2020 Benefits

Annual Enrollment

West Tennessee HEALTHCARE™

What's in your packet?

September, 2019

Dear Colleagues,

As we approach this year's annual enrollment, we look forward to 2020. Here's to your continued journey to optimal health and overall well-being. Do it for yourself – and for your family! They need you and we do too.

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

Are you leaving money on the table? See page 3 for more information…

Are you currently participating in the PPO plan? See page 3 to learn how you can save hundreds in 2020 on your premiums.

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:
  - o Immunizations
  - o Well woman exam including pap smears
  - o Mammogram
  - o Colonoscopy
  - o 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.

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.

We are honored to have you as a member of our team!

Wendie Carlson, MBA, SPHR, SHRM-CHP
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 2020 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 2020, 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 10, 2019. **WTH Intranet> Links>Employee Self Service Portal**
- ❑ Print confirmation

If you do not actively enroll in 2020 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 17, 2019	Jackson Madison County General Hospital*	7:00 am – 4:00 pm
• October 18, 2019	Jackson Madison County General Hospital*	11:00 am – 7:00 pm
• October 19, 2019	Jackson Madison County General Hospital*	6:30 am – 11:00 am
• October 23, 2019	Volunteer Hospital (Martin)	7:00 am – 1:00 pm
• October 24, 2019	Milan General Hospital	7:00 am – 11:00 am
• October 29, 2019	Camden General Hospital	7:00 am – 11:00 am
• October 30, 2019	Bolivar General Hospital	7:00 am – 11:00 am
• November 1, 2019	Dyersburg Hospital	7:00 am – 4:00 pm
• November 6, 2019	Prime Care Medical Center (Selmer location)	7:00 am – 11:00 am

Are you leaving money on the table?

In order to get maximum contributions from West Tennessee Healthcare into your HRA, HSA or health incentive account, do the following.

- Complete your annual health assessment by December 15, 2019
  - And, $100 will be deposited into your HRA or HSA (Option 1 and 3 participants),
  - Or, $50 will be deposited into your health incentive account (Option 2 PPO plan participants).
  - Incentives will be deposited in January 2020.

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.
  - Once Aetna processes your claim WTH will deposit $100 into your HRA or HSA,
  - Or, $50 will be deposited into your health incentive account (Option 2 PPO plan participants)

Why? Having an established relationship with a PCP is foundational to your health, and preventive medicine is a critical, and free part of your annual wellness regime.

Are you currently enrolled in Option 2 PPO plan?

You could save $$ by changing to Option 1 Deductible with HRA

If you are participating in Option 2 PPO plan you are paying the highest premium. Is this the year you should consider changing to option 1 HRA plan?

You could save up to

- $754 per year for employee coverage,
- $1,768 per year for employee + 1, or
- $2,496 per year for family coverage in 2020 on premiums.

WTH contributes money into your HRA account automatically. These dollars are used to off-set your deductible. If not used they roll over into the next plan year.

Ask Alex… he will help you understand the difference in costs and potentially save you money if you change plans.

Changes to Option 3: High Deductible Plan with Health Savings Account (HSA)

A health savings account holds employees' tax-deductible contributions that can be used for qualified medical expenses (including eligible dental and vision). West Tennessee Healthcare contributes to these accounts, too. HSAs are only available to employees who participate in our high-deductible health plan.

Why consider the high deductible plan with HSA?

- It has the lowest bi-weekly premium because the risk is higher than alternative plans.
- There are several tax advantages:
  - Your contributions are not subject to federal income tax (FIT).
  - Once your account balance reaches $1,000 it will begin to earn interest, and you can choose investment accounts to maximize investment income, which is not subject to FIT.
  - As long as the money in your HSA is used for qualified medical, dental and vision care expenses it isn't taxed as income when you use it.
- HSAs roll over from year to year;
- You own all of the money in your HSA – the money moves with you if you leave WTH.

Often, the notion of a high deductible is frightening, so we are making changes to promote utilization in this plan. WTH contributions are being increased in 2020 to match the amounts contributed to Option 1 Medical Plan with Health Reimbursement Account (HRA):

Coverage	WTH Contributes	If you complete a Health Assessment	If you visit your PCP	Total Possible Funding
Employee	$300	+ $100	+ $100	$500 compared to $350 in 2019
Employee + 1	$550	+ $100	+ $100	$750 compared to $475 in 2019
Family	$800	+ $100	+ $100	$1,000 compared to $600 in 2019

You can also contribute to the plan, using pre-tax dollars. The combined maximum contributions allowed by the Internal Revenue Service (IRS) for 2020 are

Individual	$3,550
Family	$7,100

Catch up contributions up to $1,000 are available if you are 55+ in 2020.

New: Hospital Indemnity Plan

Our hospital indemnity plan provides fixed payments directly to members when they have a covered inpatient hospital.

Health Advocate will not be available effective 1-1-2020

Wellness exams and other preventive services are covered at 100%, regardless of which medical plan you choose.

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.

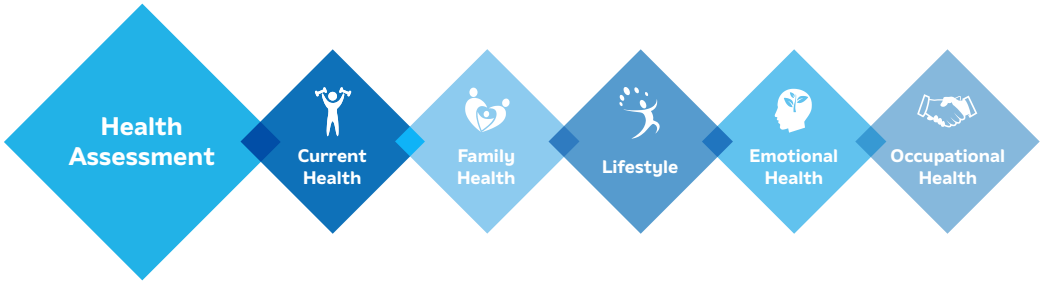
What's in it for me?

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 $100 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, 2020 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 30 days of your benefits-eligibility date for a new hire
- During Annual Enrollment
- Certain changes are permitted within 30 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 30 days of the qualifying event. If you miss the 30 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 30 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

Find the Benefit Plans Your Wallet Will Love

One thing your wallet hates? Paying too much for health insurance when you don't have to. ALEX®, your easy-to-use online benefits counselor, will look at how you and your family use insurance and point out what makes the most sense for you. That way you and your wallet can live happily ever after.

Discover your lowest-cost benefit options (and more) at Myalex.com/wth/2020

alex® | BENEFITS COUNSELOR

West Tennessee HEALTHCARE™

Save the Date: Open Enrollment October 17th - November 10th

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 is a proud participant in the Vanderbilt Health Affiliated Network (VHAN). Our active involvement in VHAN is enabling us to have a larger impact on improving the quality and lowering the cost of health care for patients in our region. Through our work with more than 6,700 providers, 60 hospitals, 15 health systems and hundreds of physician practices and clinics, we strengthen communities and improve the quality of life across the Southeast by promoting and supporting 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. You can benefit from enhanced focus and attention to your preventive health needs, from free cancer screenings to important tests to keep you and your covered family members healthy. You also have access to an expansive team of experts, like pharmacists, social workers and dieticians, working with your provider to support you when needed.

We hope you will choose to receive healthcare at one of West Tennessee Healthcare's access points whenever possible, but through VHAN 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 120 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 120 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 2020
Medical Plan Options

You have three plan options to choose from in 2020. 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 $14/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 2020 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 2020, total contributions may not exceed $3,550 individual coverage or $7,100 for family coverage.		
	Account Funding: The amount WTH contributes to your account depends on who you cover								
	Employee	$300		None			$300		
	Employee +1	$550		None			$550		
	Family	$800		None			$800		
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 $3550/individual or $7100/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 2020.

Prescription Drug Plan for 2020

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

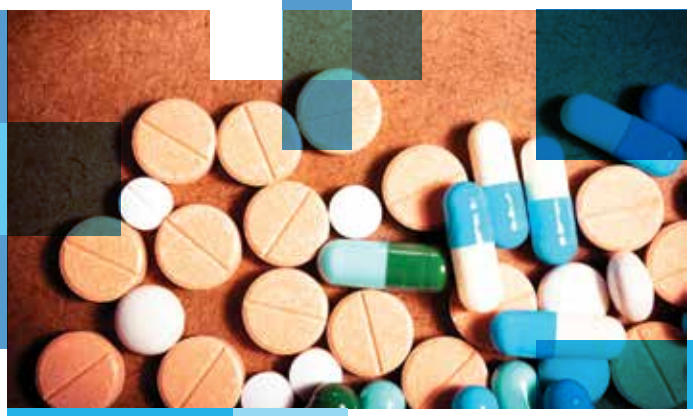
Employee Out of Pocket Maximum for Pharmacy Benefits Only
Medical Plan Option 1: Deductible with HRA Plan and
Medical Plan Option 3: PPO Co-pay Plan

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 $2,700 or $103.84 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 $2,700

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 2020, 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, 2020. 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

Effective with your benefits for 2020, you will have choices in selecting your vision plan. 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 2020

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 with HRA	$59.00	$120.00	$169.00
Employees making less than $14/hour	$71.00	$149.00	$210.00
Employees making between $14 - 74.99/hour	$83.00	$178.00	$251.00
Employees making $75/hour or more			
Option 2: Co-pay Plan Employees making less than $75/hour	$100.00	$217.00	$306.00
Employees making $75/hour or more	$112.00	$246.00	$347.00
Option 3: High Deductible with HSA	$59.00	$116.00	$160.00
Employees making less than $75/hour	$71.00	$145.00	$201.00
Employees making $75/hour or more			
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 with HRA	$118.00	$240.00	$338.00
Employees making less than $14/hour	$142.00	$298.00	$420.00
Employees making between $14 - 74.99/hour	$166.00	$356.00	$502.00
Employees making $75/hour or more			
Option 2: Co-pay Plan Employees making less than $75/hour	$200.00	$434.00	$612.00
Employees making $75/hour or more	$224.00	$492.00	$694.00
Option 3: High Deductible with HSA	$118.00	$232.00	$320.00
Employees making less than $75/hour	$142.00	$290.00	$402.00
Employees making $75/hour or more			
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.

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

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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.

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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**

Allison Wright—Employee Wellness Coordinator
healthyheights@wth.org • 731.265.1119

2020 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 2020 (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 2020 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 2020. Failure to enroll by March 31 deems participants ineligible during the 2020 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 WELLNESS CENTER Disease Management

Meeting your match

West Tennessee HEALTHCARE

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?

Rhonda Taylor
Benefits Administrator
731-265-1128
rhonda.taylor@wth.org

OR

Voya Financial Advisors, Inc.
731-668-9818

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PLAN | INVEST | PROTECT

VOYA® FINANCIAL

Voya.com

Other Voluntary Benefits

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

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

Allstate BENEFITS

Protection for the treatment of cancer and 29 specified diseases

Cancer Insurance

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.

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.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer at initial enrollment
- Includes coverage for cancer and 29 specified diseases
- Benefits are paid directly to you unless otherwise assigned
- Coverage available for dependents
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts (employee only)
- Coverage may be continued; refer to your certificate for details
- Additional benefits have been added to enhance your coverage

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.**

DID YOU KNOW?

Early detection, improved treatments and access to care are factors that influence cancer survival[1]

20.3 million

The number of cancer survivors in the U.S. is increasing, and is expected to jump to nearly 20.3 million by 2026[2]

Offered to the employees of:

West Tennessee Healthcare

[1]Life After Cancer: Survivorship by the Numbers, American Cancer Society, 2017.
[2]Cancer Treatment & Survivorship Facts & Figures, 2016-2017

POD53051

Meet TJ

TJ is like anyone else who has been diagnosed with cancer. He is concerned about his wife and how she will cope with his disease and its treatment. Most importantly, he worries about how he will pay for his treatment.

Here is what weighs heavily on his mind:

- Major medical only pays a portion of the expenses associated with my treatment
- I have copays I am responsible for until I meet my deductible
- If I am not working due to treatments, I must cover my bills, rent/mortgage, groceries and other daily expenses
- If the right treatment is not available locally, I will have to travel to get the treatment I need

Here's how TJ's story of diagnosis and treatment turned into a happy ending, because he had supplemental Cancer Insurance to help with expenses.

CHOOSE

TJ chooses benefits to help protect himself and his wife if diagnosed with cancer or a specified disease

USE

TJ undergoes his annual wellness test and is diagnosed for the first time with prostate cancer. His doctor reviews the results with him and recommends pre-op testing and surgery.

Here's TJ's treatment path:

- TJ travels to a specialized hospital 400 miles from where he lives and undergoes pre-op testing
- He is admitted to the hospital for laparoscopic prostate cancer surgery
- TJ undergoes surgery and spends several hours in the recovery waiting room
- He is transferred to his room where he is visited by his doctor during a 2-day hospital stay
- TJ is released under doctor required treatment and care during a 2-month recovery period

TJ continues to fight his cancer and follow his doctor recommended treatments.

CLAIM

TJ's Cancer claim paid him cash benefits for the following:

Wellness
Cancer Initial Diagnosis
Continuous Hospital Confinement
Non-Local Transportation
Surgery
Anesthesia
Medical Imaging
Inpatient Drugs and Medicine
Physician's Attendance
Anti-Nausea

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits
An easy-to-use website that offers 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.

Wellness Benefit

Biopsy for skin cancer; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer), 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.

Benefits (subject to maximums as listed on the attached rate insert)

HOSPITAL CONFINEMENT AND RELATED BENEFITS

Continuous Hospital Confinement - inpatient admission and confinement

Government or Charity Hospital - confinements in lieu of all other benefits, except Waiver of Premium

Private Duty Nursing Services - full-time nursing services authorized by attending physician

Extended Care Facility - within 14 days of a hospital stay; payable up to the number of days of the hospital stay

At Home Nursing - private nursing care must begin within 14 days of a covered hospital stay; payable up to the number of days of the previous hospital stay

Hospice Care Center or Team - terminal illness care in a facility or at home; one visit per day

RADIATION/CHEMOTHERAPY AND RELATED BENEFITS

Radiation/Chemotherapy for Cancer - covered treatments to destroy or modify cancerous tissue

Blood, Plasma and Platelets - transfusions, administration, processing, procurement, cross matching

Hematological Drugs - boosts cell lines for white/red cell counts and platelets; payable when Radiation/Chemotherapy for Cancer benefit is paid

Medical Imaging - initial diagnosis or follow-up evaluation based on covered imaging exam

SURGERY AND RELATED BENEFITS

Surgery* - based on Certificate Schedule of Surgical Procedures

Anesthesia - 25% of Surgery benefit for anesthesia received by an anesthetist

Bone Marrow or Stem Cell Transplant - autologous, non-autologous for treatment of cancer or specified disease other than Leukemia, or non-autologous for treatment of Leukemia

Ambulatory Surgical Center - payable only if Surgery benefit is paid

Second Opinion - second opinion for surgery or treatment by a doctor not in practice with your doctor

MISCELLANEOUS BENEFITS

Inpatient Drugs and Medicine - not including drugs/medicine covered under the Radiation/Chemotherapy for Cancer or Anti-Nausea benefits

Physician's Attendance - one inpatient visit by one physician

Ambulance - transfer to or from hospital where confined by a licensed service or hospital-owned ambulance

Non-Local Transportation - obtaining treatment not available locally

Outpatient Lodging - more than 100 miles from home

Family Member Lodging and Transportation - adult family member travels with you during non-local hospital stays for specialized treatment. Transportation not paid if Non-Local Transportation benefit is paid

Physical or Speech Therapy - to restore normal body function

New or Experimental Treatment - payable if physician judges to be necessary and only for treatment not covered under other policy benefits

Prosthesis - surgical implantation of prosthetic device for each amputation

Hair Prosthesis - wig or hairpiece every two years due to hair loss

Nonsurgical External Breast Prosthesis - initial prosthesis after a covered mastectomy

Anti-Nausea Benefit - prescribed anti-nausea medication administered on outpatient basis

Waiver of Premium** - must be disabled 90 days in a row due to cancer, as long as disability lasts

OPTIONAL/ADDITIONAL BENEFITS

Cancer Initial Diagnosis - for first-time diagnosis of cancer other than skin cancer

Wellness Benefit - once per year for one of 23 exams. See left for list of wellness tests

SPECIFIED DISEASES

29 Specified Diseases Covered - 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

*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. Does not pay for other surgeries covered by other benefits **Premiums waived for employee only

Cancer Insurance (GVCP3)

Includes coverage for 29 Specified Diseases

from Allstate Benefits

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 1
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	$200
Hospice Care Team (per visit)	$200
RADIATION/CHEMOTHERAPY/RELATED BENEFITS	**PLAN 1**
Radiation/Chemotherapy for Cancer[1] (every 12 months)	$10,000
Blood, Plasma, and Platelets[1] (every 12 months)	$10,000
Hematological Drugs[1] (every 12 months)	$200
Medical Imaging[1] (every 12 months)	$500
SURGERY AND RELATED BENEFITS	**PLAN 1**
Surgery[2]	$1,500
Anesthesia (% of surgery benefit)	25%
Bone Marrow or Stem Cell Transplant (once/year)	
1. Autologous	$500
2. Non-autologous (cancer or specified disease treatment)	$1,250
3. Non-autologous (Leukemia)	$2,500
Ambulatory Surgical Center (daily)	$250
Second Opinion	$200
MISCELLANEOUS BENEFITS	**PLAN 1**
Inpatient Drugs and Medicine (daily)	$25
Physician's Attendance (daily)	$50
Ambulance (per confinement)	$100
Non-Local Transportation[1] (coach fare or amount shown per mile*)	0.40/Mile
Outpatient Lodging (daily; limit $2,000/12 mo. period)	$50
Family Member Lodging (daily per trip; max. 60 days)	$50
and Transportation (coach fare or amount shown per mile**)	0.40/Mile
Physical or Speech Therapy (daily)	$50
New or Experimental Treatment[3] (every 12 months)	$5,000
Prosthesis[3] (per amputation)	$2,000
Hair Prosthesis (every 2 years)	$25
Nonsurgical External Breast Prosthesis[1]	$50
Anti-Nausea Benefit[1] (once per calendar year)	$200
Waiver of Premium (employee only)	Yes
OPTIONAL/ADDITIONAL BENEFITS	**PLAN 1**
Cancer Initial Diagnosis (one-time benefit)	$2,000
Wellness Benefit	$100

[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. *At least 70 miles away, up to 700 miles. **Transportation up to 700 miles per continuous hospital confinement.

PLAN 1 PREMIUMS

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

Issue ages: 18 and over if actively at work

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

FOR HOME OFFICE USE ONLY - GVCP3

Opt 1-2Hosp; 4Rad; 1Surg; 1Misc; 2Init; 0ICU; 4Well; 0Prog

V.2019.05.29 FA Rate Insert Creation Date: 8/30/2019

Practical benefits for everyday living.℠

When you choose Allstate Benefits, you receive more than just coverage that helps you protect your finances when faced with life's uncertainties; you also get the support of the Good Hands® promise.

We've been insuring and protecting families for over 50 years with the name that America knows and trusts. Our affordable and valuable coverage options help empower hard-working individuals and their families to make the best decisions for their care and finances.

After you've elected coverage, register with our website, MyBenefits, for anytime access to your coverage and benefit information. Plus, MyBenefits allows you to file fast and easy claims that we'll deposit right into your bank account (direct deposit authorization required).

Allstate Benefits. We can help give you and your family financial peace of mind. Are you in good hands?®

DEFINITIONS

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.

CERTIFICATE SPECIFICATIONS

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

Termination of Coverage
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.

Spouse/domestic partner coverage ends upon divorce/termination of partnership or your death. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Portability Privilege
Coverage may be continued under the Portability Provision when coverage under the policy ends. Refer to your Certificate of Insurance for details.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation
We do not pay benefits for a pre-existing condition during the 12-month period beginning on the date that person's coverage starts. 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. A pre-existing condition can exist even though a diagnosis has not yet been made.

Exclusions and Limitations
We do not pay for any loss except for losses due to cancer or a specified disease. Benefits are not paid for conditions caused or aggravated by cancer or a specified disease. Treatment and services must be needed due to cancer or a specified disease and be received in the United States or its territories.

Hospice Care Team Limitation: Services are not covered for food or meals, well-baby care, volunteers or support for the family after covered person's death.

Blood, Plasma and Platelets Limitation: Does not include immunoglobulins or blood replaced by donors.

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.

For the **Radiation/Chemotherapy for Cancer** benefit, we do not pay for: any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; treatment planning, consultation or management; the design and construction of treatment devices; basic radiation dosimetry calculation; any type of laboratory tests; X-ray or other imaging used for diagnosis or monitoring; the diagnostic tests related to these treatments; or any devices or supplies including intravenous solutions and needles related to these treatments.

Allstate BENEFITS

This brochure is for use in enrollments sitused in TN and is incomplete without the accompanying rate insert.

This material is valid as long as information remains current, but in no event later than August 30, 2022.
Group Cancer benefits are provided under policy form GVCP3, or state variations thereof.

The coverage provided is 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. There may be instances when a law requires that benefits under this coverage be paid to a third party, rather than to you. If you or a dependent have coverage under Medicare, Medicaid, or a state variation, please refer to your health insurance documents to confirm whether assignments or liens may apply.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

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.

Allstate BENEFITS

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

Accident Insurance

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right 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.

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 support, thanks to the cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to be on the mend.

Here's How It Works

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

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer
- Benefits are paid directly to you unless otherwise assigned
- Pays in addition to other insurance coverage
- Coverage also available for your dependents
- Premiums are affordable and can be conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details

With Allstate Benefits, you can protect your finances against life's slips and falls. **Are you in Good Hands? You can be.**

*National Safety Council, Injury Facts®, 2017 Edition

DID YOU KNOW?

The number of injuries suffered by workers in one year, both on- and off-the-job, includes:*

ON-THE-JOB (in millions)

Work **4.4**

OFF-THE-JOB (in millions)

Home **9.2**

Non-Auto **4.0**

Auto **2.2**

Offered to the employees of:

West Tennessee Healthcare

POD53050

Meet Daniel & Sandy

Daniel and Sandy are like most active couples: they enjoy the outdoors and a great adventure. They have seen their share of bumps, bruises and breaks. Sandy knows an accidental injury could happen to either of them. Most importantly, she worries about how they will pay for it.

Here is what weighs heavily on her mind:

- Major medical will only pay a portion of the expenses associated with injury treatments
- They have copays they are responsible for until they meet their deductible
- If they miss work because of an injury, they must cover the bills, rent/mortgage, groceries and their child's education
- If they need to seek treatment not available locally, they will have to pay for it

Daniel's story of injury and treatment turned into a happy ending, because he had supplemental Accident Insurance to help with expenses.

CHOOSE

Daniel and Sandy choose benefits to help protect their family if they suffer an accidental injury.

USE

Daniel was playing a pick-up game of basketball with his friends when he went up for a jump-shot and, on his way back down, twisted his foot and ruptured his Achilles tendon.

Here's Daniel's treatment path:

- Taken by ambulance to the emergency room
- Examined by a doctor and X-rays were taken
- Underwent surgery to reattach the tendon
- Was visited by his doctor and released after a one-day stay in the hospital
- Had to immobilize his ankle for 6 weeks
- Was seen by the doctor during a follow-up visit and sent to physical therapy to strengthen his leg and improve his mobility

Daniel would go online after each of his treatments to file claims. The cash benefits were direct deposited into his bank account.

Daniel is back playing basketball and enjoying life.

CLAIM

Daniel's Accident claim paid cash benefits for the following:

Ambulance Services
Medicine
Medical Expenses (Emergency Room and X-rays)
Initial Hospital Confinement
Hospital Confinement
Tendon Surgery
General Anesthesia
Accident Follow-Up Treatment
Physical Therapy (3 days/week)

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.

Finances

Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel

Can help pay for expenses while receiving treatment in another city.

Home

Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses

Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access

allstatebenefits.com/mybenefits

An easy-to-use website that offers 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.

Dependent Eligibility

Coverage may include you, your spouse and your children.

[1]Multiple dismemberments, dislocations or fractures are limited to the amount shown in the rate insert. [2]Up to three times per covered person, per accident. [3]Two or more surgeries done at the same time are considered one operation. [4]Paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. [5]Two treatments per covered person, per accident. *Must begin or be received within 180 days of the accident. **Within 3 days after the accident.

Benefits (subject to maximums as listed on the attached rate insert)

BASE POLICY BENEFITS

Accidental Death*

Common Carrier Accidental Death - riding as a fare-paying passenger on a scheduled common-carrier

Dismemberment[1,]* - amount paid depends on type of dismemberment. See Injury Benefit Schedule in rate insert

Dislocation or Fracture[1] - amount paid depends on type of dislocation or fracture. See Injury Benefit Schedule in rate insert

Initial Hospitalization Confinement - initial hospitalization after the effective date

Hospital Confinement - up to 90 days for any one injury

Intensive Care - up to 90 days for each period of continuous confinement

Ambulance Services - transfer to or from hospital by ambulance service

Medical Expenses - expenses incurred for medical or surgical treatment. Expenses are limited to physician fees, X-rays and emergency room services. Includes treatment for dental repair to sound natural teeth if repair is diagnosed by a dentist as necessary and as a result of injury

Outpatient Physician's Treatment - treatment outside the hospital for any cause. Payable up to 2 visits per covered person, per calendar year and a maximum of 4 visits per calendar year if dependents are covered

BENEFIT ENHANCEMENT RIDER

Hospital Admission** - first hospital confinement occurring during a calendar year, and 12 months after rider effective date. Payable when a benefit has been paid under the Hospital Confinement Benefit in the base policy

Lacerations** - treatment for one or more lacerations (cuts)

Burns** - treatment for one or more burns, other than sunburns

Skin Graft - receiving a skin graft for which a benefit is paid under the Burns benefit

Brain Injury Diagnosis** - first diagnosis of concussion, cerebral laceration, cerebral contusion or intracranial hemorrhage within three days of an accident. Must be diagnosed within 30 days after the accident by CT Scan, MRI, EEG, PET scan or X-ray

Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)* - must first be treated by a physician within 30 days after the accident

Paralysis** - spinal cord injury resulting in complete/permanent loss of use of two or more limbs for at least 90 days

Coma with Respiratory Assistance - unconsciousness lasting 7 or more days; intubation required. Medically induced comas excluded

Open Abdominal or Thoracic Surgery[3,] **

Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery[3,] * - surgery received for torn, ruptured, or severed tendon, ligament, rotator cuff or knee cartilage; pays the reduced amount shown for arthroscopic exploratory surgery

Ruptured Disc Surgery[3,] * - diagnosis and surgical repair to a ruptured disc of the spine by a physician

Eye Surgery - surgery or removal of a foreign object by a physician

General Anesthesia* - payable only if the policy Surgery benefit is paid

Blood and Plasma** - transfusion after an accident

Appliance - physician-prescribed wheelchair, crutches or walker to help with personal locomotion or mobility

Medical Supplies - purchased over-the-counter medical supplies. Payable only if the policy Medical Expenses benefit is paid

Medicine - purchased prescription or over-the-counter medicines. Payable only if the policy Medical Expenses benefit is paid

Prosthesis* - physician-prescribed prosthetic arm, leg, hand, foot or eye lost as a result of an accident. Payable only if a benefit is paid for loss of arm, leg, hand, foot or eye under the Dismemberment benefit

Physical Therapy - one treatment per day; maximum of 6 treatments per accident. Chiropractic services are excluded. Not payable for same visit for which Accident Follow-Up Treatment benefit is paid. Must take place no longer than 6 months after accident

Rehabilitation Unit[4] - must be hospital-confined due to an injury immediately prior to being transferred to rehab. Not payable for the days on which the Hospital Confinement benefit is paid

Non-Local Transportation[2] - treatment obtained at a non-local hospital or freestanding treatment center more than 100 miles from your home. Does not cover ambulance or physician's office or clinic visits for services other than treatment

Family Member Lodging - one adult family member to be with you while you are confined in a non-local hospital or freestanding treatment center. Not payable if family member lives within 100 miles one-way of the treatment facility. Up to 30 days per accident. Only payable if the Non-Local Transportation benefit is paid

Post-Accident Transportation - after a three-day hospital stay more than 250 miles from your home, with a flight on a common carrier to return home. Payable only if a benefit is paid for Hospital Confinement

Accident Follow-Up Treatment[5] - must take place no longer than 6 months after the accident. Payable only if the policy Medical Expenses benefit is paid. Not payable for the same visit for which the Physical Therapy benefit is paid

Group Voluntary Accident (GVAP1)

On- and Off-the-Job Accident Insurance from Allstate Benefits

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the brochure

BASE POLICY BENEFITS		PLAN 1
Accidental Death	Employee	$40,000
	Spouse	$20,000
	Children	$10,000
Common Carrier Accidental Death (fare-paying passenger)	Employee	$200,000
	Spouse	$100,000
	Children	$50,000
Dismemberment[1]	Employee	$40,000
	Spouse	$20,000
	Children	$10,000
Dislocation or Fracture[1]	Employee	$4,000
	Spouse	$2,000
	Children	$1,000
Initial Hospitalization Confinement (pays once)		$1,000
Hospital Confinement (pays daily)		$200
Intensive Care (pays daily)		$400
Ambulance Services	Ground	$200
	Air	$600
Medical Expenses (pays up to amount shown)		$500
Outpatient Physician's Treatment (pays per visit)		$50.00

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

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

PLAN 1 PREMIUMS

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

Issue ages: 18 and over if actively at work

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

Injury Benefit Schedule is on reverse

FOR HOME OFFICE USE ONLY - GVAP1
Opt 1 - 2.0U Base; 1.0U BER
ABQ V02.13.2019 Rate Insert Creation Date: 8/30/2019

INJURY BENEFIT SCHEDULE

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

COMPLETE DISLOCATION	PLAN 1
Hip joint	$4,000
Knee or ankle joint[3], bone or bones of the foot[3]	$1,600
Wrist joint	$1,400
Elbow joint	$1,200
Shoulder joint	$800
Bone or bones of the hand[3], collarbone	$600
Two or more fingers or toes	$280
One finger or toe	$120
COMPLETE, SIMPLE OR CLOSED FRACTURE	**PLAN 1**
Hip, thigh (femur), pelvis[4]	$4,000
Skull[4]	$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[4], hand or wrist[4]	$1,400
Lower jaw[4]	$800
Two or more ribs, fingers or toes, bones of face or nose	$600
One rib, finger or toe, coccyx	$280
LOSS	**PLAN 1**
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

[3]Knee joint (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). [4]Pelvis (except coccyx). Skull (except bones of face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

CERTIFICATE SPECIFICATIONS

Conditions and Limits
When an injury results in a covered loss within 90 days (unless otherwise stated on the Benefits page) 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.

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

Dependent Eligibility/Termination
Coverage may include you, your spouse and your children. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Spouse coverage ends upon valid decree of divorce or your death.

When Coverage Ends
Coverage under the policy and riders (if included) ends on the earliest of: the date the policy or certificate is canceled; the last day of the period for which you made any required contributions; the last day you are in active employment, except as provided under the Temporarily Not Working provision; the date you are no longer in an eligible class; or the date your class is no longer eligible.

Continuing Your Coverage
You may be eligible to continue coverage when coverage under the policy ends. Refer to your Certificate of Insurance for details.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations for the Base Policy and Benefit Enhancement Rider: Benefits are not paid for: injury incurred before the effective date; act of war or participation in a riot, insurrection or rebellion; suicide or attempt at suicide; injury while under the influence of alcohol or any narcotic, unless taken upon the advice of a physician; any bacterial infection (except pyogenic infections from an accidental cut or wound); participation in aeronautics unless a fare-paying passenger on a licensed common-carrier aircraft; committing or attempting an assault or felony; driving in any race or speed test or testing any vehicle on any racetrack or speedway; hernia, including complications; serving as an active member of the Military, Naval, or Air Forces of any country or combination of countries.

This brochure is for use in enrollments sitused in TN and is incomplete without the accompanying rate insert.

This material is valid as long as information remains current, but in no event later than August 30, 2022.

Group Accident benefits are provided under policy form GVAP1, or state variations thereof. Benefit Enhancement Rider benefits are provided under rider form GVAPBER, or state variations thereof.

The coverage provided is 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. There may be instances when a law requires that benefits under this coverage be paid to a third party, rather than to you. If you or a dependent have coverage under Medicare, Medicaid, or a state variation, please refer to your health insurance documents to confirm whether assignments or liens may apply.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

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.

Allstate BENEFITS

Allstate BENEFITS

Protection when faced with a critical illness diagnosis and you need treatment

Critical Illness Insurance

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly and stress levels may rise.

Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Here's How It Works

You choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer at initial enrollment
- Coverage available for dependents
- Covered dependents receive 50% of your Basic-Benefit Amount
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are affordable and conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details
- 25% of your Basic-Benefit Amount is paid for Advanced Alzheimer's Disease and Advanced Parkinson's Disease

With Allstate Benefits, you can make treatment decisions without putting your finances at risk. **Are you in Good Hands? You can be.**

[1]https://www.cdc.gov/heartdisease/heart_attack.htm
[2]https://www.cdc.gov/stroke/facts.htm

DID YOU KNOW ?

Every **40 seconds,** an American will suffer a heart attack[1]

Every **40 seconds,** someone in the U.S. has a stroke[2]

Offered to the employees of:

West Tennessee Healthcare

Meet Ashley

Ashley is like any single parent who has been diagnosed with a critical illness. She's worried about her future, her children and how they will cope with her treatments. Most importantly, she worries about how she will pay for it all.

Here is what weighs heavily on her mind:

- Major medical only pays a portion of the expenses associated with my treatment
- I have copays I am responsible for until I meet my deductible
- If I am not working due to my treatments, I must cover my bills, rent/mortgage, groceries and my children's education
- If the right treatment is not available locally, I will have to travel to get the treatment I need

Ashley's story of diagnosis and treatment turned into a happy ending, because she had supplemental Critical Illness Insurance to help with expenses.

CHOOSE

Ashley chooses Critical Illness benefits to help protect her and her children, if they are diagnosed with a critical illness.

USE

During Ashley's annual wellness exam, her doctor noticed an irregular heartbeat. She underwent an electrocardiogram (EKG) test and stress test, which confirmed she had a blockage in one of her coronary arteries.

Here's Ashley's treatment path:

- Ashley has her annual wellness exam
- Her doctor notices an abnormality in her heartbeat; tests are performed and she is diagnosed with coronary artery disease
- After visits with doctors, surgeons and an anesthesiologist, Ashley undergoes surgery
- Surgery is performed to remove the blockage with a bypass graft. She is visited by her doctor during a 4-day hospital stay and released
- Ashley follows her doctor required treatment during a 2-month recovery period, and has regular doctor office visits

Ashley is doing well and is on the road to recovery.

CLAIM

Ashley's Critical Illness claim paid her cash benefits for the following:

Wellness

Coronary Artery Bypass Surgery

The cash benefits were direct deposited into her bank account.

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits
Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits

An easy-to-use website that offers 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.

Wellness - Biopsy for skin cancer; Bone Marrow Testing; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer), PSA (prostate cancer); 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; Ultrasound screening for abdominal aortic aneurysms.

Benefits (subject to maximums as listed on the attached rate insert)

Benefit paid upon diagnosis of one of the following conditions

INITIAL CRITICAL ILLNESS BENEFITS*

Heart Attack - the death of a portion of the heart muscle due to inadequate blood supply. Established (old) myocardial infarction and cardiac arrest are not covered

Stroke - the death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. Transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are not covered

Major Organ Transplant - transplant of heart, lung, liver, pancreas or kidneys. Transplanted organ must come from a human donor

End Stage Renal Failure - irreversible failure of both kidneys, resulting in peritoneal dialysis or hemodialysis. Renal failure caused by traumatic events, including surgical trauma, are not covered

Coronary Artery Bypass Surgery - to correct narrowing or blockage of one or more coronary arteries with bypass graft. Abdominal aortic bypass, balloon angioplasty, laser embolectomy, atherectomy, stent placement and non-surgical procedures are not covered

Waiver of Premium (employee only) - premiums waived if disabled for 90 consecutive days due to a critical illness

CANCER CRITICAL ILLNESS BENEFITS*

Invasive Cancer - malignant tumor with uncontrolled growth, including Leukemia and Lymphoma. Carcinoma in situ, non-invasive or metastasized skin cancer and early prostate cancer are not covered

Carcinoma In Situ - non-invasive cancer, including early prostate cancer (stages A, I, II) and melanoma that has not invaded the dermis. Other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), benign tumors and polyps are not covered

SUPPLEMENTAL CRITICAL ILLNESS I BENEFITS*

Advanced Alzheimer's Disease - must exhibit impaired memory and judgment and be certified unable to perform at least three daily activities[1] without adult assistance

Advanced Parkinson's Disease - must exhibit two or more of the following: muscle rigidity, tremor, or bradykinesis (slowness in physical and mental responses); and be certified unable to perform at least three daily activities[1] without adult assistance

Benign Brain Tumor - a non-cancerous tumor confirmed by biopsy or surgical excision, or specific neuroradiological examination, and persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption. Tumors of the skull, pituitary adenomas, and germinomas are not covered

Coma - unconsciousness due to sickness or traumatic brain injury, with severe neurologic dysfunction and unresponsiveness for 14 consecutive days. Requires significant medical intervention and life support. Medically induced Coma is not covered

Complete Blindness - irreversible reduction of sight in both eyes

Complete Loss of Hearing - total and irreversible loss of hearing in both ears

Paralysis - total and permanent loss of voluntary movement or motor function of 2 or more limbs

Occupational HIV - exposure to HIV must be accidental and during normal occupational duties. Must not have previously tested positive for HIV

OPTIONAL/ADDITIONAL BENEFIT

Wellness Benefit - 23 exams. Once per person, per calendar year; see left for list of wellness services and tests

*Benefits paid once per covered person. When all benefits have been used, the coverage terminates.
[1] Daily activities include: bathing, dressing, toileting, bladder and bowel continence, transferring and eating.

Critical Illness Insurance (GVCIP2)

from **Allstate Benefits**

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
Major Organ Transplant (100%)	$10,000	$20,000
End Stage Renal Failure (100%)	$10,000	$20,000
Coronary Artery Bypass Surgery (25%)	$2,500	$5,000
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
OPTIONAL/ADDITIONAL BENEFIT	**PLAN 1**	**PLAN 2**
Wellness Benefit (per year)	$50	$50

See reverse for premiums

PLAN 1 - BI-WEEKLY PREMIUMS

$10,000 Basic Benefit Amount

AGE	EE, EE + CH	EE + SP, F
	Non-Tobacco	
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	
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 - BI-WEEKLY PREMIUMS

$20,000 Basic Benefit Amount

AGE	EE, EE + CH	EE + SP, F
	Non-Tobacco	
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	
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

FOR HOME OFFICE USE ONLY - GVCIP2
Opt 1 - PX; 1.0U Base; CR; SBR W; 2.0U WR;
Opt 2 - PX; 2.0U Base; CR; SBR W; 2.0U WR;
ABQ V 12.31.2018 Proposal Creation Date: 8/30/2019

CERTIFICATE SPECIFICATIONS

Eligibility
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.

Dependent Eligibility/Termination
Family members eligible for coverage are your spouse or domestic partner and children. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Spouse coverage ends upon valid decree of divorce or your death. Domestic partner coverage ends when the domestic partnership ends or your death.

When Coverage Ends
Coverage under the policy ends on the earliest of: the date the policy is canceled; you stop paying your premium; the last day of active employment; you are no longer eligible; a false claim is filed; when all benefits have been paid under the policy.

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

BENEFIT CONDITIONS

Conditions and Limits
A diagnosis occurring before your coverage begins is not payable; however, a diagnosis of any covered critical illness after your effective date will be payable. Benefits are subject to the Pre-Existing Condition Limitation, as well as all other limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the certificate and be diagnosed by a physician while coverage is in effect. The date of diagnosis for each illness must be separated by 30 days. Emergency situations outside the U.S. will be considered when you return to the U.S.

If the first diagnosis of cancer occurs before the effective date of coverage, benefits are paid for a subsequent diagnosis of cancer after the effective date, subject to the terms and conditions in the certificate.

Pre-Existing Condition Limitation
Benefits are not paid 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. 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 medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

Exclusions
Benefits are not paid for: war or participation in a riot, insurrection or rebellion; intentionally self-inflicted injury or action; illegal activities or occupations; suicide while sane, or self-destruction while insane, or any attempt at either; substance abuse, including alcohol, alcoholism, drug addiction, or dependence upon any controlled substance.

Allstate BENEFITS

This brochure is for use in enrollments sitused in TN, and is incomplete without the accompanying rate insert.

This material is valid as long as information remains current, but in no event later than August 30, 2022.

Group Critical Illness benefits are provided under policy form GVCIP2, or state variations thereof.

The coverage provided is limited benefit supplemental critical Illness insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations, are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

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®

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.

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.

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.

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

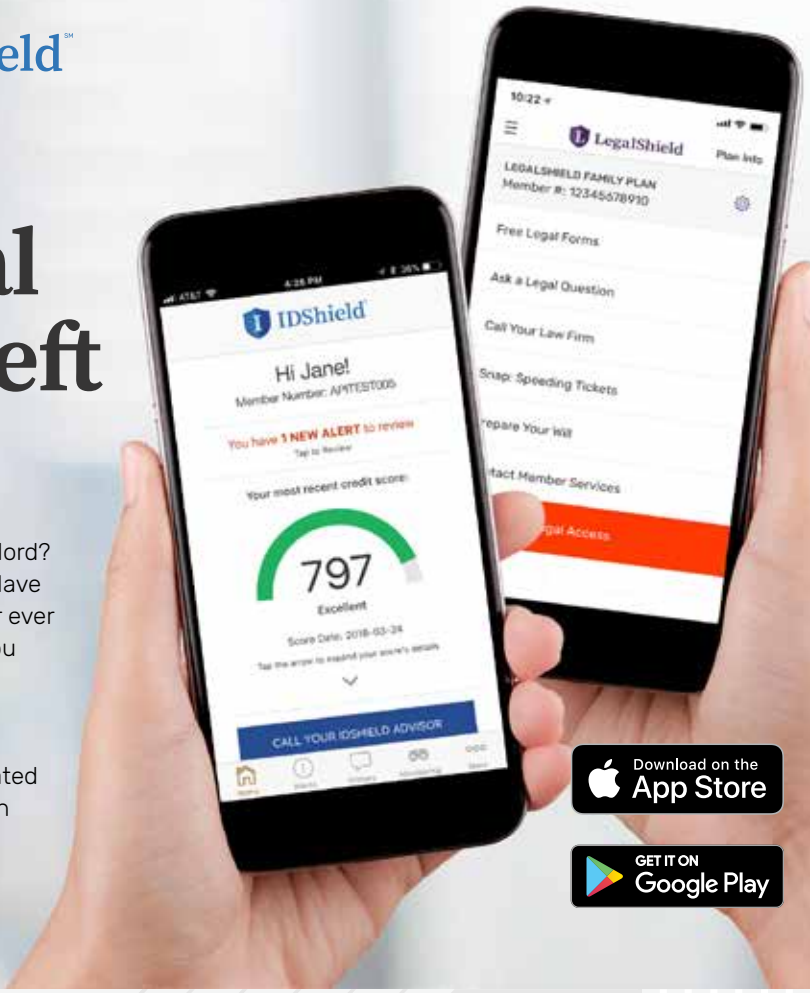
Combined Insurance Company of America
Chicago, IL

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.



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.

NEW

Hospital Indemnity Plan

INFORMATION WILL BE POSTED ON THE INTRANET


West Tennessee
HEALTHCARE