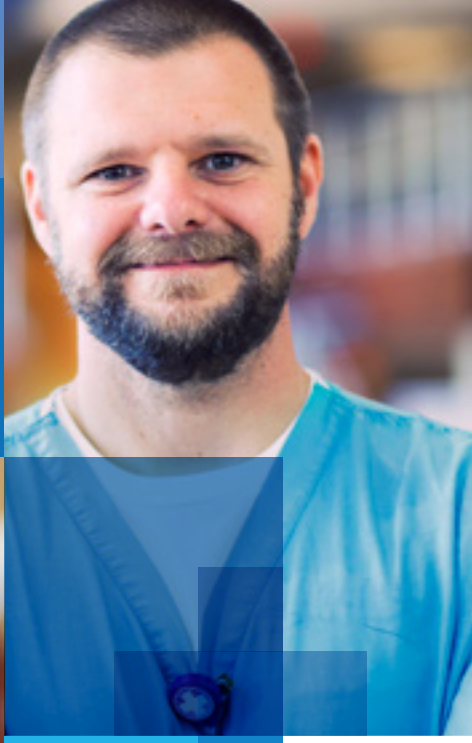


2019 Benefits

Annual Enrollment

West Tennessee HEALTHCARE

What's in your packet?

West Tennessee HEALTHCARE™

September, 2018

Dear Colleagues,

As we approach our annual benefits enrollment period, I wanted to take this opportunity to thank you for all that you do every day, for our patients, their family members, and our community. West Tennessee Healthcare's vision is to be chosen by our staff, our physicians and our community as the best place to work, the best place to practice and the best place to receive comprehensive care.

Each year we review our benefits portfolio to ensure our offerings are market based, comprehensive, and meet our employees' needs. As health care costs continue to rise across the nation, I am pleased to report that the changes we have made over the years have helped us keep our costs in line, so medical premium increases for 2019 are minimal for the third year in a row. Increases for medical:

- $1.00/paycheck for individual coverage (if you work 40 hours/week, the increase is 1¼ pennies per hour of your pay);
- $2.00/paycheck for employee plus one (2½ pennies per hour of your pay); and
- $3.00/paycheck for employee plus family (less than 4 pennies per hour of your pay).

What can you do to keep your premiums low?

- Make an appointment for you and all family members with your primary care physician for an annual exam – preventive services are covered by the plan at 100%.
- Choose to have medical services at West Tennessee Healthcare facilities whenever possible.
- Participate in annual screenings appropriate to your gender, age and family history. Examples:
  - Immunizations
  - Well woman exam including pap smears
  - Mammogram
  - Colonoscopy
  - Prostate exam
- Know your numbers and be engaged in actively improving your health and well being.
- Eat well and exercise regularly!
- Get a flu shot.

This year we continue to focus our efforts on Healthy Heights, our program dedicated to improving the health and well-being of our employees. Our voluntary benefit offerings for life, dependent life, short and long term disability, accident, cancer, critical illness, identity theft protection and others are an important part of life planning and financial wellness; we hope you will consider your options carefully.

Please read through the entire packet – there is a lot of information here and you are responsible for understanding your benefits and enrolling properly. Again, thanks for all you do.

Wendie Carlson, MBA, SPHR
Chief Human Resources Officer

What You Need To Do

Note: This year the annual enrollment is considered to be a "passive enrollment". What this means is that your current selections will roll over to 2019 without you having to go into the portal to make any changes. This will happen to all benefits except Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA). You must re-enroll in these benefits each year. If you are going to have medical coverage with WTH for 2019, you must complete the tobacco surcharge form. If you're enrolling a spouse, you must also complete the spousal surcharge form.

Enrollment Checklist

- ❑ Review enrollment packet posted on the WTH Intranet to determine benefit selections. If you have any questions, be sure to **ASK ALEX**! Link located on **WTH Intranet>Human Resources>Benefits**
- ❑ Review enrollment instructions in the Employee Self Service Portal Instruction Manual located on the **WTH Intranet>Human Resources>Benefits**
- ❑ Before enrolling, make sure any new eligible dependents are listed. Instructions for adding dependents are located in the instruction manual.
  - ❑ If new dependents are added you must send copies of appropriate verification documents with your employee number to Benefits
    - To verify a spouse, you will be required to furnish a copy of the state-issued marriage license or marriage certificate and the first page of your Federal Tax Return (1040) or documents proving joint ownership, such as mortgage statements, credit card statements, bank statements, and leasing agreements listing both parties' names as co-owner.
    - Verification of children will require a state-issued birth certificate or legal documents related to foster or adoption placement.
    - Documents should be sent to Benefits with employee name and identification number on each document, faxed to 731-265-1130, or brought to an annual enrollment support open house session.
- ❑ Optional: Attend an annual enrollment support open house session (see dates below)
  - To learn more about your choices;
  - Talk with benefit vendors
  - Get questions answered
  - Hand deliver verification documents for newly added dependents
- ❑ Enter your benefit selections in the Employee Self Service Portal by Sunday, November 11, 2018. **WTH Intranet> Links>Employee Self Service Portal**
- ❑ Print confirmation

If you do not actively enroll in 2018 benefits using the Employee Self Service Portal, some of your benefits will default to current plans. Exceptions:

- Flexible spending accounts will not default from previous year selection.
- Health savings account contributions will not default from previous year selection.

Annual Enrollment Open House Dates:

• October 18, 2018	Jackson Madison County General Hospital*	7:00 am – 4:00 pm
• October 19, 2018	Jackson Madison County General Hospital*	11:00 am – 7:00 pm
• October 20, 2018	Jackson Madison County General Hospital*	6:30 am – 11:00 am
• October 24, 2018	Humboldt General Hospital	7:00 am – 11:00 am
• October 25, 2018	Milan General Hospital	7:00 am – 11:00 am
• October 26, 2018	Bolivar General Hospital	7:00 am – 11:00 am
• October 29, 2018	Volunteer Hospital (Martin)	7:00 am – 11:00 am
• November 1, 2018	Camden General Hospital	7:00 am – 11:00 am
• November 2, 2018	Dyersburg Hospital	7:00 am – 7:00 pm
• November 7, 2018	Prime Care Medical Center (Selmer location)	7:00 am – 12:00 pm

Incentives are Changing in 2019

In 2019 we are using more incentives to reward behaviors that we believe, as health care professionals, are essential to improve employee health. To obtain incentives –

- Complete your health assessment by December 15, 2018.

  Why? We want you to know your numbers and understand your health risks.

- Go see your primary care provider (PCP) for an annual wellness or well-woman exam in 2019.

  Why? Having an established relationship with a PCP is foundational to your health, and preventive medicine is a critical part of your annual wellness regime. Wellness exams and other preventive services are covered at 100%, regardless of which medical plan you choose.

Option 1 Medical Plan: 2019 Funding for Health Reimbursement Account (HRA) Participants

- Funds from your HRA are used to offset your out-of-pocket expenses and are applied by Aetna at the time your claims are processed.
- West Tennessee Healthcare automatically contributes to your HRA:
  - $300 for individual coverage;
  - $550 for employee plus one;
  - $800 for family coverage.

  Note: These amounts are pro-rated for employees entering the plan after January 1, 2019.
- Unused funds can be rolled over from year to year, up to maximums allowed under the plan.
- Earn up to $200 additional incentive funding for 2019:
  - Complete the Aetna on line Health Assessment by December 15, 2018; $100 will be deposited into your HRA in January, 2019.
  - Go see your primary care provider (PCP) for an annual wellness or well-woman exam in 2019. Once Aetna processes your claim WTH will deposit another $100 into your HRA.

Option 2 Medical Plan: 2019 Funding for PPO Plan participants

- You can earn up to $100 in incentives which will be placed into a Health Incentive Account:
  - Complete the Aetna on line Health Assessment by December 15, 2018; $50 will be deposited into your health incentive account in January, 2019.
  - Go see your primary care provider (PCP) for an annual wellness or well-woman exam in 2019. Once Aetna processes your claim WTH will deposit another $50 into your health incentive account.
  - Funds from your health incentive account can be used to offset your out-of-pocket expenses.

Option 3 Medical Plan: 2019 Funding for Health Savings Account (HSA) Participants

- Total annual pre-tax contributions from the employee and WTH may not exceed $3,500 for individual or $7,000 for family coverage in 2019. This is an increase of $50 for individual and $100 for family.
- West Tennessee Healthcare automatically contributes to your HSA:
  - $200 for individual coverage;
  - $325 for employee plus one;
  - $450 for family coverage.

  Note: These amounts are pro-rated for employees entering the plan after January 1, 2019.

  Employees age 55 or older may contribute an additional $1,000 per year.
- Earn up to $150 additional incentive funding for 2019:
  - Complete the Aetna online Health Assessment by December 15, 2018; $50 will be deposited into your HSA in January, 2019.
  - Go see your primary care provider (PCP) for an annual wellness or well-woman exam in 2019. Once Aetna processes your claim, WTH will deposit another $100 into your HSA the following calendar quarter.

Health Risk Assessment

Complete yours to earn additional $$ in your HRA and HSA account.

Available Oct 1st – December 15th

(link can be found on the intranet-Human Resources-Benefits)

To complete the assessment, you will need to "Know Your Numbers".

- HDL cholesterol
- LDL cholesterol
- Total cholesterol
- Triglycerides
- Glucose
- Blood Pressure
- Height
- Weight

These numbers were provided to you at your Annual Health Update if you had your labs completed for Healthy Heights. You can also obtain these numbers by visiting your PCP (primary care provider) and having your annual wellness visit, which is 100% covered under our medical plan.

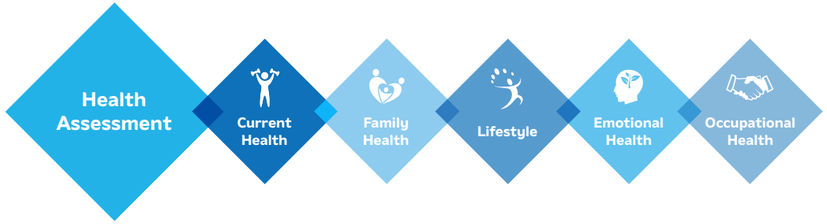
What's in it for me?

Not only does West Tennessee Healthcare provide you with the health risk assessment so that you can take the first step in living a healthier life, but also they PAY you for taking it!

Employees on the Option 1 HRA plan will earn $100 EXTRA in their HRA. Employees on the Option 2 will earn $50 EXTRA in a Health Incentive Account. Employees on the Option 3 plan will earn $50 EXTRA in their HSA.

We ask: how can you take care of others, if you are not taking care of yourself?

Healthy Heights (our employee well-being program) provides employees with the tools and resources needed to attain and sustain a healthy state of well-being so that they can provide compassionate and exceptional care to the patients and communities we serve!



Questions and Answers About the Assessment

Why does WTH offer the health assessment?

The goal of the health assessment is to help improve your health and well-being in two ways.

- First, it provides health information you can use for discussions with your physician and helps you understand the effect that lifestyle choices may have on your health.
- Second, it helps WTH know what types of education and support programs would be most useful to our employees. There are many things that contribute to weight, BMI, cholesterol and glucose numbers. Some of those things can be controlled; some can't. The goal of the assessment is to help you, not to increase premiums.

What does hospital leadership and the benefits department see?

Your individual information is not seen by hospital leadership or the benefits department. All they see is collective data on all employees as a group.

How is this collective information used?

The collective data WTH receives on all employees will help us understand the health of our employee population at large. We will use this information to establish education and support programs that will be of the most benefit to our employees to help improve the health of our population.

Will my individual health insurance premium go up as a result of my numbers?

No.

Eligibility

Annual enrollment is your opportunity to review your benefits and make choices for the upcoming calendar year. Elections made during this annual enrollment period will become effective on January 1, 2018 and will remain in effect for the entire year, unless you experience a qualifying life or family status event.

The IRS allows employees to make certain benefit contributions through pre-tax salary reductions, which lower your taxes and save you money. Because of these tax savings, the IRS allows you to make benefit elections and changes only during certain times of the year:

- Within 31 days of your benefits-eligibility date for a new hire
- During Annual Enrollment
- Certain changes are permitted within 31 days of a qualifying life or family status event

Qualifying family or life status events include:

- Marriage
- Divorce
- Death of a dependent
- Birth or adoption of a child
- Dependent becomes ineligible for coverage
- Spouse gains or loses employment
- Switching from part-time to full-time (or vice versa) by employee or spouse
- Taking unpaid leave of absence by employee or spouse
- A significant change in the health coverage of the employee or employee's spouse attributable to the spouse's employment

Supporting documentation – such as birth certificates, marriage licenses, divorce decree, proof of new coverage etc. will be required.

Changes must be made within 31 days of the qualifying event. If you miss the 31 day period, you will be required to wait until the next Annual Enrollment to change your benefits. It is your responsibility to notify Human Resources within 31 days of the qualifying event.

Benefits that may only be selected upon hire, during Annual Enrollment or with a qualified life event include:

- Medical and Prescription Drug Plan
- Dental Plan
- Vision Plan
- Life and Accidental Death and Dismemberment (AD & D) Insurance
- Dependent Life Insurance
- Flexible Spending Accounts

1 in 5 Employees Regrets Their Benefits Choices*

Don’t Be the One

According to a recent national poll of full-time, benefits-eligible employees, 1 in 5 people say they often regret their benefit choices.

We want you to be happy with your benefits.

To find a plan that provides the right level of coverage for your needs and that doesn’t take too much money out of your paycheck, please visit ALEX®.

Discover your lowest-cost benefit options (and more) at Myalex.com/wth/2019

alex® | BENEFITS COUNSELOR

West Tennessee HEALTHCARE™

Save the Date: Open Enrollment October 17th-November 11th

*Source: The 2017 ALEX Benefits Communication Survey (Research Conducted by Harris Poll®)

Employee Coverage Costs and Savings

Cost Sharing

West Tennessee Healthcare pays a large portion of the premium cost for your healthcare coverage. The employee share of the cost depends on level of coverage chosen and whether the coverage includes spouse and/or dependent children.

The Premium Schedule lists the costs for medical, dental and vision coverage. This contribution will be deducted from each pay period on a pre-tax basis.

Pre-Tax Deductions Means Savings for the Employee

West Tennessee Healthcare helps the employee to save money by taking advantage of regulations that allow them to pay for benefit premiums with pre-tax dollars. Pre-tax dollars are dollars earned before state, federal and social security taxes are deducted. This applies to all benefit premiums except dependent life, short term disability, cancer, accident, critical illness, long term disability, prearranged funeral, Air Evac, ID Shield and Legal Shield.

What are pre-tax deductions?

Pre-tax deductions reduce an employee’s taxable wages, meaning they will likely owe less federal income tax and FICA tax (Social Security and Medicare taxes).

Dependent Child Definition

A dependent child (up to age 26) is defined as son, daughter, stepson, stepdaughter, eligible foster child, adopted child, or child for whom the employee has permanent legal and physical custody without regard to whether the child is married, financially supported by the employee, resides with the employee or is a full-time student.

Important Information: 30 day notification requirements

If the employee has a change of status, they have 30 days from the date of the qualifying event to notify Human Resources and supply supporting documents to make benefit changes.

Coverage for status changes are effective the date of the change in status.

If you do not fulfill this notification requirement, you must wait for the next annual enrollment period to make the changes.

Newborns must be added to your coverage. To add a newborn to your coverage, you must notify Benefits in Human Resources within 30 days of the birth.

Vanderbilt Health
Affiliated Network

West Tennessee Healthcare joined the Vanderbilt Health Affiliated Network (VHAN) in 2014 acting on our strategic plan to provide health care leadership as part of a clinically integrated network. VHAN is a collaborative alliance of physicians, health systems, and employers driving a new level of clinical innovation and teamwork to enhance patient care, contain costs and improve the health of communities in Tennessee and surrounding states. The network includes more than 5,000 providers, 60 hospitals, 12 health systems and hundreds of physician practices and clinics who work together to strengthen communities and improve the quality of life across the Southeast through better health.

When you choose health care services from providers in VHAN such as primary care doctors, hospitals, or imaging facilities, you are getting high-quality care at your best benefit plan level. We hope you will choose to receive healthcare at one of West Tennessee Healthcare's access points whenever possible, but you also have a wide range of options across the state. Here is a brief description of your network options.

Tier 1 Providers: VHAN (Vanderbilt Health Affiliated Network)

- When you choose from more than 5,000 VHAN Tier 1 providers you'll have the lowest deductible, coinsurance percentage and out of pocket maximum.
- You also have access to more than 110 walk-in, urgent care, and pediatric after-hours clinics across the state.

Tier 2 Providers: Aetna National Network

- In addition to providers in VHAN, Aetna has a strong presence throughout the United States. If you have a dependent college student, are travelling or live outside of VHAN's service area, you'll have in-network access to high caliber hospitals and physicians.
- When you choose Tier 2 providers, your deductible, coinsurance percentage and out of pocket maximum will be higher than Tier 1, but significantly lower than if you go out-of-network.

Tier 3 Providers: Out-of-Network

- When you choose Tier 3 or out-of-network providers, your deductible and coinsurance percentage will be significantly higher and there is no annual out-of-pocket maximum.

How to Find Tier 1 (VHAN) Primary Care Provider or Specialist

1. Visit vhan.com/findaprovider.
2. You can find a primary care doctor by searching for Family Medicine or Internal Medicine as the specialty.
3. To find a VHAN urgent care or a walk-in clinic: Bookmark quickcare.vhan.com on your phone or device for more than 110 urgent care, walk-in, and pediatric after-hours clinics across Tennessee.

How to Find Tier 2 (Aetna National Network) Providers

1. Visit Aetna.Docfind website.
2. Select Enter DocFind (the box in the middle of the page).
3. Read the privacy statement and select Continue to DocFind.
4. Complete the General Search requested information by entering your zip code and the distance for your search.
5. Select a Provider Category (medical, behavioral health, etc.) and then select the Provider Type (primary care physician, specialist, etc.).
6. Select your Plan – Enter Aetna POS II Providers for all providers in Aetna's National Network.
7. Click on Start Search. If you want to refine your search, click on More Options.

CHOICES 2018
Medical Plan Options

You have three plan options to choose from in 2018. Options 1 and 3 are Consumer Driven Health Plans with Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs) and Option 2 offers a Preferred Provider Organization (PPO) plan. **Documents for each option are posted to WTH Intranet on the Human Resources page.**

OPTION 1 · Deductible with HRA

- WTH funds your health reimbursement account to offset deductibles
- Company funded HRA promotes informed consumer choices
- Unused account funds can roll over from year to year but are forfeited at termination
- This plan offers reduced employee premiums for employees earning $12/hour or less

OPTION 2 · PPO Plan

- This is the highest cost health plan, therefore premiums are highest under this plan
- Office co-pays provide less risk and greater predictability for out-of-pocket costs
- Deductible and coinsurance will be applied to lab and imaging services that occur in physician office.
- Co-pays will be applied to physician charges only.

OPTION 3 · High Deductible with HSA

- WTH partially funds your health savings account to offset highest deductibles
- Employee contributes pre-tax contributions to the health savings account to offset out-of-pocket costs and save for future health care expenses
- Unused account funds can roll over from year to year
- HSA account accumulates interest and can be invested
- Account funds are portable at termination so the HSA lets you build up savings to offset future health care expenses
- This plan has the lowest premium but highest deductible and out-of-pocket risk

If you don't actively participate in annual enrollment, your medical plan choice for 2018 will be selected for you based on your current plan selection.

By actively participating in annual enrollment you can select any of the three plans offered.

How the Medical Plans Work

All three plans pay 100% for preventive care. The plans differ when it comes to how you pay for expenses before and after you meet your deductible. The other big difference in the plans is that Option 1 Deductible plan offers an HRA, while Option 3 High Deductible plan offers an HSA. Here's a rundown of how the plans work, starting with how WTH can help offset your costs.

	Option 1 Deductible w/HRA			Option 2 PPO			Option 3 High Deductible w/HSA		
Account Funding	A Health Reimbursement Account (HRA) fully funded by WTH.			This plan does not offer an HRA or HSA			A Health Savings Account (HSA) partially funded by WTH. You can also contribute tax-free money to your HSA. In 2018, total contributions may not exceed $3,450 individual coverage or $6,900 for family coverage.		
	Account Funding: The amount WTH contributes to your account depends on who you cover								
	Employee	$400		None			$200		
	Employee +1	$650		None			$325		
	Family	$900		None			$450		
Your Deductible	You pay 100% of the costs until you meet your deductible. However, your HRA will be used to offset your deductible and other health care expenses covered by the plan. Deductible below includes account funding.			You pay 100% of the costs until you meet your deductible. However, your HRA will be used to offset your deductible and other health care expenses covered by the plan. Deductible below includes account funding.			You pay 100% of the costs until you meet your deductible. However, you can use your HSA to offset your deductible, to pay for your portion of covered medical expenses (coinsurance) and other eligible medical expenses not covered by your medical insurance. Deductible below includes account funding.		
	VHAN	**Aetna**	**Out-of-network**	**VHAN**	**Aetna**	**Out-of-network**	**VHAN**	**Aetna**	**Out-of-network**
Employee	$1,000	$1,250	$1,500	$600	$850	$1,100	$1,500	$2,000	$2,500
Employee +1	$1,000 per person	$1,250 per person	$1,500 per person	$600 per person	$850 per person	$1,100 per person	$3,000*	$4,000*	$5,000*
Family	$1,000 per person not to exceed $3,000	$1,250 per person not to exceed $3,750	$1,500 per person not to exceed $4,500	$600 per person not to exceed $1,800	$850 per person not to exceed $2,550	$1,100 per person not to exceed $3,300	$3,000*	$4,000*	$5,000*
							* HSA Deductible Note: No individual deductible for employee plus one or more		
Out of Pocket Maximums	Once you reach the out-of-pocket amount below (including your deductible), the plan will pay 100% of the remaining eligible expenses for in-network care and services for the rest of the year. There is no out-of-pocket maximum if you go out-of-network.								
	VHAN	**Aetna**	**Out-of-network**	**VHAN**	**Aetna**	**Out-of-network**	**VHAN**	**Aetna**	**Out-of-network**
Employee	$3,000	$4,600	No Max	$3,000	$4,600	No Max	$5,000	$6,350	No Max
Employee +1	$3,000 per person	$4,600 per person	No Max	$3,000 per person	$4,600 per person	No Max	$5,000 per person	$6350 per person	No Max
Family	$3,000 per person or $9,000 per family*	$4,600 per person or $9,200 per family*	No Max	$3,000 per person or $9,000 per family	$4,600 per person or $9,200 per family*	No Max	$5,000 per person or $10,000 per family*	$6,350 per person or $12,700 per family*	No Max

*Family out of pocket maximum will not exceed $9000 (VHAN) and $9,200 (Aetna National Network)

**Flexible Spending Accounts (FSA) can be used for Options 1 and 2.

What You Pay for Care/Services

This is only a summary of your medical benefits. Please refer to the plan document for complete details. A copy of the plan document is located on the WTH Intranet.

	Option 1 Deductible w/ HRA			Option 2 PPO Co-pay			Option 3 High Deductible w/ HSA		
	Tier 1	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**
Preventive Care	$0	$0	80% after deductible	$ 0	$0	80% after deductible	$0	$0	80% after deductible
Routine Office Visits	15% after deductible	30% after deductible	80% after deductible	$20 Copay	$20 Copay	80% after deductible	15% after deductible	30% after deductible	80% after deductible
Specialist Care	15% after deductible	30% after deductible	80% after deductible	$40 Copay	$40 Copay	80% after deductible	15% after deductible	30% after deductible	80% after deductible
Emergency Care	15% after deductible	30% after deductible	80% after deductible	15% after $100 copay Copay waived if admitted	30% after $100 copay Copay waived if admitted	30% after $100 copay Copay waived if admitted	15% after deductible	30% after deductible	80% after deductible
X-Rays & Laboratory Tests	15% after deductible	30% after deductible	80% after deductible	15% after deductible	30% after deductible	80% after deductible	15% after deductible	30% after deductible	80% after deductible
Inpatient & Outpatient Hospitalization	15% after deductible	30% after deductible	80% after deductible	15% after deductible	30% after deductible	80% after deductible	15% after deductible	30% after deductible	80% after deductible
Inpatient & Outpatient Mental Health Care Facility	15% after deductible	30% after deductible	80% after deductible	IP - 15% after deductible **OP - 100% after $40 copay**	IP - 30% after deductible **OP - 100% after $40 copay**	80% after deductible	15% after deductible	30% after deductible	80% after deductible

More Information on Health Accounts

If you enroll in the Option 1 Deductible w/HRA or the Option 3 High Deductible w/HSA, you'll get money from WTH to help pay your medical expenses. If you enroll in Option 1 Deductible Plan you automatically have a Health Reimbursement Account (HRA) funded by WTH to help offset your deductible. If you enroll in Option 3 High Deductible Plan, WTH will put money in a Health Saving Account (HSA) for you. In addition, you can contribute your own tax-free money to the HSA subject to IRS maximum limitations (updated annually).

Here's How These Accounts Work

	Health Reimbursement Account (HRA)	Health Savings Account (HSA)
Who administers this account?	Aetna	PayFlex/Aetna
Who contributes?	WTH	WTH and You (optional). Total annual contributions from you and WTH may not exceed $3450/individual or $6900/family for the year.
What can I use the money for?	Eligible medical such as office visits. The HRA cannot be used for dental or vision expenses.	Eligible health care expenses including your deductible, dental and vision expenses, in- and out-of-network office visits, prescription drugs, etc. (Only medical expenses count toward your deductible.) Ineligible expenses are subject to a tax penalty. For a list of eligible expenses, go to www.irs.gov.
Who owns the money in the account?	You as long as eligible at WTH.	You do. You can take it with you if your leave WTH.
Is there an account fee?	No	No, as long as you are employed by WTH.
How do I access my account?	Your HRA is part of your medical plan and funds from your account will be used to offset your out-of-pocket expenses.	You will receive a debit card to access your HSA funds. You can also pay for eligible expenses with any other form of payment and request a withdrawal/reimbursement from your account.
Does the money earn interest?	No	Yes
Can I take the unused balance with me if I leave WTH?	No	Yes. It's always your money - including any earnings from interest or any investment gains or losses.
Can I roll over unused dollars from year to year?	Yes	Yes, even after you leave WTH.
Can I contribute to a Health Care Flexible Account (FSA)?	Yes	Yes, a Limited Purpose Health Care FSA is available to reimburse dental and vision expenses. After your HSA deductible is met, you can use your FSA to pay for eligible medical expenses too.
Do I have access to the cash in my account?	No	Yes (non-medial distributions are taxable and subject to 20% penalty prior to age 65; no penalty for 65+ distributions).
Must I report my account on my federal income tax form?	No, your HRA is part of the plan.	Yes, the IRS requires that you include Form 8889 with your federal income tax return each year that your have an HSA, to report contributions and withdrawals, but no tax applies if your withdrawals are for eligible health care expenses.
Is there a catch-up contribution?	No	Yes, you can make an HSA catch-up contribution up to $1000 if you are age 55+ in 2018.

Prescription Drug Plan for 2018

WTH has a 3-Tier, Closed Formulary plan.

What you pay falls into one of these tiers or levels:

Tier 1: Generic	You pay the **lowest cost** for drugs in this level.
Tier 2: Preferred Brand	You pay a **slightly higher cost** for drugs in this level.
Tier 3: Non Preferred Brand	You pay the **highest cost** for drugs in this level.

Closed formulary means the plan covers only prescription drugs in the formulary.

With your health plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percent of the prescription price.

Medical Plan Option 1: Deductible with HRA Plan and
Medical Plan Option 2: PPO Co-pay Plan

In House 30 day supply	**Tier 1**	Generic	$10 Co-pay
	Tier 2	Preferred Brand	25% x cost of drug with Min $30 and Max $50 Co-pay
	Tier 3	Non-preferred Brand	25% x cost of drug with Min $55 and Max $75 Co-pay
In House 90 day supply maintenance medications, you pay two times monthly co-pay and receive 90 day supply.	**Tier 1**	Generic	$20 Co-pay
	Tier 2	Preferred Brand	25% x cost of drug with Min $60 and Max $100 Co-pay
	Tier 3	Non-preferred Brand	25% x cost of drug with Min $110 and Max $150 Co-pay

Example

Tier 3: Non-preferred Brand 30 day in house	25% x cost of drug with minimum $55 and maximum $75 co-pay		
Example: If drug cost is →	$55 – $220	$220.01 – $299.99	$300 or more
Then variable co-pay is →	$55	25% x Cost	$75
Specialty	Depends on Tier Status		

Medical Plan Option 3: High Deductible with HSA

After deductible is met co-pays above will apply

Medical Plan Option 1: Deductible with HRA Plan and Medical Plan Option 2: PPO Co-pay Plan			
Non-WTH Retail Pharmacy Variable co-pay 30 day supply	**Tier 1**	Generic	$15 Co-pay
	Tier 2	Preferred Brand	35% x cost of drug with Min $55 and Max $75 Co-pay
	Tier 3	Non-preferred Brand	35% x cost of drug with Min $80 and Max $100 Co-pay
Specialty	Depends on Tier Status		
Medical Plan Option 3: High Deductible with HSA			
After deductible is met co-pays above will apply			
Employee Out of Pocket Maximum for Pharmacy Benefits Only **Medical Plan Option 1: Deductible with HRA Plan and Medical Plan Option 3: PPO Co-pay Plan**			
The Affordable Care Act set maximum limits on how much consumers can be required to pay out of pocket annually for their medical care and prescription drugs. This will be very beneficial to those with chronic illness and high cost prescriptions. The out of pocket maximum is for pharmacy only, and will be in addition to separate out of pocket maximum specific to medical care. This affects Option 1 HRA Plan and Option 2 PPO Plan only. Single – $2,000 Family – $4,000			
Step Therapy – Applies to All Plans			
WTH participates in a step therapy program for prescriptions used for the treatment of high cholesterol, digestive disorders and anxiety/depression. This drug coverage review promotes the appropriate use of equally effective but lower cost drugs first. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs.			

Flexible Spending Accounts (FSA)

A flexible spending account (FSA) allows you to set aside pretax money to pay for eligible out of pocket expenses. This helps to reduce your taxes and increase your take home pay. WTH has two types of FSAs, health care and dependent care. Because of pretax dollars, these accounts are regulated by the IRS. ***Please see the Aetna Flexible Spending Account flyer found on the WTH Intranet on the Human Resources page.***

Health Care FSA reimburses you for eligible health care expenses not otherwise paid by your plan (deductibles, copays, and coinsurance). These include medical, dental, vision, hearing and prescription drug expenses. Over-the-counter (OTC) items with a written prescription may also be reimbursed. The current annual health care FSA pretax contribution limit is $2,550 or $98.07 per pay period. The minimum contribution is $130 annually or $5 per pay period. If you and your spouse each have a health care FSA, you can each contribute $2,550.

To use your Health Care FSA funds, you may use the PayFlex Card, your account debit card, to pay for your eligible expenses. When you use the card, the funds automatically come out of your FSA. Note: Save all of your receipts and Explanation of Benefits (E0B) from your insurance plan. These may be needed to verify the use of your funds. If you pay for eligible expenses with cash, check or personal credit card, you can submit an online request for reimbursement or you can fill out a paper claim form and fax or mail to PayFlex.

For Health Care FSA, the U.S. Department of the Treasury modified the use-it-or-lose-it rule to permit your plan to allow carryover of unused funds up to $500 into the next year. The carryover amount does not count towards your annual maximum for the next year. Any unused funds greater than the carryover limit will be forfeited to the plan, after the last day of the plan year.

Dependent Care FSA reimburses you for eligible child and adult care expenses. Such expenses include day care, before and after school care, nursery school, preschool and summer day camp. The current annual dependent care FSA pretax contribution limit is $5,000 per household/family or $192.30 per pay period. If you and your spouse each have a dependent care FSA, you are limited to $5,000 between the two of you.

To use your Dependent Care FSA funds, claims can be made either online or by printing out a claim form, filling it out and either faxing or mailing in to PayFlex.

The Dependent Care FSA has the use-it-or-lose-it rule. WTH has the grace period for the account and you will have an additional 75 days to spend your dependent care FSA dollars.

Note: Per IRS rules, employees enrolled in Option 3 High Deductible Medical Plan with a Health Savings Account (HSA) cannot be enrolled in the standard Health Care FSA. HSA participants may enroll in the Limited Purpose FSA that can be used for dental and vision charges only.

DELTA DENTAL®

Effective with your benefits for 2018, you will have choices in selecting your dental plan. Delta Dental of Tennessee will administer WTH dental plans, including claims processing for expenses incurred on or after January 1, 2018. WTH is offering two options, Option 1 - Low Option and Option 2 - High Option. Please review and carefully choose the best plan for you and your family.

	OPTION 1 – LOW OPTION		OPTION 2 – HIGH OPTION	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible				
Individual/Family	$50/$150 Waived for Preventive		$50/$150 Waived for Preventive	
Maximum				
Annual	$1,000		$2,000	
Life Time Orthodontia	Not Covered		$1,500	
Preventative				
Cleanings, X-Rays	100%	50%	100%	100% after deductible
Basic Restorative				
Endodontics, periodontics, oral surgery, fillings, simple extractions, sealants	80%	50%	90%	70%
Major Restorative				
Prosthetics	50%	50%	60%	50%
Orthodontia				
Adult and children	Not Covered		50%	50%
Frequency and Limitations				
Routine cleanings	2 per 12 month period		2 per 12 month period	
Bite wing xrays	2 per 12 month period <age 19 1 per 12 months >age 19		2 per 12 month period <age 19 1 per 12 months > age 19	
Sealants	1st and 2nd molars < age 19 1 per 60 months		1st and 2nd molars < age 19 1 per 60 months	
Full mouth xray	1 per 60 months		1 per 60 months	
Periodontal Maintenance	2 per 24 months combined with cleaning		2 per 24 months combined with cleaning	
Prosthetic	Replace 1 per 84 months		Replace 1 per 84 months	
Alternate benefit on restoration	Composite filling filled throughout		Composite filling filled throughout	
Missing Tooth coverage	No		Yes	
Fillings	Vendor Standard		Vendor Standard	
Implant Coverage	No		Yes	

Customer Service Representatives are available Monday – Friday, 7:00 a.m. to 5:00 p.m. 1-800-223-3104

Secure online Consumer Toolkit at **DeltaDentalTN.com/ConsumerToolkit** allows you to:

- Check benefit eligibility
- Find current benefit information
- Print an ID card
- Review claims And More…

Find a Dentist – Go to **DeltaDentalTN.com/FindaDentist**

Your Delta Dental benefits at your fingertips. Download the Delta Dental Mobile App for Apple iOS or Android at http://uqr.to/mobileapp to:

- Find a dentist
- Check benefits and claims
- Access mobile ID card
- Access Toothbrush Timer

eyeMed℠

Effective with your benefits for 2018, you will have choices in selecting your vision plan. Eye Med Vision Care will be your new vision insurance for claims incurred on or after January 1, 2018. WTH is offering two options, Option 1 - Low Option and Option 2 - High Option. Please review and carefully choose the best plan for you and your family.

	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
		Reimbursement to member up to:		Reimbursement to member up to:
	OPTION 1 - LOW OPTION		OPTION 2 - HIGH OPTION	
Exam With Dilation as Necessary	$5 Copay	$40	$0 Copay	$40
Frequency	Once every 12 months		Once every 12 months	
Frames Any available frame at provider location	$0 Copay $130 Allowance 20% off balance over $130	$91	$0 Copay $150 Allowance 20% off balance over $150	$105
Frequency	Once every 24 months		Once every 12 months	
Standard Plastic Lenses Single Vision	$25 Copay	$30	$0 Copay	$30
Bifocal	$25 Copay	$50	$0 Copay	$50
Trifocal	$25 Copay	$70	$0 Copay	$70
Lenticular	$25 Copay	$70	$0 Copay	$70
Standard Progressive	$25 Copay	$76	$0 Copay	$96
Premium Progressive Tier 1	$45 Copay	$76	$20 Copay	$96
Premium Progressive Tier 2	$55 Copay	$76	$30 Copay	$96
Premium Progressive Tier 3	$70 Copay	$76	$45 Copay	$96
Premium Progressive Tier 4	$25 Copay 20% off retail less $120 Allowance	$76	$0 Copay 20% off retail less $120 Allowance	$96
Frequency	Once every 24 months		Once every 12 months	
Covered Lens Options Std Polycarbonate < age 19	$0 Copay	$5	$0 Copay	$5
Contact Lenses (in lieu of lenses) Conventional	$130 Allowance 15% off balance over $130	$104	$150 Allowance 15% off balance over $150	$120
Disposable	$130 Allowance	$104	$150 Allowance	$120
Medically Necessary	$0 Copay, Paid-in-full	$210	$0 Copay, Paid-in-full	$210
Frequency	Once every 24 months		Once every 12 months	

Customer Service Representatives – Available Monday through Saturday, 6:30 am to 10:00 pm CST, Sunday, 10:00 am to 7:00 pm CST

Your vision benefits, 24/7 – Secure online access at **eyemed.com**

Find a provider – eyemed.com

Download the **EyeMed Members App** on your iPhone, iPad, or Antroid to view your benefit details and ID card right at your fingertips.

Contact Lenses can be ordered through contactsdirect.com and you will receive an additional $20 discount on top of your lens allowance.

Watch your **EyeMed Member Portal** for "special offers" and coupons on contacts.

Medical, Dental and Vision Premiums 2019

Employee insurance premiums are deducted on a pre-taxed basis each pay period.

Bi-weekly Rates for Full Time Employees

Medical Plan	Individual	Employee + 1	Family
Option 1 Deductible Plan w/HRA (making less than $12/hour)	$56.00	$113.00	$158.00
Option 1 Deductible Plan w/HRA (making $12 and more/hour)	$67.00	$140.00	$197.00
Option 2 Co-pay Plan	$95.00	$204.00	$287.00
Option 3 High Deductible w/HSA	$55.00	$107.00	$149.00
Dental Plans	**Individual**	**Employee + 1**	**Family**
Low Option	$3.94	$8.29	$13.66
High Option	$7.74	$15.90	$26.21
Vision Plans	**Individual**	**Employee + 1**	**Family**
Low Option	$2.10	$3.98	$5.85
High Option	$4.72	$8.96	$13.16

Bi-weekly Rates for Part Time Employees

Medical Plan	Individual	Employee + 1	Family
Option 1 Deductible Plan w/HRA (making less than $12/hour)	$112.00	$226.00	$316.00
Option 1 Deductible w/HRA (making $12 and more/hour)	$134.00	$280.00	$394.00
Option 2 Co-pay Plan	$190.00	$408.00	$574.00
Option 3 High Deductible w/HSA	$110.00	$214.00	$298.00
Dental Plans	**Individual**	**Employee + 1**	**Family**
Low Option	$7.88	$16.58	$27.32
High Option	$14.00	$27.99	$46.18
Vision Plans	**Individual**	**Employee + 1**	**Family**
Low Option	$2.10	$3.98	$5.85
High Option	$4.72	$8.96	$13.16

Dependent Life Insurance

Dependent life insurance is available through Aetna to eligible dependents. Annual Enrollment is the only time you may apply for this coverage after your initial eligibility period. Employee must be enrolled in supplemental life to enroll dependents.

Options Available

Option	Spouse*	Children	Per Pay Period
1	$7,500	$2,500/child	$1.92
2	$15,000	$5,000/child	$4.41
3	$20,000	$7,500/child	$6.18
4	$50,000	$10,000/child	$13.00

***Employees with Spouse Coverage may increase coverage by one level without any evidence of insurability. First time enrollers or those requesting more than one level increase will be required to complete evidence of insurability (EOI). EOI is not required for children. EOI will be mailed to your home address.**

Life and Accidental Death and Dismemberment Insurance

Available for employees in a full time, 7 on 7 off, weekenders or RN55 status.

WTH provides, at no cost to you, basic life and accidental death and dismemberment insurance coverage equal to one times your annual base salary, rounded up to the nearest thousand.

Evidence of Insurability

The evidence of insurability consists of a detailed medical questionnaire, though a medical exam may also be required.

Supplemental Life Insurance

You may purchase supplemental life insurance for an additional 1 or 2 times your annual base salary, up to a maximum benefit of $1,500,000 when combined with your basic coverage amount.

Employees currently enrolled in supplemental life (1 times annual salary) can increase coverage to 2 times annual salary up to guaranteed issue amount of $300,000 without evidence of insurability (EOI). Amounts over $300,000 require EOI. Employees not currently enrolled in supplemental life can enroll but will be required to complete EOI and coverage will be determined by Aetna Medical Underwriting.

Base Annual Salary

For calculating per pay period rate for life insurance, base annual salary is your base hourly rate before any differentials are paid, multiplied by 2,080 hours.

Cost of Supplemental Life Insurance

Your monthly cost will be $.16 per $1,000 of coverage

- Multiply Base Annual Salary by 1 or 2 depending on amount of coverage requested
- Round above figure to next highest $1,000
- Divide by 1,000
- Multiply your answer by $.16
- Multiply by 12 and divide by 26 to get the estimated amount you will pay per pay period

Supplemental Accidental Death and Dismemberment (AD&D)

You may purchase an additional 1 or 2 times your annual salary in accidental death and dismemberment coverage. The cost is $.018 per $1000 per month.

Short Term Disability Insurance (STD)

For eligible employees (full-time status) you may apply for STD coverage during annual enrollment. Coverage is determined by Aetna after you complete the evidence of insurability.

To calculate an estimated cost of your STD coverage, complete the following steps:

- Multiply your base rate (hourly base rate before any differentials are added) by 40
- Multiply your answer by 60% to determine weekly benefit. Round answer to nearest dollar, not to exceed $1,000
- Multiply your weekly benefit by $.83
- Divide by 10, multiply by 12 and divide by 26 to determine pay period deduction

Long Term Disability Insurance (LTD)

Full-time employees that have at least 5 years of employment are automatically covered under the WTH paid LTD policy. Employer paid LTD pays 50% of an employee's monthly covered earnings up to a maximum of $12,000 per month. Full-time employees with less than 5 years of service have the option to purchase a voluntary LTD policy. Voluntary coverage pays 50% of employee's monthly covered earnings up to a maximum of $5,000 per month.

Aetna Resources For Living℠

Employee Assistance Program (EAP)
To access services:
1-866-326-7196
www.resourcesforliving.com
Username: wth
Password: eap

West Tennessee Healthcare

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional well-being support

You can call us 24 hours a day for in-the-moment emotional well-being support. You can also access up to 6 counseling sessions per issue each year.

Visit with a counselor face to face, online with televideo or get in-the-moment support by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Relationship support
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem and personal development

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Summer programs for kids
- School and financial aid research
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Home repair and improvement
- Household services and more

74.03.962.1-ARFL C (8/17)

aetna®

Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

You'll also find access to these helpful tools:

Discount Center
Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel and more.

Fitness discounts
Save on gym memberships at over 9,000 locations nationwide and home fitness equipment. Participating gyms and programs include 24 Hour Fitness, LA Fitness, Anytime Fitness®, Zumba® Fitness, Nutrisystem® and more.

myStrength
myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation

You can also get a 25 percent discount on tax preparation services.

*Services must be for financial matters related to the employee and eligible household members.

Other services

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

West Tennessee HEALTHCARE

Healthy HEIGHTS

Employee Well-Being Program

We Pay You to Be Well!

Healthy Heights is here to take care of you so that you can take care of others! The only requirement needed is Labs (collected at your AHU @ EHS).

Benefits

- FREE Gym Membership
- Education
- Food Discounts
- FREE EAP Counseling
- FREE Prenatal Classes
- 24/7 Healthline
- $150 for Meeting Health Goal

To see all the benefits of the Healthy Heights Program visit **www.wth.org/misc/employees/healthy-heights**

Johnna Cunha—Employee Wellness Coordinator
healthyheights@wth.org • 731.265.1119

2019 Living Well
Diabetes

West Tennesee Healthcare –
Employees, Spouses, Adult Dependents

Due to IRS regulations, HSA Medical Plan participants are not eligible to participate in the LivingWell Diabetes Program because the program offers disease treatment in addition to preventing future complications related to diabetes.

Program Benefits

- All Diabetes medications designated by the program as "standard of care" free of customary co-payment for enrolled diseases
- Appropriate lab tests provided through Medical Center Lab free of charge – A1C, Urine Microalbumin and Cholesterol Panel
- Appointments with educators/coaches for counseling, information and training free of charge
- Glucose meter / strips (diabetes) free of charge
- Insulin pumps and related supplies are not covered (Insulin for pumps may be covered)

Provider Role

- Provides routine primary care for participant
- Provides treatment plan which includes:
  - Guidelines for the participant related to blood glucose monitoring, exercise and food intake
  - Frequency of follow-up visits
  - Communication of changes as indicated for the various areas of treatment
- Orders labs through Medical Center Lab
- Monitor nationally recognized diabetes measures (e.g., HEDIS), to be determined each program year.

Participant Role

- Become qualified in diabetes self-management by completing one "Mini-Camp" enrollment session (2-hour class), then participating in Disease Management program at LIFT (frequency and duration of in-person and telephonic contacts specified by assigned coach)
- Follow the prescribed regimen as given by the Provider and Coach for medications, exercise, food intake, monitoring and coaching calls
- Fill all prescriptions for approved diabetic medications through the approved West Tennessee Healthcare Pharmacy and have all related labs drawn at Medical Center Lab
- Keep appointments with the Provider and Coach as scheduled. If unable to keep appointments, reschedule as soon as possible
- Follow the guidelines as presented in the Disease Management Program Agreement
- Failure of a participant to comply with all components of the program will result in disenrollment from the program
- Participant must have a primary care provider
- WTH Employees: Appointments may not be scheduled as paid time.
- Monitor nationally recognized diabetes measures (e.g., HEDIS), to be determined each program year.

Coach Role

- Coaches will assess each employee individually to identify frequency and method of coaching (face to face visit vs. telephonic). Minimum coaching calls/visits will occur quarterly.
- Serve as a "conduit for care" between the participant, provider and secondary coaches (educator, dietitian, pharmacist, physical therapist)
- Assess and address the physical and educational needs of the participant
- Assess the food intake, exercise, and monitoring records of the participant and discuss indications of the assessment
- Monitor compliance of the participant to the Disease Management Program Agreement
- Monitor nationally recognized diabetes measures (e.g., HEDIS), to be determined each program year.

The Diabetes Disease Management Program 2019 (DDMP) provides West Tennessee Healthcare Medical Plan participants (employees, spouses, dependents 18 years & older) with the opportunity to receive certain healthcare benefits related to diabetes. Whereas, program enrollment may occur throughout the 2019 calendar year, the program may cease at any time.

Eligibility status may be affected by non-compliance to the prescribed regimen. Termination of Medical Plan coverage also results in cessation of program benefits.

Enrollment

- Enrollment sessions ("Mini-Camp") for diagnosed diabetic patients will be held at various times at the LIFT Wellness Center from January through March 2019. Failure to enroll by March 31 deems participants ineligible during the 2019 calendar year. Returning members must attend one mini-camp per calendar year.
- If you have never been diagnosed with diabetes, but you have symptoms or recent lab results that indicate you may have diabetes, we recommend you follow up with your PCP as soon as possible.
- Newly hired employees of WTH who are participants in the West Tennessee Healthcare Medical Plan, and their spouses and dependents 18 years and older, may enroll in the Disease Management Program after they become eligible participants in the medical plan.
- Newly diagnosed employees, spouses, and dependents may enroll in the Disease Management Program throughout the year with documentation/date of diagnosis.

Participant Training

Registration and participation in Mini-Camp is required. **Returning Members must attend one mini-camp per calendar year.** You may access the sign-up sheet for Mini-Camps in public folders under Disease Management Living Well Diabetes or call (731)-425-6956.

LIFT WELLNESS CENTER
Disease Management

Kick the Habit

TOBACCO CESSATION PROGRAM

Kick the Habit is a 4-week course that provides motivation, education, and support to help you reach the goal of tobacco cessation.

- Each week features different aspects of Tobacco Cessation
- A Registered Nurse leads the program and also includes Dietitian, Exercise Specialist, and a Pharmacist
- Support group setting

Time: **5:30-6:30 pm**

Call **731-425-6956** to register

Classes offered quarterly during the months of **February, May, August** and **November**

Cost: $50
(WTH employees and spouses are free)

Receive a $50 LIFT gift card upon completion

For more information call Disease Management at **731-425-6956**

West Tennessee HEALTHCARE

Lift Disease Management
WELLNESS CENTER

Other Voluntary Benefits

Representatives will be on site during the annual enrollment to discuss and/or enroll you in any of these Voluntary Benefits. All deductions except Air Evac are payroll deducted.

ALLSTATE

Cancer Insurance
Accident Insurance
Critical Illness Insurance
Contact: Harry Graves, 731-668-0032

COMBINED

Combined Insurance—Lifetime Term Life Benefit with Insurance Funding for Long Term Care
Contact: Harry Graves, 731-668-0032

HOMESTEADERS

Final Expense Plus (Prearranged Funeral)
Contact: Dick Arrington, 731-668-9734

LEADERS CREDIT UNION

Available to open an account or make changes to an existing account. Note: If you wish to open an account with Leaders, there will be a onetime $10 membership fee. You will be required to show two (2) forms of government ID (driver's license, SS card, voting registration).
Contact: 731-664-1784 Ext. 253
E-mail: Loyalty@Leaderscu.com

AIR EVAC

Available to enroll in air ambulance membership
Payments for Air Evac can now be payroll deducted with a one-time deduction.
Contact: Dustin White: dustin.white@amgh.us

ID SHIELD LEGAL SHIELD

Identity monitoring and protection and/or Legal assistance.
Contact: James Rambo 901-553-0132
Enroll Online: legalshield.com/info/westtnhealth

HEALTHCARE ADVOCATE

24/7 Help for members to navigate healthcare and insurance-related issues.
Contact: 1-866-695-8622
or visit online at: HealthAdvocate.com/members

FINAL EXPENSE PLUS – CORPORATE FUNERAL PROVIDERS

This plan allows the opportunity to prepay for funeral and final expenses. Optional payment plans of 3, 5, 7 or 10 years are available. Regular full time and part time employees are eligible for enrollment upon employment.

SEE MORE DETAILED INFO IN THE VENDOR APPENDIX ON THE FOLLOWING PAGES

Vendor Appendix

Meeting your match

Your employer offers matching contributions if you participate in your employer's defined contribution retirement plan. That means your employer will match a certain level or percentage of your own contribution, so you can sock away some extra retirement savings without missing a step. Quite the pair you could be!






Plan eligibility and employer match eligibility

All employees are eligible to make pre-tax 403(b) and 457(b) and/or Roth 403(b) and 457(b) contributions at date of hire. Full-time employees and part-time employees (hired prior to October 1, 2005) are eligible to receive the 403(b) match following 90 days of service.

403(b) vesting: when the match is officially yours to keep

If your date of hire is before February 1, 2009, you will be 100% vested in all matching contributions.

If your date of hire is on or after February 1, 2009, you will be subject to a 3-year vesting cliff, by which your matching contributions will be 100% vested on or following 3 years of service from your date of hire. Participants are fully vested upon death or age 65.

403(b) withdrawals: when you may take money out

· Separation from service
· Hardship
· Age 59½
· Death (beneficiary)
· Loans

403(b) rollovers into the Plan:

· 401(k)
· 403(b)
· 457(b)
· 401(a)
· Pension plan lump sums
· Traditional IRA

The formula: how your 403(b) contributions will be matched

If you are eligible, West Tennessee Healthcare will match 50% of what you defer up to a maximum of 6% of your base salary. The total effective match is 3% of your base salary.

Example: Julie works full-time [based on 80 hours] at West Tennessee Healthcare for an hourly base rate of $12.50. In the chart below, you will see what Julie could contribute per pay period to the 403(b) plan and what her match would be per pay period.

Julie %	Julie $	WTH %	WTH $
1.00%	$10.00	0.50%	$5.00
2.00%	$20.00	1.00%	$10.00
3.00%	$30.00	1.50%	$15.00
4.00%	$40.00	2.00%	$20.00
5.00%	$50.00	2.50%	$25.00
6.00%	$60.00	3.00%	$30.00

For current IRS limits on retirement savings account contributions, go to www.voya.com/IRSlimits.

Additional information:

If you have completed a hardship distribution from your 403(b) account 6 months prior to starting contributions, you will be ineligible to contribute to the plan or receive the match until the 6-month suspension has passed.

Non-vested 403(b) matching contributions are not available for loans. Employer matching contributions are not available for hardship distributions. Distributions from the Roth 403(b) money source are allowed for separation from service only. Distributions from the 457(b) Plan are allowed for separation from service only.

Effective July 1, 2011, and applicable only to a participant who has reached IRC Section 402(g) limit prior to receiving the full matching contribution, West Tennessee Healthcare may contribute to the plan an additional discretionary matching contribution equal to the difference between such full matching contribution and the matching contribution actually received.

If you are already contributing 6% or a dollar amount equal to 6% or more and if you have met the eligibility requirements above, you are already set to receive the full West Tennessee Healthcare match following 90 days of service.

You may enroll in the 403(b) Plan and/or 457(b) Plan and/or increase or decrease your contributions to the Plans at any time throughout the year by completing a salary reduction agreement or payroll authorization/change form, as applicable.

Enrollment and investment materials may be obtained by contacting the vendor listed above. 403(b) and 457(b) annual contribution limits are not correlated.

This notice is not intended as tax or legal advice. Neither your employer nor the investment provider under the Plan can provide you with tax or legal advice.

Questions?

Judy Hime,
Benefits/Compensation Manager
731-265-1125
judy.hime@wth.org

OR

Voya Financial Advisors, Inc.
731-668-9818

Steve R. Little*
slittle@voyafa.com

Brad W. Little**
blittle@voyafa.com

Bryan A. Bush**
bbush@voyafa.com

Justin B. Howell**
jhowell@voyafa.com

Kyle L. Williams**
kyle.williams@voyafa.com

* Registered Representatives of and securities offered through Voya Financial Advisors, Inc. (member SIPC)

** Investment Advisor Representative and Registered Representative of, and securities and investment advisory services offered through Voya Financial Advisors, Inc. (member SIPC)

You should consider the investment objectives, risks, and charges and expenses of the variable product and its underlying fund options offered through a retirement plan, carefully before investing. The prospectuses/prospectus summaries contain this and other information, which can be obtained by contacting your local representatives. Please read the information carefully before investing.

Variable annuities are intended as long-term investments designed for retirement purposes. Early withdrawals from a 403(b) plan will be subject to an IRC 10% premature distribution penalty tax, if taken prior to age 5912, unless an exception applies. The 10% IRC premature distribution penalty tax on early withdrawals doesn't apply to amounts contributed to 457(b) plans or amounts rolled into those plans from other 457 plans. Money taken from the annuity will be taxed as ordinary income in the year the money is distributed. Account values fluctuate with market conditions, and when surrendered the principal may be worth more or less than its original amount invested. An annuity does not provide any additional tax deferral benefit, as tax deferral is provided by the plan. Annuities may be subject to additional fees and expenses to which other tax-qualified funding vehicles may not be subject. However, an annuity does provide other features and benefits, such as lifetime income payments and death benefits.

For 403(b)(1) fixed or variable annuities, employee deferrals (including earnings) may generally be distributed only upon your: attainment of age 59½, severance from employment, death, disability, or hardship. Note: Hardship withdrawals are limited to employee deferrals made after 12/31/88. Exceptions to the distribution rules: No Internal Revenue Code withdrawal restrictions apply to '88 cash value (employee deferrals (including earnings) as of 12/31/88) and employer contributions (including earnings). However, employer contributions made to an annuity contract issued after December 31, 2008 may not be paid or made available before a distributable event occurs. Such amounts may be distributed to a participant or if applicable, the beneficiary: upon the participant's severance from employment or upon the occurrence of an event, such as after a fixed number of years, the attainment of a stated age, or disability.

Insurance products, annuities and retirement plan funding issued by (third party administrative services may also be provided by) Voya Retirement Insurance and Annuity Company, One Orange Way, Windsor, CT 06095-4774. **Securities are distributed by Voya Financial Partners LLC (member SIPC).** All companies are members of the Voya® family of companies. **Securities may also be distributed through other broker-dealers with which Voya has selling agreements.** Insurance obligations are the responsibility of each individual company. Products and services may not be available in all states.

HealthAdvocate™

Always at your side

FREE Service for ALL Employees

Find the right doctors

We'll also locate the right hospitals, dentists and other leading healthcare providers anywhere in the country.

Schedule appointments

We can help expedite the earliest appointments with providers including hard-to-reach specialists and arrange treatments and tests.

Get cost estimates

You'll receive estimates or common medical procedures in your area to help make informed decisions.

Help resolve insurance claims

Our experts get to the bottom of your issue to assist with negotiating billing and payment arrangements.

Your Lifeline

for Healthcare and Insurance Help

HealthAdvocate.com

866.799.2728

Help is only a phone call away.

We invite you and your families to take advantage of this free benefit and get the help you need when it comes to your healthcare.

Cancer Insurance

from Allstate Benefits

Benefits are paid to you

Protection for the treatment of cancer and 29 specified diseases

1 CHOOSE
You choose benefits to help protect yourself and family members, if diagnosed with cancer or specified disease

2 USE
You or a covered family member are diagnosed with cancer or a specified disease and seek medical treatment

3 CLAIM
You go online and file a claim. The cash benefits are paid to you, to use however you wish

Receiving a cancer diagnosis can be one of life's most frightening events. Unfortunately, statistics show you probably know someone who has been in this situation.

With Cancer insurance from Allstate Benefits, you can rest a little easier. Our coverage pays you a cash benefit to help with the costs associated with treatments, to pay for daily living expenses – and more importantly – to empower you to seek the care you need.

Factors that influence cancer survival[1]

The number of cancer survivors in the United States is increasing, and is expected to jump to nearly 19 million by 2024[2]

Here's How It Works

You choose the coverage that's right for you and your family. Our Cancer insurance pays cash benefits for cancer and 29 specified diseases to help with the cost of treatments and expenses as they happen. Benefits are paid directly to you unless otherwise assigned. With the cash benefits you can receive from this coverage, you may not need to use the funds from your Health Savings Account (HSA) for cancer or specified disease treatments and expenses.

With Allstate Benefits, you can protect your finances if faced with an unexpected cancer or specified disease diagnosis.

Are you in Good Hands? You can be.

[1]www.cancer.org/research/infographicgallery/survivorship-life-after-cancer?_ga=1.252987849.1528396581.1424877086
[2]Cancer Treatment & Survivorship Facts & Figures, 2014-2015

Key Features

- Benefits are paid directly to you unless otherwise assigned
- Coverage available for you or your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts (Employee only)
- Coverage may be continued
- Additional benefits may be added to your coverage, if your employer has chosen to make them available to you

See reverse for plan details

Offered to the employees of:

West Tennessee Healthcare

Allstate BENEFITS

YOU DECIDE how to use the cash benefits

Our cash benefits provide you with greater coverage options by allowing you to determine how to use them.

Finances
Can help protect your HSAs, savings, retirement plans and 401ks from being depleted

Travel
You can use your cash benefits to help pay for expenses while receiving treatment in another city

Home
You can use your cash benefits to help pay the mortgage, continue rental payments, or perform needed home repairs for your after care

Expenses
The lump-sum cash benefit can be used to help pay your family's living expenses such as bills, electricity and gas

Allstate BENEFITS

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. ©2016 Allstate Insurance Company. www.allstate.com or allstatebenefits.com

Benefits

Hospital Confinement and Related Benefits		
Continuous Hospital Confinement	Extended Care Facility	
Government or Charity Hospital	At Home Nursing	
Private Duty Nursing Services	Hospice Care	
Radiation/Chemotherapy and Related Benefits		
Radiation/Chemotherapy for Cancer	Blood, Plasma, and Platelets	
Medical Imaging	Hematological Drugs	
Surgery and Related Benefits		
Surgery	Second Opinion	Anesthesia
Ambulatory Surgical Center	Bone Marrow or Stem Cell Transplant	
Miscellaneous Benefits		
Inpatient Drugs and Medicine	Family Member Lodging and Transportation	
Ambulance	Prosthesis	Non-Local Transportation
Outpatient Lodging	Hair Prosthesis	Physician's Attendance
Physical or Speech Therapy	New or Experimental Treatment	
Nonsurgical External Breast Prosthesis	Anti-Nausea Benefit	
Waiver of Premium (Employee only)		
Additional Wellness Benefit		
Biopsy for skin cancer	Chest X-ray	Bone Marrow Testing
Echocardiogram	EKG	Colonoscopy
Flexible sigmoidoscopy	Hemoccult stool analysis	
HPV (Human Papillomavirus) Vaccination	Lipid panel (total cholesterol count)	
Mammography, including Breast Ultrasound	Pap Smear, including ThinPrep Pap Test	
Stress test on bike or treadmill	Thermography	
Serum Protein Electrophoresis (test for myeloma)		
Doppler screening for carotids or peripheral vascular disease		
Ultrasound screening for abdominal aortic aneurysms		
Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer) and PSA (prostate cancer)		
Additional Benefit		
Cancer Initial Diagnosis Benefit		

Access Your Benefits and Claim Filings

Accessing your benefit information using MyBenefits has never been easier.

MyBenefits is an easy-to-use website that offers you 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

For use in enrollments situsued in: TN.

This material is valid as long as information remains current, but in no event later than September 1, 2019. Group Cancer and Specified Disease benefits are provided by policy form GVCP3, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Cancer and Specified Disease Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Cancer Insurance (GVCP3)

Group Voluntary Cancer

from Allstate Benefits

See attached **Important Information About Coverage.**

Offered to the employees of: West Tennessee Healthcare

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN
Continuous Hospital Confinement (daily)	$200
Government or Charity Hospital (daily)	$200
Private Duty Nursing Services (daily)	$200
Extended Care Facility (daily)	$200
At Home Nursing (daily)	$200
Hospice Care Center (daily) or Hospice Care Team (per visit)	$200 $200
RADIATION/CHEMOTHERAPY AND RELATED BENEFITS	**PLAN**
Radiation/Chemotherapy for Cancer[2] (every 12 months)	$10,000
Blood, Plasma, and Platelets[2] (every 12 months)	$10,000
Medical Imaging[1]	$500
Hematological Drugs[1]	$200
SURGERY AND RELATED BENEFITS	**PLAN**
Surgery[2]	$1,500
Anesthesia (% of surgery)	25%
Ambulatory Surgical Center (daily)	$250
Second Opinion	$200
Bone Marrow or Stem Cell Transplant 1. Autologous 2. Non-autologous (cancer or specified disease treatment) 3. Non-autologous (Leukemia)	 1. $500 2. $1,250 3. $2,500

[1]Pays actual cost up to amount listed. [2]Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. [3]Pays actual charges up to amount listed.

MISCELLANEOUS BENEFITS	PLAN
Inpatient Drugs and Medicine (daily)	$25
Physician's Attendance (daily)	$50
Ambulance (per confinement)	$100
Non-Local Transportation[1] (per trip or mile)	Coach Fare or $0.40/mi
Outpatient Lodging (daily)	$50
Family Member Lodging (daily) and Transportation[1] (per trip or mile)	$50 Coach Fare or $0.40/mi
Physical or Speech Therapy (daily)	$50
New or Experimental Treatment[3] (every 12 months)	$5,000
Prosthesis[3]	$2,000
Hair Prosthesis (every 2 years)	$25
Nonsurgical External Breast Prosthesis[1]	$50
Anti-Nausea Benefit[1]	$200
Waiver of Premium (Employee only)	Yes
ADDITIONAL BENEFITS	**PLAN**
Cancer Initial Diagnosis	$2,000
Wellness Benefit	$100

PLAN PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Bi-Weekly	$9.90	$15.36	$13.74	$19.18

EE = Employee; EE + SP = Employee + Spouse; EE + CH = Employee + Child(ren); F = Family

Allstate BENEFITS For use in enrollments situsued in: TN. This rate insert is part of forms ABI327241X and ABI30590-1 and is not to be used on its own.

This material is valid as long as information remains current, but in no event later than September 1, 2019. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. ©2016 Allstate Insurance Company. www.allstate.com or allstatebenefits.com.

ABI327241X-Insert-JMC

Group Cancer (GVCP3)

Important Information About Coverage

Provides details of base policy and rider coverage in all states. State-specific information is noted when it varies from the standard. Below is a list of base policy and rider benefits available with Group Cancer coverage. Please refer to your policy for the specific items that apply to your coverage. You will receive a policy that details the specifications for the coverage you purchased.

Issue ages are 18 and over if Actively at Work.

Actual Charges vs. Actual Cost

Actual Charge – Amount billed for a treatment or service before any insurance discounts or payments.

Actual Cost – Amount actually paid by or on behalf of you, accepted as full payment by the provider of goods or services.

CA - Actual Charge is replaced with: **Amount Charged -** Amount billed for a treatment or service before any insurance discounts or payments. **Actual Cost** is replaced with: **Cost -** Amount actually paid by or on behalf of you, accepted as full payment by the provider of goods or services.

SD - Actual Charge is replaced with: **Charge -** Amount billed for a treatment or service before any insurance discounts or payments. **Actual Cost** is replaced with: **Cost -** Amount actually paid by or on behalf of you, accepted as full payment by the provider of goods or services.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis, Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease, Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or C), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

Hospital and Related Benefits (see Benefit Amounts)

Government or Charity Hospital – Paid in lieu of all other benefits except Waiver of Premium.

Extended Care Facility – Must begin within 14 days of a hospital stay. Up to the number of days of the previous hospital stay.

CA - Benefit is not available.

At Home Nursing – Must begin within 14 days of a hospital stay. Up to the number of days of the previous hospital stay.

AZ - Benefit is replaced with: **Home Health Services -** Up to the number of days of the previous hospital stay.

CA - Benefit is not available.

Hospice Care – Per day in freestanding care center or 1 visit per day of hospice care at home.

CA - Benefit is not available.

Radiation/Chemotherapy and Related Benefits (see Benefit Amounts)

Blood, Plasma, and Platelets – Includes charges for transfusions, administration, processing, procurement and cross-matching. Does not include donor replaced blood or immunoglobulins.

Medical Imaging – Once/calendar year.

Hematological Drugs – Only when Radiation/Chemotherapy for Cancer benefit paid.

Surgery and Related Benefits (see Benefit Amounts)

Surgery – Per certificate Schedule of Surgical Procedures. Two or more surgeries done at the same time are considered one operation; the operation with the largest benefit will be paid. Outpatient is paid at 150% of the amount listed in the Schedule of Surgical Procedures.

CA - The lesser of the amount based on procedure listed in certificate Schedule of Surgical Procedures, or the amount charged to the covered person. Two or more surgeries done at the same time are considered one operation; the operation with the largest benefit will be paid. Outpatient is paid at 150% of the amount listed in the Schedule of Surgical Procedures.

Surgery and Related Benefits (see Benefit Amounts) (continued)

Ambulatory Surgical Center – For surgery at an ambulatory surgical center, if listed in the Schedule of Surgical Procedures.

Bone Marrow or Stem Cell Transplant – Once/calendar year.

Miscellaneous Benefits (see Benefit Amounts)

Inpatient Drugs and Medicine – Not paid if covered under the Radiation/Chemotherapy for Cancer or Anti-Nausea Benefits.

Physician's Attendance – One inpatient visit per day.

Non-Local Transportation – At least 70 miles away, up to 700 miles.

Outpatient Lodging – More than 100 miles from home. Limit $2,000/12 mo. period.

Family Member Lodging and Transportation – Lodging up to 60 days. Transportation up to 700 miles per continuous hospital confinement.

New or Experimental Treatment – For physician-approved treatments not covered under other benefits.

Prosthesis – Surgically implanted prosthetic device; pays per amputation.

AZ, KS - The Prosthesis benefit is replaced with: **Prosthesis and Reconstructive Breast Surgery - Prosthesis:** Per amputation. **Reconstructive Breast Surgery:** Following a covered mastectomy.

Nonsurgical External Breast Prosthesis – Initial nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy.

AZ, KS - The following is added: Not paid when the Prosthesis and Reconstructive Breast Surgery benefit is paid.

SD - Nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy.

Anti-Nausea Benefit – Per calendar year; not paid for medication administered on inpatient basis.

Waiver of Premium (Employee only) – If disabled 90 days in a row due to cancer; pays for as long as disability lasts.

Optional/Additional Benefits (see Benefit Amounts)

Cancer Initial Diagnosis – Pays once; skin cancer not covered.

CA - Benefit is replaced with: **Invasive Cancer Initial Diagnosis -** Pays once; skin cancer not covered. Subject to the Pre-Existing Condition Limitation provision, the "first diagnosis of cancer" includes a recurrence of a cancer, as long as you are diagnosed after the effective date of coverage and have not received or been recommended by your physician to receive any treatment of the cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months.

IL - Benefit is not subject to the Pre-Existing Condition Limitation.

ND - Pays once; skin cancer not covered. The first diagnosis of cancer includes a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months.

SD - Benefit is replaced with: **Cancer Diagnosis -** Pays once, upon diagnosis of a new form or type of cancer; skin cancer not covered.

Wellness – Once/year. Eligible wellness tests are: Biopsy for skin cancer; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer) and PSA (prostate cancer); Bone Marrow Testing; Chest X-ray; Colonoscopy; Doppler screening for carotids or peripheral vascular disease; Echocardiogram; EKG; Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening for abdominal aortic aneurysms.

CA - The following is added to the list of wellness tests: Any generally medically accepted cancer screening test not listed above.

NC - Pap Smear, including ThinPrep Pap Test is replaced with: Cervical Cancer Screening.

Optional/Additional Benefits (see Benefit Amounts) (continued)

VA - The Blood test for PSA (prostate cancer) is deleted from the list of wellness tests. The following is added as a separate benefit: **PSA Testing and Digital Rectal Exams -** Once/year for covered persons age 50 and over; age 40 and over for covered persons at high risk for prostate cancer.

Intensive Care – Confinement for any illness or accident; up to 45 days for each stay in intensive care unit or step-down intensive care unit.

KS, TN - Confinement for any covered cancer or specified disease; up to 45 days for each stay in intensive care unit or step-down intensive care unit.

Progressive Benefit Rider (see Benefit Amounts)

Progressive Benefit Rider – Pays once, for diagnosis of cancer other than skin cancer. The benefit increases the longer coverage is in force prior to diagnosis. The first diagnosis of cancer includes a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months.

CA, ND, RI - Rider is not available.

SD - Pays once, for diagnosis of cancer other than skin cancer. The benefit increases the longer coverage is in force prior to diagnosis. The diagnosis of cancer includes a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 6 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months.

UT - Pays once, for diagnosis of cancer other than skin cancer. The benefit increases the longer coverage is in force prior to diagnosis. The first diagnosis of cancer includes a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 6 consecutive months immediately preceding the effective date of coverage, or any 6 consecutive months.

Your Eligibility

Coverage may include you, your spouse or domestic partner and children under age 26.

DC - Coverage may include you, your spouse, domestic partner or civil union partner and children under age 26.

HI - Coverage may include you, your spouse, domestic partner or certified reciprocal beneficiary, and your children under age 26.

Termination of Coverage

(a) Coverage under the policy ends on the date the policy is canceled; the last day premium payments were made; the last day of active employment, unless coverage is continued due to Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence; the date you or your class is no longer eligible. PROGRESSIVE BENEFIT RIDER ONLY - discovery of fraud or material misrepresentation in a claim.

NC - Coverage under the policy ends on the date the policy is canceled; the last day premium payments were made; the last day of active employment, unless coverage is continued due to Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence; the date you or your class is no longer eligible.

(b) Spouse/domestic partner coverage ends upon divorce/termination of partnership or your death.

DC - Spouse/domestic/civil union partner coverage ends upon divorce/termination of partnership or your death.

(c) Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

IL - Coverage for children ends when the child reaches age 26 (30 if a military veteran who is an Illinois resident) unless he or she continues to meet the requirements of an eligible dependent.

Termination of Coverage (continued)

MA - Coverage for children ends the earlier of when the child reaches age 26 or 2 years following loss of dependent status under the Internal Revenue Code, unless he or she continues to meet the requirements of an eligible dependent.

PA - The following is added: Coverage will not terminate due to age on a child who was a full-time student and whose studies were interrupted by active duty service in the military.

Portability Privilege

Coverage may be continued under the Portability Provision when coverage under the policy ends.

PR - The **Portability Privilege** is replaced with: **Conversion Privilege -** Coverage may be converted to an individual policy when coverage under the group policy ends.

Pre-Existing Condition

(a) We do not pay benefits for a pre-existing condition during the 12-month period beginning on the date that person's coverage starts.

NC - The following is added: This exclusion will not apply to your newborn, adopted or foster child under age 18 if we're notified within 31 days of the child's birth or date of placement.

PA - We do not pay benefits for a pre-existing condition during the 1-year period beginning on the date that person's coverage starts.

PR - We do not pay benefits for a pre-existing condition during the 8-month period beginning on the date that person's coverage starts.

UT - We do not pay benefits for a pre-existing condition during the 6-month period beginning on the date that person's coverage starts.

(b) A pre-existing condition is a disease or condition for which: symptoms existed within the 12-month period prior to the effective date; or medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date.

CA - A pre-existing condition is a disease or condition for which medical treatment was recommended or received from a medical professional within the 12-month period prior to the effective date.

IN , NC, VA - A pre-existing condition is a disease or condition for which medical advice or treatment was recommended or received from a medical professional within the 12-month period prior to the effective date.

ND - A pre-existing condition is a disease or physical condition for which treatment was received from a medical professional within the 12-month period prior to the effective date.

PA - A pre-existing condition is a disease or condition for which medical advice or treatment was recommended or received from a medical professional within the 90-day period prior to the effective date.

SD - A pre-existing condition is a disease or condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date.

UT - A pre-existing condition is a disease or condition which first manifested itself within the 6 months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(c) A pre-existing condition can exist even though a diagnosis has not yet been made.

CA, IN, NE, NC, ND, OR, SD, UT - (c) is deleted.

Cancer and Specified Disease Benefits Exclusions and Limitations

(a) We do not pay for any loss, except for losses due to cancer or a specified disease.

CA - We only pay for a loss when cancer or a specified disease is the proximate cause of the loss.

(b) Benefits are not paid for conditions caused or aggravated by cancer or a specified disease.

CA - We do not pay for any loss when cancer or a specified disease is only a remote cause of the loss. The following is added: We do not pay for any loss due to precancerous conditions, including but not limited to: leukoplakia; actinic keratosis; hyperplasia; polycythemia; moles; or similar diseases or lesions.

Treatment and services must be needed due to cancer or a specified disease and be received in the United States or its territories.

CA - Treatment must be needed due to cancer or a specified disease and be received in the United States or its territories.

For the Surgery, New or Experimental Treatment and Prosthesis benefits, we pay 50% of the applicable maximum when specific charges are not obtainable as proof of loss.

CA - For the Surgery, New or Experimental Treatment and Prosthesis benefits, we pay 50% of the applicable amount when specific charges are not obtainable as proof of loss.

For the Radiation/Chemotherapy for Cancer benefit, we do not pay for:

(a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy;

(b) treatment planning, consultation or management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; or the diagnostic tests related to these treatments;

(c) any devices or supplies including intravenous solutions and needles related to these treatments.

Intensive Care Benefits Exclusions and Limitations

(a) Benefits are not paid for:

(1) attempted suicide or intentional self-inflicted injury;

MO - attempted suicide while sane or intentional self-inflicted injury;

(2) intoxication or being under the influence of drugs not prescribed by a physician;

CA - any loss sustained or contracted in consequence of the covered person being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician;

OR, SD - (2) is deleted.

(3) alcoholism or drug addiction.

OR, SD - (3) is deleted.

(b) Benefits are not paid for confinements to a care unit that does not qualify as a hospital intensive care unit including progressive care, subacute intensive care, intermediate care, private rooms with monitoring, step-down and other lesser care units.

(c) Benefits are not paid for step-down confinements in the following units: telemetry or surgical recovery rooms; post-anesthesia care; progressive care; intermediate care; private monitored rooms; observation units in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms; emergency, labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit.

(d) Benefits are not paid for confinements occurring during a hospitalization prior to the effective date.

(e) Children born within 10 months of the effective date are not covered for confinement occurring or beginning during the first 30 days of the child's life.

GA, NE, NC, OK, UT - (e) is deleted.

(f) We do not pay for ambulance if paid under the Cancer and Specified Disease Ambulance benefit.

Allstate BENEFITS

ABJ30590-1

Rev. 7/16. This material is valid as long as information remains current, but in no event later than July 15, 2019. Group Voluntary Cancer benefits are provided by policy form GVCP3, or state variations thereof. Cancer Initial Diagnosis Progressive Benefit ("Progressive Benefit") Rider provided by GPCPR1, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Cancer and Specified Disease Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Accident Insurance

from Allstate Benefits

Benefits are paid to you

Protection for accidental injuries on- or off-the-job, 24-hours a day

1 CHOOSE
You choose the benefits to help protect yourself and any family members from accidental injury expenses

2 USE
You experience an accidental injury and seek medical attention from a medical professional

3 CLAIM
You go online and file a claim. The cash benefits are paid to you, to use however you wish

Even when you live well, accidents happen. Treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.

Every 10 minutes, more than **700 Americans suffer an injury** severe enough to seek medical help.[1]

Most major medical insurance plans only pay a portion of the bills. Our coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

With accident insurance from Allstate Benefits, you can gain the advantage of financial protection, thanks to the cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to get well.

Here's How It Works

Our coverage pays you cash benefits that correspond with a variety of covered occurrences, such as: dismemberment; dislocation or fracture; hospital confinement; ambulance services; and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more.

With Allstate Benefits, you can protect your finances against life's slips and falls.

Are you in Good Hands? You can be.

[1]National Safety Council, Injury Facts, 2014

Key Features

- Guaranteed Issue coverage, meaning no medical questions to answer at initial enrollment
- Coverage available for spouse and child(ren)
- Premiums are affordable and are conveniently payroll deducted
- Coverage can be continued, as long as premiums are paid to Allstate Benefits

See reverse for plan details

Offered to the employees of:

West Tennessee Healthcare

Allstate BENEFITS

YOU DECIDE how to use the cash benefits

Our cash benefits provide you with greater coverage options because you get to determine how to use them.

Finances
Can help protect your HSAs, savings, retirement plans and 401ks from being depleted

Travel
You can use your cash benefits to help pay for expenses while receiving treatment in another city

Home
You can use your cash benefits to help pay the mortgage, continue rental payments, or perform needed home repairs for your after care

Expenses
The lump-sum cash benefit can be used to help pay your family's living expenses such as bills, electricity and gas

Allstate BENEFITS

Benefits

Base Policy	
Accidental Death	Common Carrier Accidental Death
Dismemberment	Dislocation or Fracture
Hospital Confinement	Initial Hospital Confinement
Intensive Care	Ambulance
Medical Expenses	Outpatient Physician's Treatment
Benefit Enhancement Rider	
Hospital Admission	Lacerations
Burns	Skin Graft
Brain Injury Diagnosis	Paralysis
Coma with Respiratory Assistance	Blood and Plasma
General Anesthesia	Appliance
Medicine	Physical Therapy
Non-Local Transportation	Ruptured Disc Surgery
Eye Surgery	Open Abdominal or Thoracic Surgery
Medical Supplies	Prosthesis
Rehabilitation Unit	Family Member Lodging
Post-Accident Transportation	Accident Follow-up Treatment
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)	

Access Your Benefits and Claim Filings

Accessing your benefit information using **MyBenefits** has never been easier.

MyBenefits is an easy-to-use website that offers you 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

For use in enrollments sitused in: TN.

This material is valid as long as information remains current, but in no event later than September 1, 2019.
Group Accident benefits are provided by policy form GVAP1, rider form GVAPBER, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Accident Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Group Voluntary Accident (GVAP1)

On- and Off-the-Job Accident Insurance

from Allstate Benefits

See attached **Important Information About Coverage.**

Offered to the employees of:

West Tennessee Healthcare

BENEFIT ENHANCEMENT RIDER		PLAN
Hospital Admission[2]		$500
Ruptured Spinal Disc Surgery		$500
Lacerations[2] (Pays once/year)		$50
Accident Follow-Up Treatment		$50
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)		$50
Burns[2] (Pays once/accident; other than sunburns)	< 15% of body surface > 15% or more	$100 $500
Skin Graft (Pays once/accident; % of Burns Benefit)		50%
Brain Injury Diagnosis[2] (Pays once)		$150
Paralysis[2] (Pays once)	Paraplegia Quadriplegia	$7,500 $15,000
Coma with Respiratory Assistance (Pays once)		$10,000
Open Abdominal or Thoracic Surgery[2]		$1,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Surgery Exploratory	$500 $150
Eye Surgery (Pays once/accident)		$100
Rehabilitation Unit		$100
General Anesthesia		$100
Family Member Lodging		$100
Blood and Plasma[2] (Pays once/accident)		$300
Appliance (Pays once/accident)		$125
Medical Supplies (Pays once/accident)		$5
Medicine (Pays once/accident)		$5
Prosthesis (Pays once/accident)	1 device 2 or more devices	$500 $1,000
Physical Therapy (Pays daily; max. 6 days/accident)		$30
Non-Local Transportation		$400
Post-Accident Transportation (Pays once/year)		$200

[2]Within 3 days after accident.

BENEFIT AMOUNTS

BASE ACCIDENT BENEFITS		PLAN
Accidental Death and Dismemberment[1]	Employee Spouse Children	$40,000 $20,000 $10,000
Common Carrier Accidental Death (fare-paying passenger)	Employee Spouse Children	$200,000 $100,000 $50,000
Dislocation or Fracture[1]	Employee Spouse Children	$4,000 $2,000 $1,000
Initial Hospital Confinement (Pays once)		$1,000
Hospital Confinement (Pays daily)		$200
Intensive Care (Pays daily)		$400
Medical Expenses (Pays up to amount shown)		$500
Ambulance	Ground Air	$200 $600
Outpatient Physician's Treatment (Pays per visit)		$50

[1]Up to amount shown; see Injury Benefit Schedule on reverse. Multiple losses from same injury pay only up to amount shown above.

ABJ32723X-Insert-JMC

PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Bi-Weekly	$8.32	$15.64	$17.02	$20.72

EE = Employee; EE + SP = Employee + Spouse; EE + CH = Employee + Child(ren); F = Family

INJURY BENEFIT SCHEDULE

Benefit amounts for coverage and one occurrence are shown below.
Covered spouse gets 50% of the amounts shown and children 25%.

LOSS OF LIFE OR LIMB	PLAN
Life, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	$40,000
One eye, hand, arm, foot, or leg	$20,000
One or more entire toes or fingers	$4,000
COMPLETE DISLOCATION	**PLAN**
Hip joint	$4,000
Knee or ankle joint^, bone or bones of the foot^	$1,600
Wrist joint	$1,400
Elbow joint	$1,200
Shoulder joint	$800
Bone or bones of the hand^, collarbone	$600
Two or more fingers or toes	$280
One finger or toe	$120
COMPLETE, SIMPLE OR CLOSED FRACTURE	**PLAN**
Hip, thigh (femur), pelvis++	$4,000
Skull++	$3,800
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	$2,200
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	$1,600
Foot++, hand or wrist++	$1,400
Lower jaw++	$800
Two or more ribs, fingers or toes, bones of face or nose	$600
One rib, finger or toe, coccyx	$280

^Knee joint (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). ++Pelvis (except coccyx). Skull (except bones of face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

Allstate® BENEFITS

For use in enrollments sitused in: TN. This rate insert is part of forms ABJ32723X and ABJ29977-2 and is not to be used on its own.

This material is valid as long as information remains current, but in no event later than September 1, 2019. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. ©2016 Allstate Insurance Company. www.allstate.com or allstatebenefits.com.

Group Voluntary Accident (GVAP1)
On- and Off-the-Job Accident Insurance

Important Information About Coverage

Provides details of base policy and rider coverage in all states. State-specific information is noted when it varies from the standard. Below is a list of base policy and rider benefits available with Group Accident coverage. Please refer to your employer chosen plan for the specific items that apply to your coverage. You will receive a certificate that details the certificate specifications for the coverage you purchased.

Group Accident **Issue ages are 18 and over if Actively at Work.**

Benefits Specifications (see Benefit Amounts)

Accidental Death and Dismemberment - Multiple dismemberments, dislocations, and fractures from the same accident are limited to the amount shown in the Base Accident Benefits on front page of insert.

Dislocation or Fracture - Multiple dismemberments, dislocations, and fractures from the same accident are limited to the amount shown in the Base Accident Benefits on front page of insert.

Hospital Confinement - Per day, max. 90 days/injury.

Intensive Care - Per day, max. 90 days/injury.

Outpatient Physician's Treatment - Per visit, max. 2 visits/year, 4 if dependents are covered.

Benefits Enhancement Rider Specifications (see Benefit Amounts)

Hospital Admission - Within 3 days after accident. Payable once/year, after 12 months of coverage.

Ruptured Spinal Disc Surgery - 2 or more procedures through same entry point are considered 1 operation. Within 180 days after accident.

Lacerations - Within 3 days after accident.

Accident Follow-Up Treatment - Per day, max. 2 treatments/accident. Not paid if Physical Therapy benefit paid.

Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) - Within 180 days of accident, if treatment received within 30 days of accident. Payable once/year.

Skin Graft - Within 90 days after accident.

Brain Injury Diagnosis - Must be diagnosed within 30 days after accident.

Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery - Within 180 days after accident.

Eye Surgery - Within 90 days after accident.

Rehabilitation Unit - Per day, max. 30 days confinement, max. 60 days/year. Not paid if Daily Hospital Confinement benefit paid.

General Anesthesia - Within 180 days after accident.

Appliance - Within 90 days after accident.

Medical Supplies - Within 90 days after accident.

Medicine - Within 90 days after accident.

Prosthesis - Within 180 days after accident.

Physical Therapy - Not payable for chiropractic services or if Accident Follow-Up Treatment benefit paid.

Non-Local Transportation - Per trip, max. 3 times/accident. More than 100 miles from your home.

Post-Accident Transportation - More than 250 miles from your home, by common carrier.

CA, NE, NJ, PA, UT - Limitations to the number of days between the accident and the hospitalization and/or treatment are deleted.

FL - Benefit Enhancement Rider benefits described are part of the policy and not added as a rider.

Conditions, Limitations and Exclusions Affecting Your Benefits

Conditions and Limits

Most States - When an injury results in a covered loss within 90 days (180 days for dismemberment or death), unless otherwise stated, from the date of an accident, and is diagnosed by a physician), Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories.

PA - When an injury results in a covered loss within 90 days (90-day time limit not applicable to Accidental Death and Common Carrier Accidental Death), unless otherwise stated, from the date of an accident, and is diagnosed by a physician, Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories.

TX - When an injury results in a covered loss within 90 days (180 days for dismemberment or death, unless otherwise stated, from the date of an accident, and is diagnosed by a physician), Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories, unless the treatment is the result of an emergency.

UT - When an injury results in a covered loss within 180 days, unless otherwise stated, from the date of an accident, and is diagnosed by a physician, Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories.

WA - When an injury results in a covered loss within 1 year, unless otherwise stated, from the date of an accident, and is diagnosed by a physician, Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories.

Your Eligibility

All States - Your employer decides who is eligible for your group (such as length of service and hours worked each week).

Dependent Eligibility/Termination

(a) Coverage may include you, your spouse and children.

CA, FL, MD, OR, WA - Coverage may include you, your spouse or domestic partner, and children.

HI - Coverage may include you, your spouse or reciprocal beneficiary, and children.

DC - Coverage may include you, your spouse or domestic/civil union partner, and children.

NJ, VT - Coverage may include you, your spouse or civil union partner, and children.

(b) Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

IL - Coverage for children ends when the child reaches age 26 (30 if a military veteran who is an Illinois resident), unless he or she continues to meet the requirements of an eligible dependent.

MA - Coverage for children ends the earlier of when the child reaches age 26 or 2 years following loss of dependent status under the Internal Revenue Code, unless he or she continues to meet the requirements of an eligible dependent.

PA - The following is added to item (b): Coverage will not terminate due to age on a child who was a full-time student and whose studies were interrupted by active duty service in the military.

Dependent Eligibility/Termination (continued)

(c) Spouse coverage ends upon valid decree of divorce or your death.

CA, FL, MD, OR, WA - Spouse/domestic partner coverage ends upon valid decree of divorce/termination of the domestic partnership or your death.

DC - Spouse or domestic/civil union partner coverage ends upon valid decree of divorce/ termination of partnership or your death.

NJ - Spouse/civil union partner coverage ends upon valid decree of divorce or your death.

When Coverage Ends

Coverage under the policy ends on the earliest of:

(a) the date the policy is canceled;

(b) the last day of the period for which you made any required contributions;

(c) the last day you are in active employment, except as provided under the Temporarily Not Working provision;

(d) the date you are no longer in an eligible class;

(e) the date your class is no longer eligible;

(f) MT only - the date your employer discontinues their business.

Continuation of Coverage

You may be eligible to continue coverage when coverage under the policy ends. You have 60 days after coverage under the policy ends to let us know if you wish to continue coverage.

MT, NJ - You may be eligible to continue or convert coverage when coverage under the policy ends.

Certificate and Benefit Enhancement Rider Exclusions and Limitations

Benefits are not paid for:

(a) injury incurred before the effective date;

(b) act of war or participation in a riot, insurrection or rebellion;

MD - act of war.

NJ - act of war, participation in a riot or insurrection.

OK - participation in a riot, insurrection or rebellion.

VT, WA - act of war, participation in a riot or insurrection.

(c) suicide or attempt at suicide;

CO, MO - suicide, or any attempt at suicide, while sane.

(d) any injury while under the influence of alcohol or any narcotic unless taken on the advice of a physician;

CA - being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.

ID, MD, SD, VT, WA - (d) is deleted.

IN - any injury sustained or contracted while being intoxicated or under the influence of any narcotic, unless administered upon the advice of a physician.

NJ, TX - a loss sustained or contracted while being intoxicated or under the influence of any narcotic unless administered upon the advice of a physician.

OK - any injury sustained due to alcoholism or being under the influence of drugs or any narcotic, unless administered upon the advice of a physician and taken according to the physician's advice.

LA - any injury sustained or contracted while being intoxicated or under the influence of alcohol or any narcotics, unless administered on the advice of a physician.

MI - any injury caused by the covered person, sustained while under the influence of alcohol (as defined by the laws of the state of Michigan), narcotics, or any other controlled substance or drug unless administered upon the advice of a physician.

MT - any injury sustained or contracted in consequence of the covered person being intoxicated or voluntarily under the influence of any narcotic unless administered on the advice of a physician.

OR - being legally intoxicated as defined by the laws of this state or under the influence of any narcotic unless administered upon the advice of a physician.

PA - any injury sustained or contracted in consequence of being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

UT - any injury sustained while being under the influence of alcohol or any narcotic, unless administered upon the advice of a physician, if the use of alcohol or any narcotic substantially contributes to or causes the accident.

(e) bacterial infection, (except pyogenic infections from an accidental cut or wound);

AR, ID - (e) is deleted.

IL - any bacterial infection (except infections resulting from an accidental injury or infection which results from an accidental or involuntary or an unintentional ingestion of a contaminated substance).

TX - any bacterial infection (except food poisoning and pyogenic infections occurring through an accidental cut or wound).

MO - any bacterial infection (except pyogenic infections occurring with and through an accidental cut or wound, or sustained in consequence of the ingestion of a contaminated substance or material).

WV - any bacterial infection (except pyogenic infections which shall occur with and through an accident).

(f) participation in aeronautics unless a fare-paying passenger on a licensed common-carrier aircraft;

(g) committing or attempting an assault or felony;

CA - committing or attempting to commit an illegal occupation or felony.

ID, WA - participation in a felony.

MD - (g) is deleted.

NE, TX, VT - committing or attempting to commit a felony.

NJ - injury sustained while committing or attempting to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation.

(h) driving in any race or speed test or testing any vehicle on any racetrack or speedway;

ID, NJ, OK, VT - (h) is deleted.

(i) hernia, including complications;

AR, ID, MI, NJ, WV - (i) is deleted.

IL - hernia (except for hernia caused by an accident).

PA, VT - hernia, including complications due to hernia will be excluded during the first 6 months of coverage but will be covered thereafter.

Certificate and Benefit Enhancement Rider Exclusions and Limitations (continued)

(j) serving as an active member of the Military, Naval, or Air Forces of any country or combination of countries;

(k) MD only - health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

Disability Rider Exclusions and Limitations

Disability riders include:

Off-the-Job Accident and Disability Rider (R1AP)

On- and Off-the-Job Accident and Disability Rider (R2AP)

Off-the-Job Accident and Sickness Disability Rider (R3AP)

On- and Off-the-Job Accident and Sickness Disability Rider (R4AP)

On- and Off-the-Job Accident Disability Rider for Insured Spouse (R5AP)

On- and Off-the-Job Accident and Sickness Disability Rider for Insured Spouse (R6AP)

Disability riders not available in CA, MT
R5AP and R6AP not available in NJ
R2AP, R4AP, R5AP, R6AP not available in PR

The following applies to riders (R1AP, R2AP, R3AP, R4AP, R5AP and R6AP)

Payable up to 12 months. (See definition page 4).

The following applies to riders (R2AP, R4AP, R5AP and R6AP)

For any month that you receive Workers' Compensation or other state disability, the benefit is reduced by 50%. Reasonable proof will be required.

The following Rider Exclusions and Limitations apply to riders (R1AP, R2AP, R3AP, R4AP, R5AP and R6AP)

Rider Benefits are not paid for:

(a) act of war, participation in a riot, insurrection or rebellion;

MD - (a) is deleted.

NJ - act of war, participation in a riot or insurrection.

OK - participation in a riot, insurrection or rebellion.

VT - any act of war, participation in a riot or insurrection.

WA - any act of war or participation in a riot or insurrection.

(b) participation in aeronautics unless a fare-paying passenger on a licensed common-carrier aircraft;

(c) intentionally self-inflicted injuries;

(d) engaging in an illegal occupation or committing or attempting a felony;

NJ - injury sustained while committing or attempting to commit a felony or engagement in an illegal occupation.

WA - injury incurred while engaging in an illegal occupation or participation in a felony.

(e) attempted suicide;

CO, MO - attempted suicide, while sane.

VT - (e) is deleted.

(f) being under the influence of alcohol, narcotics or any other controlled substance or drug unless taken on the advice of a physician;

CA - loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless taken on the advice of a physician.

ID, SD, VT - (f) is deleted.

LA - any injury sustained or contracted while being intoxicated or under the influence of alcohol or narcotics, unless taken upon the advice of a physician.

MD - any injury sustained or contracted while being intoxicated or under the influence of any narcotic.

IN - any injury sustained or contracted while being intoxicated or under the influence of any narcotic unless taken upon the advice of a physician.

MT - any injury sustained or contracted in consequence of the covered person being intoxicated or voluntarily under the influence of any narcotic unless taken on the advice of a physician.

NJ - any loss sustained or contracted while being intoxicated or under the influence of any narcotic unless administered upon the advice of a physician.

MI - any injury caused by the insured, sustained while under the influence of alcohol, narcotics or any other controlled substance or drug unless taken upon the advice of a physician.

OK - any injury sustained due to being under the influence of narcotics or any controlled substance or drug unless administered upon the advice of a physician and taken according to the physician's advice.

OR - any injury sustained while legally intoxicated or while under the influence of any narcotic unless administered upon the advice of a physician.

PA - any injury sustained or contracted in consequence of being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

TX - the insured's being intoxicated or under the influence of any narcotic unless taken on the advice of a physician.

UT - any injury sustained while being under the influence of alcohol or any narcotic, unless administered upon the advice of a physician, if the use of alcohol or any narcotic substantially contributes to or causes the accident.

(g) alcohol abuse or alcoholism, drug addiction or dependence on any controlled substance;

ID - alcoholism, drug addiction or dependence upon any controlled substance.

MD, VT - (g) is deleted.

(h) dental or plastic surgery for cosmetic purposes;

(i) benefits are not paid during any period of incarceration;

IA - benefits are not paid for any disability that begins while incarcerated.

VT - (i) is deleted.

The following Rider Exclusion and Limitation only applies to riders (R3AP, R4AP and R6AP)

(j) mental illness without demonstrable organic disease;

VT - (j) is deleted.

The following Rider Exclusion and Limitation only applies to riders (R1AP, R2AP and R5AP)

(k) disability benefits for a sprained, strained, or lame back or any disc condition are limited to a maximum of 3 months;

VT - disability benefits for a sprained, strained, or lame back or any disc condition are limited to a maximum of 6 months.

The following Rider Exclusion and Limitation only applies to riders (R1AP and R3AP)

(l) an on-the-job accident.

Disability Rider Pre-Existing Condition Limitation

(a) Benefits are not paid during the first 12 months of coverage if caused by a pre-existing condition;

UT - Benefits are not paid on losses occurring during the first 6 months of coverage if caused by a pre-existing condition.

Disability Rider Pre-Existing Condition Limitation (continued)

(b) A pre-existing condition is a condition for which symptoms existed within the 12 months prior to the effective date; or medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date;

IN, UT - A pre-existing condition is a condition for which symptoms existed within the 6-month period prior to the effective date; or medical advice or treatment was recommended or received from a member of the medical profession within the 6-month period prior to the effective date.

MT - A pre-existing condition is a condition which existed within the 12-month period prior to the effective date; or medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

NJ, ND, VA - A pre-existing condition is a condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date.

PA - A pre-existing condition is a condition for which medical advice or treatment has been received by a covered person within 90 days immediately prior to becoming covered under the certificate. The condition shall be covered after the covered person has been covered for more than 12 months under the certificate.

(c) A pre-existing condition can exist even though a diagnosis has not yet been made;

GA, MT, PA, VA - (c) is deleted.

(d) Any disability incurred or commencing after 12 months of coverage will not be subject to the pre-existing condition limitation;

VA - (d) in Virginia only.

(e) Any loss which begins after the first 12 months of a covered person's effective date of coverage will not be considered a pre-existing condition and will be eligible for payments under this plan. A pre-existing condition does not include a condition admitted on the application which was not excluded by a signed waiver.

MD - (e) in Maryland only.

Disability Definitions

Total Disability - When, because of sickness or injury, you can't perform the material and substantial duties of your own occupation (as defined) and are under a physician's care.

Own Occupation - Your occupation when a total disability period begins; if you're unemployed at that time, it means any gainful occupation for which you're suited by education, training, or experience.

Termination Provision for Disability Riders - The riders end on: (a) the end of the grace period; (b) the date the policy terminates; (c) the date the certificate terminates; (d) the next renewal date after your request to terminate the rider; or (e) the next renewal date after your 70th birthday.

Allstate BENEFITS

ABJ29977-2

Rev. 8/16. This material is valid as long as information remains current, but in no event later than July 15, 2019.
Group Accident benefits are provided by policy form GVAP1 and the following rider forms, if included, or state variations thereof. Benefit Enhancement Rider provided by rider form GVAPBER. Off-the-Job Accident Disability Rider provided by rider R1AP. On- and Off-the-Job Accident Disability Rider provided by rider R2AP. Off-the-Job Accident and Sickness Disability Rider provided by rider R3AP. On- and Off-the-Job Accident and Sickness Disability Rider provided by rider R4AP. On- and Off-the-Job Accident Disability Rider for Insured Spouse provided by rider R5AP. On- and Off-the-Job Accident and Sickness Disability Rider for Insured Spouse provided by rider R6AP.

Coverage is provided by Limited Benefit Supplemental Accident Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Critical Illness Insurance

from Allstate Benefits

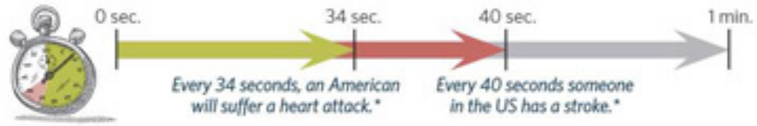
Benefits are paid to you | **Protection for out-of-pocket expenses upon a positive diagnosis**

1 CHOOSE
You choose the benefits to protect yourself and any family members if diagnosed with a covered critical illness

2 USE
You go to your annual exam, the doctor runs tests, the results come back and you're diagnosed with a critical illness

3 CLAIM
You go online and file a claim. The cash benefits are paid to you, to use however you wish

You can't predict the future, but you can plan for it. We invite you to put yourself in Good Hands with Critical Illness insurance from Allstate Benefits.



Our coverage helps offer financial support if you are diagnosed with a covered critical illness. With the expense of treatment often so high, seeking the treatment you need seems like a heavy financial burden. But when a diagnosis occurs, what you should be focusing on is getting better. With Allstate Benefits, you gain the power to take control of your health when faced with a covered event.

Here's How It Works

You select the benefit coverage amount you want based on your individual need and your budget. If you have covered family members, our coverage also provides cash benefits for them. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

With Allstate Benefits, you gain the power to make treatment decisions without putting your finances at risk.

Are you in Good Hands? You can be.

* http://www.criticalillnessinsuranceinfo.org/learning-center/critical-illness-coverage-facts.php.

Key Features

- Guaranteed Issue coverage, meaning no medical questions to answer at initial enrollment
- Coverage available for spouse and child(ren)
- Benefits are paid regardless of any other coverage
- Premiums are affordable and are conveniently payroll deducted
- Coverage may be continued

See reverse for plan details

Offered to the employees of:

West Tennessee Healthcare

Allstate BENEFITS

YOU DECIDE how to use the cash benefits

Our cash benefits provide you with greater coverage options because you get to determine how to use them.

Finances
Can help protect your HSAs, savings, retirement plans and 401ks from being depleted

Travel
You can use your cash benefits to help pay for expenses while receiving treatment in another city

Home
You can use your cash benefits to help pay the mortgage, continue rental payments, or perform needed home repairs for your after care

Expenses
The lump-sum cash benefit can be used to help pay your family's living expenses such as bills, electricity and gas

Allstate BENEFITS

Benefits

Base Policy Initial Critical Illness Benefits		
Heart Attack	Major Organ Transplant	Waiver of Premium*
Stroke	End Stage Renal Failure	Coronary Artery Bypass Surgery

Cancer Critical Illness Benefits	
Invasive Cancer	Carcinoma in Situ

Supplemental Critical Illness Benefits I	
Benign Brain Tumor	Complete Loss of Hearing
Paralysis	Advanced Alzheimer's Disease
Coma	Advanced Parkinson's Disease
Complete Blindness	Occupational HIV

Wellness (Pays annually when one of 23 screening exams is performed)	
Biopsy for skin cancer	Hemoccult stool analysis
Blood test for triglycerides	HPV Vaccination (Human Papillomavirus)
Bone Marrow Testing	Lipid panel (Total cholesterol count)
CA15-3, CA125, CEA and PSA (Blood tests)[1]	Mammography (Including Breast Ultrasound)
Chest X-ray	Pap Smear (ThinPrep Pap Test included)
Colonoscopy	Serum Protein Electrophoresis (Myeloma test)
Doppler screenings for carotids and peripheral vascular disease	Stress test on bike or treadmill
Echocardiogram	Thermography
EKG (Electrocardiogram)	Ultrasound screening (abdominal aortic aneurysms)
Flexible sigmoidoscopy	

[1] Breast, ovarian, colon and prostate cancer. *Employee only.

Access Your Benefits and Claim Filings

Accessing your benefit information using MyBenefits has never been easier.

MyBenefits is an easy-to-use website that offers you 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

For use in enrollments situsedin: TN.

This material is valid as long as information remains current, but in no event later than September 1, 2019.
Group Critical Illness benefits provided by policy form GVCIP2, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Critical Illness Insurance. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Critical Illness (GVCIP2)

Group Voluntary Critical Illness Insurance

from Allstate Benefits

See attached **Important Information About Coverage.**

Offered to the employees of:

West Tennessee Healthcare

BENEFIT AMOUNTS

†Covered Dependents Receive 50% Of Your Benefit Amount

INITIAL CRITICAL ILLNESS BENEFITS†	PLAN 1	PLAN 2
Heart Attack (100%)	$10,000	$20,000
Stroke (100%)	$10,000	$20,000
Coronary Artery Bypass Surgery (25%)	$2,500	$5,000
Major Organ Transplant (100%)	$10,000	$20,000
End Stage Renal Failure (100%)	$10,000	$20,000
Waiver of Premium (employee only)	Yes	Yes
CANCER CRITICAL ILLNESS BENEFITS†	**PLAN 1**	**PLAN 2**
Invasive Cancer (100%)	$10,000	$20,000
Carcinoma in Situ (25%)	$2,500	$5,000
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS I†	**PLAN 1**	**PLAN 2**
Advanced Alzheimer's Disease (25%)	$2,500	$5,000
Advanced Parkinson's Disease (25%)	$2,500	$5,000
Benign Brain Tumor (100%)	$10,000	$20,000
Coma (100%)	$10,000	$20,000
Complete Blindness (100%)	$10,000	$20,000
Complete Loss of Hearing (100%)	$10,000	$20,000
Paralysis (100%)	$10,000	$20,000
Occupational HIV (100%)	$10,000	$20,000
ADDITIONAL BENEFIT	**PLAN 1**	**PLAN 2**
Wellness Benefit (per year)	$50	$50

BI-WEEKLY PREMIUMS

PLAN 1
$10,000 Basic Benefit Amount

non-tobacco

AGES	EE, EE+CH	EE+SP, F
18-35	$3.18	$4.80
36-50	$7.22	$10.86
51-60	$14.74	$22.14
61-63	$23.00	$34.52
64+	$33.74	$50.62

tobacco

AGES	EE, EE+CH	EE+SP, F
18-35	$4.86	$7.32
36-50	$11.84	$17.80
51-60	$24.34	$36.54
61-63	$35.16	$52.78
64+	$51.80	$77.72

PLAN 2
$20,000 Basic Benefit Amount

non-tobacco

AGES	EE, EE+CH	EE+SP, F
18-35	$5.40	$8.12
36-50	$13.48	$20.24
51-60	$28.52	$42.80
61-63	$45.02	$67.54
64+	$66.50	$99.76

tobacco

AGES	EE, EE+CH	EE+SP, F
18-35	$8.74	$13.14
36-50	$22.70	$34.08
51-60	$47.72	$71.58
61-63	$69.36	$104.06
64+	$102.60	$153.94

EE = Employee, EE+SP = Employee + Spouse, EE+CH = Employee + Child(ren), F = Family

Allstate BENEFITS

For use in enrollments situsedin: TN. This rate insert is part of forms ABJ32725X and ABJ30427-1 and is not to be used on its own.

This material is valid as long as information remains current, but in no event later than September 1, 2019. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. ©2016 Allstate Insurance Company. www.allstate.com or allstatebenefits.com.

ABJ32725X-Insert-JMC

Allstate Benefits | allstatebenefits.com

Group Voluntary Critical Illness (GVCIP2)

Important Information About Eligibility, Termination and Portability

Provides details of base policy and rider coverage in all states. State-specific information is noted when it varies from the standard. Below is a list of base policy and rider benefits available with Group Critical Illness coverage. Please refer to your employer-chosen plan for the specific items that apply to your coverage. You will receive a certificate that details the certificate specifications for the coverage you purchased.

Group Critical Illness Issue ages are 18 and over, if Actively at Work.

Benefit Specifications (see Benefit Amounts)

Heart Attack Exclusion - A cardiac arrest is not a heart attack and is not covered by this benefit.

Stroke Exclusions - Does not include: Transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

Coronary Artery Bypass Surgery Exclusions - Does not include: abdominal aortic bypass, balloon angioplasty, laser embolectomy, atherectomy, stent placement, or other non-surgical procedures.

NJ - The Coronary Artery Bypass Surgery benefit is replaced with: Coronary Artery Disease. The exclusion is replaced with: Coronary Artery Disease Condition: There must be 80% or greater narrowing or blockage of coronary arteries due to atherosclerotic heart disease.

Invasive Cancer Exclusions - Does not include: carcinoma in situ, tumors related to HIV, non-invasive or metastasized skin cancer, or early prostate cancer. Includes: Leukemia and Lymphoma.

CA - Does not include: basal cell and squamous cell skin cancers, skin cancers other than melanoma, pre-cancerous lesions (such as intraepithelial neoplasia), benign (non-cancerous) tumors or polyps, or cancer that has not spread to adjacent tissue (carcinoma in situ/non-invasive cancer). We rely on the physician's diagnosis to determine whether the cancer is invasive.

Carcinoma in Situ Exclusions - Does not include: other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), or benign tumors or polyps.

CA - Does not include: basal cell and squamous cell skin cancers, skin cancers other than melanoma in situ, pre-cancerous lesions (such as intraepithelial neoplasia), benign (non-cancerous) tumors or polyps. We rely on the physician's diagnosis to determine whether the cancer is invasive.

Second Event Initial Critical Illness Benefit Conditions - There must be at least 12 months between each diagnosis. A covered person can receive a Second Event Benefit only once for each initial critical illness.

Second Event Cancer Critical Illness Benefit Conditions - There must be at least 12 months between each diagnosis. Not payable if the covered person receives treatment during that 12-month period. "Treatment" does not include maintenance drug therapy or routine follow-up office visits. A covered person can receive the benefit only once for each cancer critical illness.

NJ - There must be at least 6 months between each diagnosis. Not payable if the covered person receives treatment during that 6-month period. "Treatment" does not include maintenance drug therapy or routine follow-up office visits. A covered person can receive the benefit only once for each cancer critical illness.

Advanced Alzheimer's Disease Conditions - Must have impaired memory and judgement, and be unable to perform 3 or more daily activities.*

CA, ID - This benefit is not available.

FL - Must have impaired memory and judgment, and be unable to perform 2 or more daily activities.

Advanced Parkinson's Disease Conditions - Must have 2 or more physical signs and be unable to perform 3 or more daily activities.*

*Daily activities are: bathing, dressing, toileting, continence, transferring and eating.

CA, ID - This benefit is not available.

Benign Brain Tumor Exclusions - Does not include: tumors of the skull, pituitary adenomas, or germinomas.

Paralysis - Permanent loss of use of 2 or more limbs.

GA - The Paralysis benefit is only payable if it is the result of an accident and/or sickness.

Occupational HIV (available in Supplemental Critical Illness I only) - Exposure must be accidental and during the normal course of duties of the covered person. The covered person must not have previously tested HIV positive.

CA, GA, ID - This benefit is not available.

Increasing Critical Illness Benefit Limitation - Increases your basic benefit amount by the amount shown, only on the first 5 coverage year anniversaries.

CA, FL, NJ - This benefit is not available.

CA - The following benefit is added: **Transient Ischemic Attack (25%) -** Does not include: stroke, head injury or peripheral neurologic disorders.

CA - The following is added to the **Wellness Benefit -** Any other medically accepted cancer screening test not listed above.

Second Evaluation Benefit Rider

Second Consultation - By a physician other than your current physician.

Non-Local Transportation - Limit $5,000/12-month period.

Outpatient Lodging - Limit $1,000/12-month period. More than 75 miles from home.

Family Member Lodging and Transportation - Lodging limit $1,000/12-month period. Transportation limit $5,000/12-month period.

CO, DC, FL, NJ, WA - This rider is not available.

Conditions, Limitations and Exclusions Affecting Your Benefits

Conditions and Limits

Most States - Benefits are not payable for any critical illness diagnosed prior to the effective date. Benefits are also subject to the Pre-Existing Condition Limitation, if applicable, as well as all other limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the policy and be diagnosed by a physician while coverage is in effect. The date of diagnosis for each illness must be separated by 90 days. Emergency situations while you are outside the U.S. will be considered when you return to the U.S.

CT, NJ - The following statement does not apply: The date of diagnosis for each illness must be separated by 90 days.

TN - The second to last sentence is replaced with: The date of diagnosis for each illness must be separated by 30 days.

GA - The following is added: The basic-benefit amounts paid for all critical illnesses combined will never exceed $250,000 for each covered person.

Dependent Eligibility/Termination

(a) Family members eligible for coverage are your spouse or domestic partner and children;

DC - Family members eligible for coverage are your spouse, domestic or civil union partner, and children.

HI - Family members eligible for coverage are your spouse or domestic partner, children, and your certified reciprocal beneficiary.

ID - Family members eligible for coverage are your spouse and children.

NJ - Family members eligible for coverage are your legal spouse or civil union partner or domestic partner and children.

(b) Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent;

IL - Coverage for children ends when the child reaches age 26 (30 if a military veteran who is an Illinois resident), unless he or she continues to meet the requirements of an eligible dependent.

MA - Coverage for children ends the earlier of when the child reaches age 26 or 2 years following loss of dependent status under the Internal Revenue Code, unless he or she continues to meet the requirements of an eligible dependent.

PA - The following is added to item (b): Coverage will not terminate due to age on a child who was a full-time student and whose studies were interrupted by active duty service in the military.

(c) Spouse coverage ends upon valid decree of divorce or your death;

NJ - Spouse or civil union partner coverage ends upon valid decree of divorce or your death.

(d) Domestic partner coverage ends when the domestic partnership ends or your death.

DC - Domestic/civil union partner coverage ends when the partnership ends or your death.

ID - (d) is deleted.

Your Eligibility

All States - Your employer decides who is eligible for your group (such as length of service and hours worked each week). Issue ages are 18 and over.

When Coverage Ends

Coverage under the policy ends on the earliest of:

(a) the policy is canceled;
(b) you stop paying your premium;
(c) the last day of active employment;
(d) you are no longer eligible;
(e) a false claim is filed;
(f) when all critical illness benefits have been paid;
(g) **GA -** or the date you request to discontinue coverage.

Continuing Your Coverage

You may be able to continue coverage when coverage under the policy ends. Refer to your Certificate of Insurance for details.

NJ - Continuing Your Coverage is replaced with: Conversion - Coverage may be converted under the Conversion Provision when coverage under the policy ends.

Pre-Existing Condition Limitation (if applicable)

CA - Limitation not applicable.

(a) We do not pay benefits for a critical illness that is, caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis is within 12 months after the effective date of coverage;

IL - We do not pay benefits for a critical illness that is caused by or results from a pre-existing condition when the date of diagnosis is within 12 months after the effective date of coverage.

NJ - We do not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis is within 6 months after the effective date of coverage.

ME, UT - We do not pay benefits for a critical illness that is, or is caused by, contributed to by, or results from, a pre-existing condition when the date of diagnosis is within 6 months after the effective date of coverage.

NC - The following is added to item (a): This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if we are notified within 31 days of the child's birth or date of placement. No benefits will be provided during the first 12 months of the policy for pre-existing conditions as defined in the certificate.

(b) A pre-existing condition is a condition, whether diagnosed or not, for which symptoms existed within the 12-month period prior to the effective date; or (c) medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

FL - The following is added after (c): The exception is follow-up care for breast cancer: If you have been previously found to be free of breast cancer, routine follow-up care does not constitute medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during, or as the result of, the follow-up care.

NE, OR - Item (b) is replaced with: A pre-existing condition is a condition for which symptoms existed within the 12-month period prior to the effective date.

ID, ME, UT - Items (b) and (c) are replaced with: A pre-existing condition is a condition, whether diagnosed or not, for which symptoms existed within the 6-month period prior to the effective date; or medical advice or treatment was recommended or received from a medical professional within 6 months prior to the effective date.

CT, ND, VA - (b) and (c) are replaced with: A pre-existing condition is a condition, whether diagnosed or not, for which medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

IN, NC - (b) and (c) are replaced with: A pre-existing condition is a condition for which medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

NJ - (b) and (c) are replaced with: A pre-existing condition is a condition, whether diagnosed or not, for which medical advice or treatment was recommended or received from a medical professional within 6 months prior to the effective date.

PA - (b) and (c) are replaced with: A pre-existing condition is a condition, whether diagnosed or not, for which medical advice or treatment was recommended or received from a medical professional within 90 days prior to the effective date.

Pre-Existing Condition Limitation (if applicable) (Continued)

SD - (b) and (c) are replaced with: A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of coverage.

WY - (b) and (c) are replaced with: A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received from a medical professional within 6 months prior to the effective date.

GA - The Pre-Existing Condition Limitation is deleted and replaced with the Benefit Waiting Period Limitation - (a) We do not pay benefits for a critical illness that occurs during the first 30 days following the date the covered person became insured; (b) If a diagnosis occurs during the Benefit Waiting Period the following options are available: 1. Return the coverage for a full refund, or 2. Continue coverage and receive benefits for one of the other specified critical illnesses listed in the policy.

Recurrence of Cancer

Only applies to Cancer Critical Illness, if included. Provision applies regardless of whether your plan includes a Pre-Existing Condition Limitation.

Cancer critical illness benefits are payable for a diagnosis of a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months thereafter.

NJ - The Recurrence of Cancer paragraph is replaced with: Cancer critical illness benefits are payable for a diagnosis of a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 6 consecutive months immediately preceding the effective date of coverage, or any 6 consecutive months thereafter.

Policy Exclusions and Limitations

Benefits are not paid for:

(a) war, participation in a riot, insurrection or rebellion;

CT - war, participation in an insurrection or rebellion.

ID - war or participation in a riot.

NJ - war while you are serving in the military or any unit supporting or accompanying the military, participation in a riot, insurrection or rebellion.

NC - active participation in a riot, insurrection or rebellion.

OK - participation in a riot, insurrection or rebellion.

TX - war during military service, or participation in a riot, insurrection or rebellion.

UT - war, voluntary participation in a riot, insurrection or rebellion.

(b) intentionally self-inflicted injury or action;

CA - intentionally self-inflicted injury while sane or insane.

DC - (b) is deleted.

(c) illegal activities or occupations;

CA - loss to which a contributing cause was the insured's committing or attempting a felony, or being engaged in an illegal occupation.

CT - committing or attempting to commit a felony.

IL - illegal occupations.

NE - committing or attempting a felony or illegal occupation.

TX - illegal activities or committing or attempting to commit a felony.

UT - voluntary participation in illegal activities or voluntary participation in illegal occupations.

NJ - any loss to which a contributing cause was your commission of, or attempt to commit, a felony or to which a contributing cause was your engagement in illegal activities or occupation.

WI - illegal activities or illegal occupation that results in the insured's conviction of a felony.

(d) suicide while sane, or self-destruction while insane, or any attempt at either;

CO, MO - suicide while sane, or self destruction, or any attempt at either.

(e) substance abuse, including alcohol, alcoholism, drug addiction, or dependence upon any controlled substance.

CA - loss sustained from being intoxicated or under the influence of any controlled substance unless taken on the advice of a physician.

CT - the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act, unless prescribed by a doctor for you.

DC, KY, NV, NC, SD - (e) is deleted.

IL - substance abuse, including drug addiction or dependence upon any controlled substance.

Allstate BENEFITS

ABJ30427-1

Rev. 7/16. This material is valid as long as information remains current, but in no event later than July 15, 2019. Group Critical Illness benefits are provided by policy form GVCIP2, or state variations thereof. Group Critical Illness Enhancement Rider (Second Evaluation Benefit) provided by rider form GPCIER, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Critical Illness Insurance. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits. This information highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

For Eligible Employees of West Tennessee Healthcare

If they need you, you need a Champion

Life Insurance—Valuable protection for your loved ones

You work hard to provide a good life for your family. However, what if something happens to you? If they need you, you need a champion to defend and protect your family with money to help pay for:

- Rent and mortgage
- College Education
- Retirement
- Household Expenses
- Long Term Care
- Childcare
- Family Debt
- Burial

Make a promise to protect the future. Let LifeTime Benefit Term (LBT) be your Champion. It lasts a lifetime—guaranteed. LifeTime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living or nursing care. For the same premium, LifeTime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Features

Affordable Financial Security Lifelong protection with premiums beginning as low as $3 per week.

Dependable Guarantees Guaranteed life insurance premium and death benefits last a lifetime.

Highly Competitive Rates For the same premium, LifeTime Benefit Term provides higher benefits than permanent life insurance and lasts to age 121.

Fully Portable and Guaranteed Renewable for Life Your coverage cannot be cancelled as long as premiums are paid as due.

COMBINED INSURANCE®

LBT-EE4-LTC50-Henry-2pg-TN-1017

LIFETIME BENEFIT TERM | CHAMPION
Life Insurance with Money for Long Term Care

LIFETIME BENEFIT TERM | CHAMPION

Life Insurance with Money for Long Term Care

Creative Solutions for Term Life Insurance

Guaranteed Premiums
Life insurance premiums will never increase and are guaranteed through age 100. Thereafter no additional premium is due while the coverage can continue.

Guaranteed Benefits During Working Years
Death Benefit is guaranteed 100% when it is needed most—during your working years when your family is relying on your income. While the policy is in force, the death benefit is 100% guaranteed for the longer of 25 years or age 70.

Guaranteed Benefits After Age 70
Even after age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50%. And based on current interest rates the full death benefit is designed to last a lifetime.

Paid-up Benefits
After 10 years, paid up benefits begin to accrue. At any point thereafter, if premiums stop, a reduced paid up benefit is guaranteed. Flexibility is perfect for retirement.

Long Term Care (LTC)*
If you need LTC, you can access your death benefit while you are living if you are unable to perform two of six Activities of daily Living and require nursing home, home health care, assisted living, or adult day care services and you have a Severe Cognitive Impairment that requires substantial Supervision to protect you from threat of health or safety. You will receive 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Extension of Benefits*
Extends the monthly Long Term Care benefit for up to an additional 25 months, after 100% of the base death benefit has been used for LTC.

Terminal Illness Benefit
After the cvoerage has been in force for two years, you can receive 50% of your death benefit immediately, up to $100,000, if you are diagnosed as terminally ill.

Additional Benefit Options

Accidental Death Benefit Doubles the death benefit if death results from an accident.

Child Term Benefit Death Benefits available up to $25,000. Guaranteed conversion to individual coverage at age 26—up to 5 times the benefit amount.

Waiver of Premium Waives premium if you become totally disabled.

Payor Waiver of Premium Waives premium of your spouse, if you become totally disabled.

* LTC and Extension of Benefits premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums will not be increased solely because of an independent claim.

LifeTime Benefit Term Exclusions If the insured commits suicide, while sane or insane, within two years (one year in some states) from the Date of Issue, and while this Coverage is in force, We will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Long Term Care Exclusions We will not pay Long Term Care benefits for care that is received or loss incurred as a result of: 1) an intentionally self-inflicted injury, or attempted suicide; or 2) war or any act of war, declared or undeclared, or service in the armed forces of any country; or 3) treatment of the Insured's alcohol, drug or other chemical dependence, except if the drug dependency was sustained or acquired at the hands of a Physician, or except while under treatment for an injury or sickness; or 4) the Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity. We will not pay Long Term Care benefits if the Confinement, Home Health Care services, or Adult Day Care service: 1) Is received outside the United States and its territories; or 2) is provided by ineligible providers; or3) is rendered by members of the Certificateholder's or the Insured's Immediate Family.

Here's how LifeTime Benefit Term can be Your Family's Champion

As Life Insurance

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

For Long Term Care

If you become chronically ill, LifeTime Benefit Term will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.
Your death benefit will reduce proportionately each month as your receive benefit payments for Long Term Care. Your life insurance will continue to help you protect your assets for 25 months. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero. With Extension of Benefits, if you continue to need LTC after you have exhausted your Death Benefits, you can receive up to 25 more months of benefits, for a total of 50 months of LTC benefits.

This document is a brief description of Certificate Form No. C34544TN. Group policy form is P34544TN. This document is a brief description of Certificate Form No. C34544TN and riders: Dependent Child=34546, Accidental Death Benefit=34545, Guaranteed Insurability=34547, Waiver of Premium=34551, Payor Waiver of Premium=34549, Level Term=34548, Accelerated Death Benefit for Terminal Illness=34550, Restoration of Death Benefit=34559, Long Term Care=34553TN and Extension of Benefits=34554). Benefits, rates, exclusions and limitation may vary by state. Refer to your certificate of insurance for specific details

COMBINED INSURANCE®
A Chubb Company

Combined Insurance Company of America
Chicago, IL

LegalShield℠ | IDShield℠

Affordable Legal and Identity Theft Protection

Have you ever had a dispute with a creditor, neighbor or landlord? Have you ever received a traffic ticket or signed a contract? Have you ever been a victim of a data breach? Used public Wi-Fi or ever lost your wallet? Get the legal and identity theft protection you and your family deserve with LegalShield and IDShield.

Through a nationwide network of provider law firms, LegalShield provides every member direct access to a dedicated law firm. And IDShield is the only identity theft protection plan armed with a team of licensed private investigators, ensuring that if your identity is stolen it will be fully restored.

Download on the App Store

GET IT ON Google Play

LegalShield Benefits:*

- Legal consultation and advice
- Dedicated law firm
- Legal document review (up to 15 pages each)
- Access to legal forms/contracts
- Letters and phone calls made on your behalf
- Speeding ticket assistance
- Will preparation
- 24/7 emergency legal access
- Mobile app
- And more!

IDShield Plan Benefits:*

- Identity consultation and advice
- Dedicated licensed private investigators
- Child monitoring (family plan only)*
- Social media monitoring
- Identity and credit monitoring
- Identity threat and credit inquiry alerts
- Complete identity restoration
- Monthly credit score tracker
- Password manager
- 24/7 emergency access
- Mobile app
- And more!

We have an app for that!

With the LegalShield and IDShield mobile apps, you can easily begin your Will preparation, track your alerts and have on-the-go access, 24/7 for emergency situations!

AFFORDABLE PROTECTION

Individual plans starting at $8.45 monthly

For more information visit:

The Rambo Group 901-553-0132 http://www.legalshield.com/info/westtnhealth.com

*This is a general overview of the legal and identity theft protection plans available from LegalShield for illustration purposes only. See plan details or plan contract for specific state of residence for complete terms, coverage, amounts, conditions and exclusions.
Google Play and the Google Play logo are trademarks of Google Inc. Apple, the Apple logo, and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.


West Tennessee
HEALTHCARE™