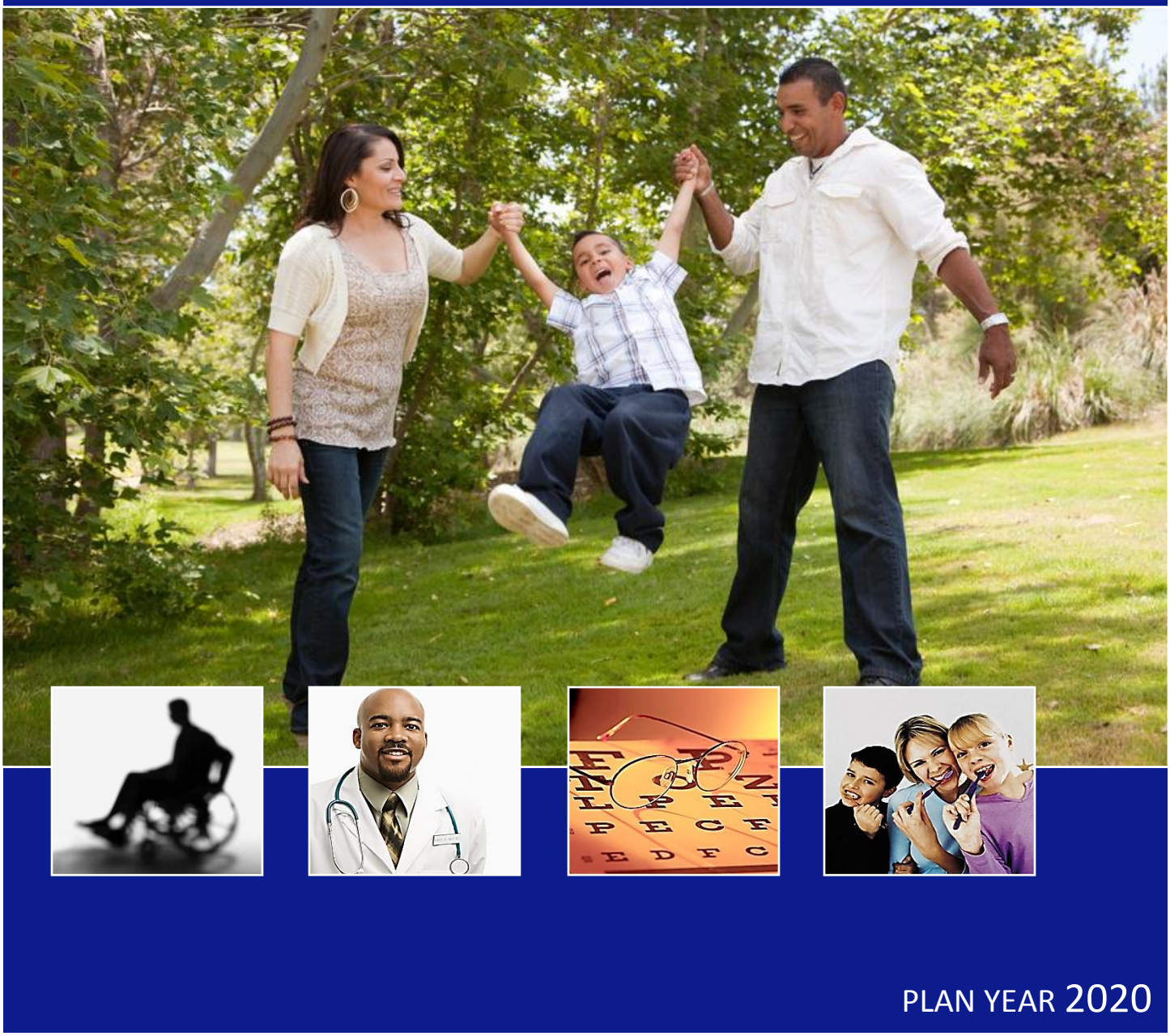
City of Murfreesboro
2020 Benefit Guide



PLAN YEAR 2020

2020 Benefits

The City of Murfreesboro is committed to offering a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

Stay Healthy

- Medical Insurance
- Dental Insurance
- Vision Insurance

Work/Life Balance

- Employee Assistance Program

Feeling Secure

- Employer Paid Life and Accidental Death & Dismemberment
- Voluntary Life Insurance
- Flexible Spending Accounts
- Employer Paid Long-term Disability Insurance

Employee Eligibility

Regular full-time employees who are regularly scheduled to work a minimum of 30 hours per week are eligible for City benefit plans, including medical/prescription drug, dental, health savings account, vision, limited and general purpose flexible spending accounts, basic life/AD&D, voluntary life, short term disability, and long term disability.

Benefit	Eligibility Date
Medical Dental Voluntary Vision Limited and General Purpose FSA (Healthcare and Dependent Care) Health Reimbursement Account (HRA)	First of the month following or coinciding with 60 days from date of hire
Basic Life & AD&D Insurance Voluntary Term Life & AD&D Insurance Long Term Disability	First of the month following or coinciding with 60 days from date of hire
Employee Assistance Program	Eligible from date of employment
GO365 Wellness Program	Eligible from date of employment

Child Eligibility

Benefit	Eligibility Date
Medical	Children up to age 26
Dental	Children up to age 26
Vision	Children up to age 26
Voluntary Term Life	Children up to age 26

When does coverage begin?

For newly eligible employees outside of annual enrollment, coverage is effective the first of the month following or coinciding with 60 days from date of hire.

Medical Insurance

There are again two plan options for City employees to choose from. The Preferred Provider Organization (PPO) and the Health Reimbursement Arrangement (HRA). Each option is explained in further detail below.

A Preferred Provider Organization (PPO) is a network of health care providers and facilities that provide services at a discount to members.

The PPO health plan is a common type of managed care health insurance. PPO health insurance plans normally include an annual deductible. This deductible represents the amount you must pay out-of-pocket before medical coverage begins. With the City's PPO plan, there will be some medical visits that require a co-pay toward the entire bill. These include routine office visits and the cost for most prescription drugs. A PPO health insurance plan also allows you to see any doctor of your choice, allowing you more control. Visits are most affordable if you stay within the network of physicians that work with your PPO medical plan. PPO plans are able to offer services at a reduced rate because of the increased patient volume. Premiums are slightly higher with the PPO plan because the deductible and out-of-pocket maximums are lower than the other plan option.

Regardless of where you reside, utilizing an in-network provider will reduce your out-of-pocket expenses. It is to your advantage to access providers who participate in your provider network. If you choose to see a non-participating provider, your claim will be considered "out-of-network" and coverage will be at the out-of-network (reduced) benefit level.

When evaluating your medical plan options, there are several health insurance terms to understand:

- **Annual Deductible**: How much *you* must pay for care before the plan pays.
- **Co-pay:** Your cost for certain services to which your deductible does not apply.
- **Co-insurance:** The cost share between you and the plan. This is the percentage you must pay for care *after* you've met your deductible.
- **Out-of-pocket maximum:** The *absolute* max you'll pay annually for in-network covered expenses. This includes annual deductible, co-insurance, and co-pays.

Understanding annual deductible vs. out-of-pocket maximum

The difference between your deductible and an out-of-pocket maximum is important. Out-of-pocket maximum is typically higher than your deductible to account for things like deductible, co-pays and co-insurance. For example, if you hit your deductible of $500 or $1,500 but continue to go for office visits with a $20 co-pay, you'll still have to pay that co-pay until you've spent your out-of-pocket maximum, at which time your insurance would take over and cover everything.

Medical Insurance, (Continued)

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) allows employers to set aside funds to help employees pay for out-of-pocket healthcare expenses. You don't make any contributions to an HRA and you don't pay taxes on the HRA money you receive. The City has elected to fund $750 for reimbursement to those employees who enroll in the Employee only or $1,500 for reimbursement to those who enroll in an employee plus child(ren), spouse, or family HRA plan. Expenses eligible for reimbursement include "in-network" deductibles and co-insurance.

HRA reimbursement is automatic with BCBST. You no longer need to complete a claim form and submit it along with your EOBs. Your provider will submit claims to BCBST and BCBST will automatically apply unused HRA money to deductible and coinsurance. If you participate in the Healthcare FSA and want to use your FSA money instead of/or before your HRA money, you must contact BCBST Consumer Coach at 1-800-527-9206 or email BCBST at ConsumerCoach@BCBST.com to opt out of automatic reimbursement.

Unused HRA dollars can be carried over annually for a maximum of $3,000 for employee only and $6,000 for employee and child(ren), spouse, or family. Pre-Medicare retiring employees can have their HRA funds roll over to their pre-Medicare retirement HRA. Premiums are slightly lower on the HRA plan because the deductible and out-of-pocket maximums are higher than the PPO plan option.

Maintenance of Benefits

Your plan includes a Maintenance of Benefits (MOB) provision. MOB is intended to ensure that all the payments for a given service, made by all health plans that may cover you or your dependents, do not exceed the amount allowed by our plan.

Plan Design Comparison

	PP0 – BCBST Preferred Network (Network P)		HRA	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible				
Individual	$500	$1,000	$1,500	$3,000
Family	$1,000	$2,000	$3,000	$6,000
HRA Contribution Employee	N/A	N/A	$750	N/A
HRA Contribution Family	N/A	N/A	$1,500	N/A
Coinsurance	Member pays 20% after deductible	Member pays 50% after deductible	Member pays 20% after deductible	Member pays 50% after deductible
Out-of-pocket Maximum				
Individual	$1,500	$3,000	$3,000	$6,000
Family	$3,000	$6,000	$6,000	$12,000
Office Visits				
Physician Visit	$20	50% after Ded	$20	50% after Ded
Specialist Visit	$25	50% after Ded	$25	50% after Ded
Preventive Care	Covered 100%	Covered at 100%	Covered 100%	Covered at 100%
Facility Services				
Hospital Care (Inpatient/Outpatient)	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Urgent Care	$35	50% after Ded	$35	50% after Ded
Emergency Room Visit (waived if admitted)	$250	$250	$250	$250
Allergy services including testing	$25	$50	$25	$50
Ambulance	20% after Ded	20% after Ded	20% after Ded	20% after Ded
Chiropractic Care – 60 visits/year	$25	$50	$25	$50
Diagnostic Services (testing, lab, x-ray)	20% (ded waived)	50% after Ded	20% (ded waived)	50% after Ded
Home Health Care	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Hospice – 180 days per lifetime*	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Infertility Testing, Treatment**	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Maternity Services				
Physician	$20 first visit, remaining visits covered 100%	---	$20 first visit, remaining visits covered 100%	---
Inpatient Facility	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Mental Health & Substance Abuse				
Office Visit	$20	50% after Ded	$20	50% after Ded
Inpatient	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Occupational Therapy – 20 visits/year	$25	$50	$25	$50
Physical Therapy – 20 visits/year	$25	$50	$25	$50
Skilled Nursing Facility – 60 days/year	20% after Ded	50% after Ded	20% after Ded	50% after Ded
Speech Therapy – 20 visits/year	$25	$50	$25	$50

* Bereavement & respite not covered

**$2000 maximum per year; $15,000 maximum per lifetime; Artificial insemination and in-vitro fertilization only.

Note: This summary is intended as a general overview of the in-network benefits provided and is not a contract. For a detailed listing of all the benefits, please refer to the benefit summaries in your enrollment packet. When referencing Out-of-Network benefits, please note that they are subject to the UCR (Usual, Customary & Reasonable) charges, and you may be balanced billed. Complete details about how the plans work are included in the 2017 Summary Plan Descriptions (SPD) and amendments.

Retiree Plan Design Comparison

	Retiree PP0 – BCBST Preferred Network (Network P)		Medicare Supplemental HRA	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible			HRA contribution can be used for premiums for individual policies, including Medicare Advantage plans or Medicare supplements.	
Individual	$500	$1,000		
Family	$1,000	$2,000		
HRA Contribution Employee	N/A	N/A		
HRA Contribution Family	N/A	N/A		
Coinsurance	Member pays 20% after deductible	Member pays 50% after deductible		
Out-of-pocket Maximum				
Individual	$1,500	$3,000		
Family	$3,000	$6,000		
Office Visits				
Physician Visit	$20	50% after Ded		
Specialist Visit	$25	50% after Ded		
Preventive Care	Covered 100%	Covered at 100%		
Facility Services				
Hospital Care (Inpatient/Outpatient)	20% after Ded	50% after Ded		
Urgent Care	$35	50% after Ded		
Emergency Room Visit (waived if admitted)	$250	$250		
Allergy services including testing	$25	$50		
Ambulance	20% after Ded	20% after Ded		
Chiropractic Care – 60 visits/year	$25	$50		
Diagnostic Services (testing, lab, x-ray)	20% (ded waived)	50% after Ded		
Home Health Care	20% after Ded	50% after Ded	The City establishes an HRA in your name and makes a monthly contribution ($180/person or $360/family) to help you pay for qualifying medical expenses.	
Hospice – 180 days per lifetime*	20% after Ded	50% after Ded		
Infertility Testing, Treatment**	20% after Ded	50% after Ded		
Maternity Services				
Physician	$20 first visit, remaining visits covered 100%	---		
Inpatient Facility	20% after Ded	50% after Ded		
Mental Health & Substance Abuse				
Office Visit	$20	50% after Ded		
Inpatient	20% after Ded	50% after Ded		
Occupational Therapy – 20 visits/year	$25	$50		
Physical Therapy – 20 visits/year	$25	$50		
Skilled Nursing Facility – 60 days/year	20% after Ded	50% after Ded		
Speech Therapy – 20 visits/year	$25	$50		

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Wellness and Prescription Drug Plan

Wellness Benefit

Your preventive health evaluation will take less than 20 minutes and consists of a health questionnaire, blood pressure screening and a comprehensive blood test. Your results are 100% confidential and will not be shared with your employer.

There is no cost for the health evaluation if you are an active full time benefit eligible employee.

Envision Pharmaceutical Services

Envision Pharmaceutical Services provides the City with prescription drug benefits. We currently have a 3-tier structure formulary to lower your out-of-pocket cost for certain brand name drugs. Envision also provides a full range of injectable and infusion biopharmaceutical products directly to patients or their physicians, and provides extensive cost-management and patient-care services.

Generic vs. Brand Name Drugs

Orchard Pharmaceuticals provides mail order service for prescription drugs. Orchard will automatically dispense the generic drug to you unless specified by you or your doctor. This will reduce your co-payment without a compromise in quality or benefit level with your prescription plan. By law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness.

The mail order service program is designed to save you time and money on your maintenance prescriptions by providing home delivery and allowing you to purchase a 90-day supply of medication for the 60-day cost (you save a co-pay).

How Do I Order My Refills?

Order refills of your existing prescriptions on-line at www.envisionpharmacies.com or through Orchard's Interactive Voice Response system (IVR) 24 hours a day, 7 days a week. By using a touch-tone phone, you may dial the toll-free number (1-866-909-5170), and then select "1" to access the automated refill center. It is easy to follow the prompted directions.

Prescription Drug Benefits PPO and HRA Plan	In-Network* Cost
Retail Pharmacy – 30 or 90 day supply	30 day/90 day
Generics	$10/$20
Preferred Brand	$30 /$60
Non-preferred Brand	$50/$100
Mail Order - 90 day supply	
Generics	$20
Preferred Brand	$60
Non-preferred Brand	$100

Section 125 Pre-Tax Program

Many of the benefits offered through the City of Murfreesboro are deducted from your paycheck before taxes (pre-tax). These benefits include Medical, Dental, Vision, Healthcare Flexible Spending Account (FSA), and Dependent Care FSA Reimbursement Accounts. By deducting premiums before taxes, your taxable income is reduced by the amount paid in premiums. For most employees, this results in a reduction in federal income and FICA taxes.
The plan year for the City of Murfreesboro's benefits program runs from January 1 through December 31. Once you make your benefit elections, you may not change your benefits during the year unless one of the following occurs:

- ✓ **Annual enrollment**, which occurs once a year for a January 1 effective date. During this time, you can add, drop or change your levels of coverage under the medical/prescription drug, dental, voluntary vision plans, and flexible spending accounts.
- ✓ **You experience a "qualifying change in status**." Because contributions for medical/prescription drug, dental, voluntary vision, and flexible spending account plans are deducted from your paycheck on a pre-tax basis, the IRS imposes some restrictions on when you can make changes to your benefit plans.

You can only make a change during the plan year (January 1 through December 31) unless you experience a qualifying change in status. Examples of qualifying change in status events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a spouse or child
- Change in your or your spouse's employment or insurance status (i.e., your spouse leaves his/her job)
- Change in residence that affects coverage (i.e., you relocate and there are no in-network providers in your area)
- Your dependent child(ren) reaching the eligibility age limit for the medical/prescription drug, dental, voluntary vision, dependent life or voluntary insurance plans
- Material change in benefits (i.e., your spouse's plan undergoes annual enrollment).

Should you experience such an event and need to make a change to your coverage, you must contact human resources and request the change within 31 days of the event. If you miss this deadline, you will not be able to make a change and you will have to wait until the next annual enrollment or until you experience another qualifying change in status. Ineligible dependents will be terminated in the event of a divorce, death, or age limit. However, the premium amount will not be reduced until next open enrollment or another qualifying event. (You have 60 days to change your coverage following a change in Medicaid or CHIP coverage eligibility.)

Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) is a great way to save money while keeping you and your family healthy. With a Healthcare FSA, you can use tax-free funds to pay for out-of-pocket medical, pharmacy, dental, and vision care expenses. You simply decide how much to contribute to your FSA for the year, and contributions are made each pay period. With a variety of convenient payment and reimbursement options, accessing and using funds in your FSA is fast and easy.

Flexible Spending Accounts provide an option to help you cover qualified healthcare expenses and/or costs associated with caring for a child while you are at work. The City offers two types of FSAs:

- Healthcare FSA: reimburses you for eligible expenses not paid by the medical plan.
- Dependent Care FSA: reimburses you for daycare expenses incurred for eligible children under age 13.

How does the FSA work?

When you establish a Flexible Spending Account, you set aside dollars each pay period before federal or state taxes are assessed. The money in the account may be used to pay certain qualified expenses.

Below is an example of the FSA savings. Note: numbers are rounded and assume 15% federal tax. (Actual tax rate will vary based on local and state taxes in your location):

	Without FSA	With FSA
Gross Semi-Monthly Pay	$1,000	$1,000
Medical Spending Account		($50)
TAXABLE PAY	$1,000	$950
Less FICA Tax	($77)	($73)
Less Federal Income Tax *(15% estimate)*	($150)	($142)
TAKE HOME PAY	$773	$735
Cost of unreimbursed medical expenses	($50)	
DISCRETIONARY INCOME	**$723**	**$735**

Increase in discretionary income each paycheck: **$12**
Increase in discretionary income annually: **$144**

If you enroll and establish a health care FSA, you set aside pre-tax dollars which reimburse you for expenses not covered by your health, pharmacy, dental or vision plan. Generally, the health care FSA can be used for any expense the Internal Revenue Service considers to be tax deductible. An expense reimbursed under your FSA cannot be claimed as a deduction on your income tax return.

Your expenses must be medically necessary. Expenses for cosmetic surgery, health club dues, non-prescription sunglasses, and cosmetics are examples of expenses that are not eligible for reimbursement. Certain over-the-counter (OTC) items and medications are considered reimbursable expenses with a prescription.

How much can I contribute?

Employees can contribute up to $2,700 in the healthcare FSA and up to $5,000 per year in the dependent care FSA. If you are married and you and your spouse file separate federal income tax returns, the limit on the dependent care FSA is $2,500 annually (per family).

Flexible Spending Account - FSA (Continued)

How can you pay claims with your Healthcare FSA?

1. Pay for eligible medical, dental, and vision services using the WageWorks VISA brand Healthcare Card, which works just like a debit card. Choose from several no-hassle reimbursement options:
2. Use the WageWorks EZ Receipts® mobile app on your smartphone to take a photo of receipts, instantly submit receipts for payment, or check claim status or FSA balances
3. Access your FSA on line and fill out a simple form to pay your provider
4. Arrange for FSA funds to be transferred to your checking account or a check to be mailed to reimburse you for expenses you've already paid.

When you enroll in a Healthcare FSA, you will automatically receive a WageWorks Healthcare Card in the mail. This card will be used for multiple years (do not throw away).

How can you pay claims with your Dependent Care FSA?

Pay for dependent care services and choose from several no-hassle payment and reimbursement options:

1. Use the WageWorks EZ Receipts® mobile app on your smartphone to take a photo of receipts, instantly submit receipts for payment, check claim status or FSA balances, and even get electronic signatures from day care providers
2. Access your FSA on line and fill out a simple form to pay your provider
3. Arrange for FSA funds to be transferred to your checking account or a check to be mailed to reimburse you for expenses you've already paid

Can I still claim the Dependent Care Tax Credit?

You cannot use the Dependent Care FSA and the Federal dependent care tax credit for the same expenses. You will need to determine which approach would be most advantageous. Lower income families may be better off claiming the child-care credit than using an FSA, but it's best to check with a Tax or Financial Advisor.

How long do I have to be reimbursed?

You have until March 15 to submit claims for eligible expenses incurred in the previous year.

Do I have to use all my FSA funds by the end of the year?

It is important to estimate your expenses for the next plan year carefully. If you participate in the Dependent Care FSA, you must use all the money in your account by year-end; the IRS requires that any funds remaining after this date be forfeited. You do, however, have until January 31 to submit claims for expenses incurred in the prior year.
If you participate in the Healthcare FSA, you may carry over up to $500 of unused funds into the next year. In other words, if you overestimate your health care expenses for 2020 and have money remaining in your account at year-end, you may carry over up to $500 and continue to incur and get reimbursed for eligible expenses from the carried-over amount. However, there are a couple of rules to keep in mind:

- Unused funds exceeding the $500 rollover limit will be forfeited.
- The carryover provision does not reduce how much you can contribute to the Healthcare FSA in the next plan year. For example, if you carry over $400, you can still make the maximum contribution ($2,700) in the next year.

Flexible Spending Account - FSA (Continued)

Flexible Spending Account Eligible and Ineligible Healthcare Expenses

IRS regulations govern the eligibility of expenses, which include those that are not fully covered by a healthcare plan and are prescribed by a physician or other licensed professional primarily for preventing, treating or mitigating a physical defect or illness. A partial list of **eligible** expenses is provided below:

- Acupuncture
- Alcoholism or drug dependency treatment centers
- Ambulance
- Artificial limbs and teeth
- Birth control pills and devices
- Braille books and magazines
- Childbirth preparation classes for mother, excluding portion for mother's coach
- Contact lenses and contact lens solutions
- Dental treatment (non-cosmetic), including dentures, and orthodontia (braces and retainers)
- Eye Examination
- Eye laser surgery
- Prescription eyewear
- Guide dog and its upkeep
- Fees to doctors, hospitals, etc. for:
- Anesthesiologist
- Chiropodists
- Chiropractor
- Clinic
- Dentist
- Dermatologist
- Gynecologist
- Midwife
- Neurologist
- Obstetrician
- Ophthalmologist
- Optometrist
- Osteopath, licensed
- Pediatrician
- Podiatrist
- Practical Nurse
- Psychiatrist
- Psychologist (medical care only)
- Sex therapist
- Surgeon
- Hearing aids/batteries
- Home modifications to accommodate handicapped person

- Most hospital services
- Insulin, syringes
- Laboratory fees
- Lip-reading lessons
- Lodging for medical care
- Medical supplies (prescribed)
- Mental institution care, mentally ill person unsafe when alone
- Mentally retarded, special home for
- Nurse's expenses and board
- Nursing care
- Obstetrical expenses
- Operation and related treatments
- Organ donation, organ transplants
- Orthopedic shoes, excess of costs over normal shoes
- Some over-the-counter expenses (with a doctor's prescription)
- Oxygen equipment
- Radial keratotomy
- Rental of medical equipment prescribed by doctor
- Smoking cessation programs
- Special schooling for physically or mentally handicapped family
- Speech therapy
- Sterilization, legal
- Telephone for the deaf
- Television closed caption decoder equipment that displays the audio part of the TV programs for the deaf
- Therapy received as medical treatment
- Transplant, medical expenses of donor/prospective donor
- Transportation expenses for essential medical care (mileage varies yearly)
- Tuition at special school for the handicapped
- Vaccinations
- Vasectomy
- Visual alert system for deaf person
- Wheelchair
- X-ray

Examples of Ineligible Healthcare Expenses

- Any illegal treatment
- Cosmetic surgery, electrolysis, teeth bleaching, and hair transplant that is not medically necessary
- Cost of illegal drugs, even if physician directed
- Cost of remedial reading classes for non-handicapped child
- Dancing or ballet, even when recommended by doctor
- Diaper service
- Fees for exercise, athletic, or health club memberships
- Funeral expenses
- Marriage counseling
- Maternity clothes
- Non-prescription sunglasses
- Vitamins, unless recommended by a physician as treatment for a specific, diagnosed medical condition
- Parenting classes
- Spousal or personal insurance premium
- Swimming lessons

Dental Insurance

Delta Dental will continue to provide dental benefits to the City for 2020. Benefits are covered according to the following summary.

Employee cost per month (pre-tax)	Delta Dental
Lifetime Orthodontics Maximum	$1000
Annual Deductible Applies to Basic and Major Services Only	Per Person $50 Per Family $150
Diagnostic and Preventive Services • Oral examinations • Prophylaxis (cleanings) • X-rays • Fluoride treatment (Up through age 17) • Space maintainers	100%
Basic Services • Restorative (fillings) • General anesthesia • Simple Extractions • Oral Surgery (surgical extractions) • Periodontics (treatment of gums and bones supporting teeth) • Endodontic (root canal therapy)	80%
Major Services • Crowns • Bridges • Partial dentures • Full Dentures • Implants	50%
Orthodontic Services • Straightening of teeth for all enrollees	50%

Vision Insurance

Employees have the option of enrolling in a VSP vision insurance plan. This is an employee-paid pre-tax plan. A pre-tax benefit can only be changed during open enrollment or due to a qualifying event (see page 2 of this guide). If you choose to participate in the VSP vision insurance plan some of the benefits you will see are as follows:

VISION PLAN OVERVIEW		
Vision Benefits	In-Network Vision Provider	Out-of-Network Provider *(Reimbursement Schedule)*
Exam	$10 exam co-pay	Up to $45
Exam Frequency	*Once every 12 months*	
Lenses for Glasses	$25 materials co-pay Standard Lens	Up to $30-$100 (Depending on type of lens)
Lenses Frequency	*Once every 12 months*	
Frames	Up to $130 ($50 wholesale)	Up to $70
Frames Frequency	*Once every 24 months*	
Contact Lenses *Elective* ****Medically Necessary***	Up to $130 100%	Up to $105 allowance $210 allowance
Contacts Frequency	*Covered in lieu of lenses +frames; once every 12 months*	

Note: This summary is intended as a general overview of the benefits provided and is not a contract. For a detailed listing of all the benefits, please refer to the benefit summaries in your enrollment packet.

Basic/ Voluntary Term Life Insurance and AD&D

All full-time employees receive Basic Life and Accidental Death & Dismemberment (AD&D) insurance with no cost to the employee. Your Basic Life insurance provided by the City will be carried by Minnesota Life. You may also purchase additional Voluntary Life insurance coverage. New hires are guaranteed the coverage amount stated below. Coverage requests for existing employees and/or spouse are subject to underwriting.

Supplemental life insurance is 100% paid by the employee on a post-tax basis through payroll deduction.

Coverage Type	Coverage Options	Additional Information
Basic Term Life & Accidental Death and Dismemberment (AD&D)* Employer-paid	• 2 x annual budgeted salary rounded to the next higher $1,000 • Minimum $10,000 • Maximum $350,000	• Coverage is automatically provided by the City • All coverage is Guaranteed – no health questions • AD&D coverage matches Basic Term Life amount
Employee Term Life Employee-paid	• $10,000 increments • Maximum coverage $500,000	• Subject to underwriting[1] • New hire only – Guaranteed issue not to exceed $250,000 (no health questions asked)
Spouse Term Life Employee-paid	• $10,000 increments • Maximum coverage $250,000	• Subject to underwriting[1] • New hire only – Guaranteed issue not to exceed $50,000

Child Term Life Employee-paid	• Up to $20,000 (live birth to Age 26)	• Up to $20,000 Guaranteed issue for each child
		• A child may only be covered by one parent
		• Employee may choose:
		  • $10,000 coverage $1.09 month
		  • $15,000 coverage $1.64 month
		  • $20,000 coverage $2.18 month

[1]May be required to fill out an evidence of insurability form before approval is determined

*Coverage reduces 50% at age 70

Long Term Disability Coverage

The City offers Long-Term Disability coverage through Cigna. This benefit covers all benefit-eligible employees at no cost to the employee.

Provided to benefit-eligible employees at no cost	Long-Term Disability
Benefits begin…	After 90 days of disability
The plan pays…	Up to 60% of your pre-disability monthly earnings

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a service paid by the City to provide confidential, professional short-term counseling, referral and follow-up for you and your family members. Everyone experiences personal problems at some point in their lives. Often it is difficult to know what to do or whom to turn for help. This is why the City has made the services of LifeServices EAP available to you and your family. You and your eligible dependents will receive six visits per year per episode.

As part of your Employee Assistance Program provided by LifeServices, you and your family will now also have access to legal and financial benefits through their partnership with Consolidated Legal Concepts, CLC. Benefits include discounts on legal consultation, do-it-yourself legal forms, document preparation, financial consultations and tax consultation and preparation.

To access WorkLife on-line services?

1. Enter this web address using an internet browser: www.lifeserviceseap.com
2. On the Homepage, click on "Website Services Login".
3. Enter the User Name as: **murfreesboro,** Enter the Log-In ID as: e**mployee**

Aflac Voluntary Plans

Offered through Aflac, voluntary plans help with out-of-pocket expenses. There is a guarantee issue with no medical questions asked this year during initial enrollment. Cash benefits are paid directly to the employee. You may enroll yourself and eligible family members. Pre-existing exclusion may apply. Plans include:

- **Accident**
  - $60 Wellness Benefit
  - Hospitalization- $1,000
  - Hospital confinement - $250/day ($400/day in ICU to a max of 15 days)
  - Accidental death - $40,000/employee, $40,000/spouse, $12,500/child
  - Dismemberment - Up to40,000
- **Cancer**
  - Cancer Wellness Screening - $75
  - Lump sum at diagnosis - $4,000 employee/spouse
  - Mammography benefit - $70/year
  - Injected Chemotherapy Benefit $600/week
  - Radiation Therapy Benefit $350/week
  - Hospital Confinement Benefit
- **Group Short-term Disability**
  - Elimination period – choose from
    - 14 days due to injury, 14 days due to sickness
    - 0 days due to injury, 7 days due to sickness
  - Benefit period – 3 months
- **Aflac Hospital Advantage Preferred Plan**
  - 4 Plan Options
  - Inpatient Hospital Confinement $1,000 per covered person
  - Rehabilitation Facility $100 per day
  - Hospital Emergency Room $100 up to 2 times per year, per policy
  - Hospital short-stay $100 up to 2 times per year, per policy
  - Waiver of premium included

All benefits and eligibility are subject to the provisions of the plan. Refer to the benefit descriptions in your packet and the plan document.

Helpful Insurance Terms

HRA — HRA stands for Health Reimbursement Arrangement/Account. With this type of plan, funds are put into an account by your employer for you to use to cover your deductible and/or co-insurance. You can choose whether or not to be reimbursed for the deductible/co-insurance with funds that you have in your Health Reimbursement Account or if you don't have enough money in your HRA, you are responsible for the remaining portion, which is known as a "bridge" deductible.

PPO — PPO means Preferred Provider Organization. This is a network of providers in which costs are lower when you see an in-network provider. You pay more (Up to 100% of the cost) if you decide to see a provider that is not in the network.

Bridge — Bridge is the portion of the deductible that you are responsible for in an HRA plan. Once your HRA is exhausted, you are responsible for "bridging" the difference between what the HRA covered and the full deductible.

Premium — Premium is the amount that you pay to be enrolled in the plan. It is just like the premium you pay for your car and home/renter's insurance. The amount of premium will vary depending on the plan you choose and whether or not you cover dependents.

Co-Pay — A type of medical plan where you pay a specified amount of out-of-pocket expenses for healthcare services (such as doctor visits and prescription drugs) at the time the service is rendered, with the plan paying the remaining cost.

Co-insurance — Co-insurance is the percentage of healthcare costs that you share with the plan once the deductible is met. For example, if the plan has an 80% co-insurance rate for a specific healthcare service, that means that once the deductible is met, the plan will pay 80% of the cost and you are responsible for the remaining 20%. Co-insurance levels may vary depending on the type of healthcare service you are receiving and whether or not you use an in-network provider.

Deductible — Deductible is the amount paid before the plan begins paying at a co-insurance rate.

Maximum out-of-pocket — Maximum out of pocket is the amount that you pay before the plan begins paying covered expenses at 100%. Some things may not be included in the maximum out-of-pocket like premiums, expenses from out-of-network providers, and services not covered by the health plan, etc.

Preventive Care — Preventive care includes services that help to prevent future illness. For a list of what's covered at $0 cost, go to www.healthcare.gov/what-are-my-preventive-care-benefits/

WHCRA – Women's Health and Cancer Rights Act of 1998 – Outlines benefits a member may be entitled to if they had or are having a mastectomy.

CHIPRA Notice – Children's Health Insurance Program – Some states have a premium assistance program that can help pay for coverage if you or your children are eligible for Medicaid or CHIP and you are eligible for employer provided health coverage.

Medicare Part D Notice – Provides important information on your prescription drug coverage under Medicare.

New Health Insurance Marketplace Coverage Options – This notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

In-Network — In-network refers to a group of providers that have contracted with the plan to provide services to members at a reduced rate.

Out-of-Network — Out-of-network refers to all other providers that are not included in the plan's network.

Self Insured — A medical plan offered by employers who directly assume the major cost of health coverage for their employees.

Key Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL

BlueCross BlueShield of Tennessee
Group Number: 125224
Member Services: (800) 565-9140
www.bcbst.com

WELLNESS

Humana Go365
(800) 708-1105
www.Go365.com

PRESCRIPTION DRUGS

Envision
Member Services: (800) 361-4542
www.envisionrx.com

Orchard Pharmaceutical Services/
Mail Service Prescription Drug Program
Member Services: (866) 822-4847
www.orchardrx.com

FLEXIBLE SPENDING ACCOUNT (FSA)

WageWorks
Member Services: (877) 924-3967
www.wageworks.com

DENTAL

Delta Dental
Group Number: 4009
Member Services: (800) 223-3104
www.deltadentaltn.com

VISION

VSP
Group Number: 30034962
Member Services: (800) 877-7195
www.vsp.com

BASIC/VOLUNTARY LIFE/ACCIDENTAL DEATH & DISMEMBERMENT

Minnesota Life
Group Number: 33970 – G
Member Services: (800) 392-7295
www.minnesotalife.com

LONG-TERM DISABILITY

Cigna
Group Number: LK964182
Member Services: (800) 362-4462
www.cigna.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life Services EAP
Member Services: (800) 822-4847
www.lifeserviceseap.com

VOLUNTARY PLANS

Aflac
(615) 796-3635 (Cell)
www.Aflac.com

CITY OF MURFREESBORO HUMAN RESOURCES

(615) 848-2553
Benefits@murfreesborotn.gov