross BlueShield of TN	106949	Customer Service: 800-565-9140 Website: www.bcbst.com
Flexible Spending Account BlueCross BlueShield of TN	106949	Customer Service: 800-565-9140 Website: www.bcbst.com
Employer Paid Life Lincoln Financial	Group ID: COOKEVL Policy Number: 10256147	Customer Service: 866-783-2255 Website: www.Lincoln4Benefits.com
Short Term Disability Lincoln Financial	Group ID: COOKEVL Policy Number: 10256148	Customer Service: 866-783-2255 Website: www.Lincoln4Benefits.com
Long Term Disability Lincoln Financial	Group ID: COOKEVL Policy Number: 10256144	Customer Service: 800-423-2765 Website: www.Lincoln4Benefits.com
Critical Illness, Accident and Hospital Indemnity The Hartford	Policy Number: 889081	Customer Service: 866-547-4205 Website: www.thehartford.com/employeebenefits
Voluntary Term Life UNUM	Group Number 633278	Customer Service: 800-275-8686 Website: www.unum.com
Group Whole Life BankersWorksite	Group Number: W5186	Customer Service: 866-458-7502 Website: www.mycoverage.bankersworksite.com
Cancer Bay Bridge Administrators	Group Number: 1750	Customer Service: 800-845-7519 Website: www.bbadmin.com Claim Questions: Claims@BBAdmin.com
Value Added Services		
EAP: EmployeeConnect Lincoln Financial	User Name: LFGsupport Password: LFGsupport1	Customer Service: 888-628-4824 Website: www.GuidanceResources.com
Online Will Preparation: LifeKeys® Services Lincoln Financial	First time user enter: Web ID LifeKeys	Customer Service: 855-891-3684 Website: www.GuidanceResources.com
TravelConnect Services Lincoln Financial	Policy Number: 10256147 UHC Global ID: 322541	Customer Service: 800-527-0218 Website: www.LincolnFinancial.com/TravelConnect
EAP: Ability Assist The Hartford	Organization Web ID: HLF902 Company Name: ABILI	Customer Service: 800-964-3577 Website: www.guidanceresources.com
Health Care Support Services: Health Champion The Hartford	Policy Number: 889081	Customer Service: 800-964-3577

ENROLLMENT INSTRUCTIONS THROUGH PREPARE BENEFITS

It's time to enroll!

With Prepare Benefits Enroll, employees enjoy convenient online access to their benefits coverage 24 hours a day, seven days a week! Login now to learn about your benefit options and confirm your elections for the upcoming year.

Where Do I Start:

1. Visit www.pbenroll.com
2. First time users will select "New User Registration"
3. Create your username and password
4. Your company identifier will be: **cookeville**
5. From the homepage select **START BENEFITS** to begin your enrollment process

Key Points to Remember when Making Elections:

1. Dependents need to be added on the dependent screen before you can add them to any plan.
2. All plan documents are available on the right hand side of the screen.
3. All rates are represented as "per pay period" on the plan screens.
4. Remember to add beneficiary information at the end of the enrollment process for any life insurance plan
5. Employees may make changes to their benefits up until the enrollment deadline listed on the home page.

Create Your Account

First, let's find your company record

First Name

Last Name

Company Identifier

(provided by HR)

PIN

(Last 4 Digits of SSN / ID)

Birth Date

(mm/dd/yyyy)

Next »

PBenroll Home | Contact

User Name

Password

Login
New User Registration
Reset Password

Medical
03:16

Healthcare News
Can you gain weight from eating too little? No, but here's why it's so easy to think you can.
Exclusive data: Overcome the 8 biggest diet challenges, based on 100,000 client results.
How do you rank as a health, fitness, and nutrition coach? Take this short quiz to learn where you're at and how to level up.

TERMS TO KNOW

Deductible - Amount an employee pays out of pocket prior to the insurance company paying a percentage of the provider charges.

Coinsurance - The amount of payment split between the employee and the insurance company. Example: Insurance company pays 80% and employee pays 20% of the charges after the deductible is met.

Out of Pocket Maximum - The maximum an employee is responsible for paying out of pocket in any one calendar year prior to the insurance company paying the entire eligible amount for the remaining of the calendar year.

Network Providers - Doctors, Hospitals and other healthcare providers who have an agreement/contract with insurance companies agreeing to charge a discounted amount for services they render.

Pre-Authorization - Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

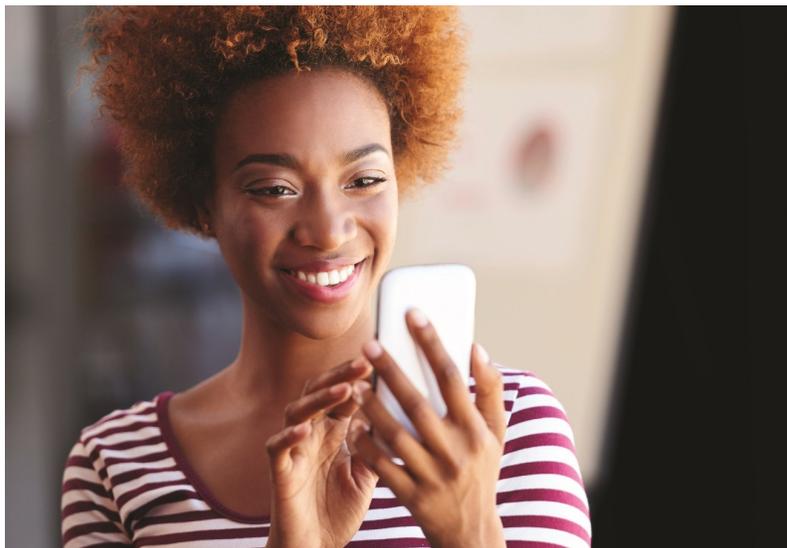
Pre-Determination - If you are having a major procedure done, your doctor or dentist can submit a pre-determination to the insurance company so you can know in advance of treatment how much of the bill you will be responsible for.

Explanation of Benefits (EOB) - The EOB is mailed to the employee after a claim is received and processed by the insurance company. The EOB will describe how the claim was processed and outline what portion of the charges are applied to the deductible, what portion the employee is responsible for, and explain if there is a denial or error processing the claim.

Appeal - If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guaranteed Issue - The maximum amount of voluntary life insurance you can choose when making your initial election that does not require the answering of medical questions.

Evidence of Insurability (EOI) - The form containing medical questions that are required to be answered if you decide to elect voluntary life insurance after you have previously declined coverage, or if you decide to increase your current coverage. This may also be needed if you decide to add disability coverage after you have previously declined.



INSURANCE COMPANY WEBSITES AND APPS

Registering on your insurance company websites and downloading the smart phone apps gives you instant access to valuable resources. In most cases you can access:

- Specific plan details
- ID cards
- In-network provider search
- Your claims history
- And other tools and resources

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to telehealth for virtual visits.

Conditions Treated*		Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	<ul style="list-style-type: none"> ■ Sudden numbness, weakness ■ Uncontrolled bleeding ■ Seizure or loss of consciousness ■ Shortness of breath ■ Chest pain ■ Head injury/major trauma ■ Blurry or loss of vision ■ Severe cuts or burns ■ Overdose 	<ul style="list-style-type: none"> ■ Costs are highest ■ No appointment needed ■ Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	<ul style="list-style-type: none"> ■ Minor cuts, sprains, burns, rashes ■ Fever and flu symptoms ■ Headaches ■ Chronic lower back pain ■ Joint pain ■ Minor respiratory symptoms ■ Urinary tract infections 	<ul style="list-style-type: none"> ■ Costs are lower than an ER visit ■ No appointment needed ■ Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	<ul style="list-style-type: none"> ■ General health issues ■ Preventive services ■ Routine checkups ■ Immunizations and screenings 	<ul style="list-style-type: none"> ■ May include coinsurance and/or deductible ■ Appointment usually needed ■ May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	<ul style="list-style-type: none"> ■ Common cold/flu ■ Rashes or skin conditions ■ Sore throat, earache, sinus pain ■ Minor cuts or burns ■ Pregnancy testing ■ Vaccinations 	<ul style="list-style-type: none"> ■ No appointment needed ■ Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	<ul style="list-style-type: none"> ■ Cold and flu symptoms such as a cough, fever and headaches ■ Allergies ■ Sinus infections ■ Family health questions 	<ul style="list-style-type: none"> ■ Cost is lower than office visit ■ No appointment needed ■ Immediate, private, and secure visits



*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

DISCLOSURE NOTICES

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, 2019. Contact your State for more information on eligibility –

ALABAMA – MEDICAID Website: http://myalhipp.com/ Phone: 1-855-692-5447	MASSACHUSETTS – MEDICAID AND CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	RHODE ISLAND – MEDICAID AND CHIP Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)
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	MINNESOTA – MEDICAID Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	NEVADA – MEDICAID Medicaid Website: https://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900
ARKANSAS – MEDICAID Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	MISSOURI – MEDICAID Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	SOUTH DAKOTA – MEDICAID Website: http://dss.sd.gov Phone: 1-888-828-0059
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	MONTANA – MEDICAID Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	SOUTH CAROLINA – MEDICAID Website: https://www.scdhhs.gov Phone: 1-888-549-0820
FLORIDA – MEDICAID Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268	NEBRASKA – MEDICAID Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	TEXAS – MEDICAID Website: http://gethipptexas.com/ Phone: 1-800-440-0493
GEORGIA – MEDICAID Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	NEW HAMPSHIRE – MEDICAID Website: https://www.dhhs.nh.gov/iii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	UTAH – MEDICAID AND CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
INDIANA – MEDICAID Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864	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	VERMONT – MEDICAID Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
IOWA – MEDICAID Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563	NEW YORK – MEDICAID Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	VIRGINIA – MEDICAID AND CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
KANSAS – MEDICAID Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	NORTH CAROLINA – MEDICAID Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	WASHINGTON – MEDICAID Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
KENTUCKY – MEDICAID Website: https://chfs.ky.gov Phone: 1-800-635-2570	NORTH DAKOTA – MEDICAID Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	WEST VIRGINIA – MEDICAID Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
LOUISIANA – MEDICAID Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	OKLAHOMA – MEDICAID AND CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	WISCONSIN – MEDICAID AND CHIP Website: https://www.dhs.wisconsin.gov/publications/pi/p10095.pdf Phone: 1-800-362-3002
MAINE – MEDICAID Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	OREGON – MEDICAID Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	WYOMING – MEDICAID Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
	PENNSYLVANIA – MEDICAID Website: http://www.dhs.pa.gov/provider/medicaidassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	

To see if any other states have added a premium assistance program since July 31, 2019, 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

DISCLOSURE NOTICES

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.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

HIPAA PRIVACY NOTICE

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

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

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

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI

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

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

DISCLOSURE NOTICES

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

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

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

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

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

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

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

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

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

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

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

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

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

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

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

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

DISCLOSURE NOTICES

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

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

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

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

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

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

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

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

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

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

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

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

DISCLOSURE NOTICES

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

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

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

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

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

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

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

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

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

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer.

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

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE / BCBST OPTION 1 (PPO) & Option 2 (HDHP) IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Employer coverage WILL BE affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will NOT be able to get this coverage back.

DISCLOSURE NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For more information about Medicare prescription drug coverage:

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

DISCLOSURE NOTICES

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

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

DISCLOSURE NOTICES

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

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

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

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

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

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

Plan contact information. Please contact your Human Resources Department.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE PART A: GENERAL INFORMATION | FORM APPROVED OMB NO. 1210-0149 (EXPIRES 5-31-2020)

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

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

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

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

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

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

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

The City of Cookeville offers ACA compliant medical coverage that meets the MEC and MV standards and also meets ACA affordability to all benefit eligible full time employees, their legal spouses and their dependent children to age 26.

Benefits Coordinator: Kim Lacy, 931-520-5291, kab@cookeville-tn.org

City of Cookeville Notice for Employer-Sponsored Wellness Programs

New rules published on May 17, 2016, under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published the sample notice below to help employers comply with the ADA:

NOTICE REGARDING 2020 WELLNESS PROGRAM

City of Cookeville wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete 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 attend one of the Wellness Fair meetings, complete a Lipid Profile, a Complete Chemistry Profile and complete a Personal Health Assessment online with BCBST. You will also need to agree to allow CRMC to share your biometric results with BCBS. Only aggregate reporting information is shared with the City of Cookeville. There is no charge for employees for any of the five tests provided at the Wellness Fair which may include; Lipid Profile, Prostate Specific Antigen (PSA), Flu Shot, 3-D Mammogram and Complete Chemistry Profile. 2019 Annual Health Fair scheduled for September 24, 25 & 26th, 2019. Any newly hired employee (hired after October 2, 2019) should attend one of the quarterly Wellness Fairs scheduled for December 10, 2019, March 11, 2020 and June 10, 2020. 2020 Annual Health Fair tentatively scheduled for September 29 – October 1, 2020 and December 9, 2020.** Additional testing is available to employees and their spouses at their own expense. You are not required to complete the series of questions or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of **\$37.20 towards** your monthly group medical plan premiums. Although you are not required to complete the wellness tests noted above or participate in the biometric screening or personal health assessment, only employees who do so **will receive \$37.20 towards your City of Cookeville group monthly medical premiums.**

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 **Benefits Coordinator, Kim Lacy, kab@cookeville-tn.org, 931-520-5291.**

The information from your results from your tests or 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. 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 **City of Cookeville will use aggregate only information** it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information 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 that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the wellness program will be maintained separate 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 Benefits Coordinator, **Kim Lacy kab@cookeville-tn.org, 931-520-5291.**



2020
EMPLOYEE
BENEFITS

Prepared by:

