TEAM MEMBER BENEFITS GUIDE

MOUNTAIN STATES HEALTH ALLIANCE

FY18

JULY 2017 - JUNE 2018

Important Contacts

Use this directory to locate contact information for all services described within this guide.

Coverage	Carrier	Phone	Web
Human Resources	HR4U Hotline	(423)431-HR4U (4748) Fax: (423)262-4703	HR4U@msha.com
Medical Plans	BlueCross BlueShield of Tennessee	(800)565-9140	www.bcbst.com/msha
Pharmacy Plans	American Health Care Mountain States Pharmacy, refills & delivery	(800)872-8276 (423)232-9857	https://www.americanhealthcare.com
Telehealth	AmWell	(855)818-DOCS	www.msha.amwell.com
Employee Assistance program (EAP)	Mountain States Psychiatry	M – Th: 8 a.m. – 5 p.m. F: 8 a.m. – noon, (423) 302-3480 All other hours, (800) 366-1132	
Dental Plans	Delta Dental	(800)223-3104	www.deltadentaltn.com
Vision Plans	Vision Service Plan (VSP)	(800)877-7195	www.vsp.com/go/mountainstateshealthalliance
Short-Term & Long-Term Disability	Matrix Absence Management	(866)533-3438	www.matrixeservices.com
Long-Term Care Insurance	UNUM Policy 499567	(800)227-4165	
Health Savings Account	Optum Bank	(844)326-7967	www.optumbank.com
Flexible Spending Account	Optum Bank	(800)243-5543	www.optumhealthfinancial.com
Retirement Plan	Lincoln Financial Group	(800)234-3500	www.lfg.com
Voluntary Benefits:			
Critical Illness and Accident	Aflac Group	(800)433-3036	www.aflacgroupinsurance.com
Voluntary Disability Insurance	Colonial Life	(800)325-4368	www.coloniallife.com
Whole Life Insurance	UNUM	(800)635-5597	www.unum.com/employees
Auto & Home Insurance	Travelers	(888)695-4640	www.travelers.com/msha
Identify Theft	ID Commander	(855)592-7941	www.idcommander.com
Pet Insurance	Pet First	(866)937-PETS (7387)	www.petfirst.com/msha
Purchasing Power	Purchasing Power	(866)670-3479	www.MSHA.PurchasingPower.com
Personal and Family Legal Coverage	LegalGUARD Plan by LegalLEASE	(888)416-4313	http://msha.vsc-legalease.com
EnrollVB	Voluntary Benefits Informational Portal Please identify yourself as a MSHA team Member	(877)454-3001	service@willard-block.com www.EnrollVB.com/MSHA

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MOUNTAIN STATES HEALTH ALLIANCE

Welcome

Mountain States Health Alliance (MSHA) provides you with a variety of benefits to help meet your needs and the needs of your family, including healthcare coverage, disability coverage, life insurance and more. If you are a current team member, you can make changes to your benefits each year during the Open Enrollment period for the following plan year (July 1st – June 30th).

If you are a newly eligible team member, you must enroll within 30 days of the date you became eligible. You must complete the online enrollment before any benefits are effective, including the company paid benefits.

To help you get ready to enroll, this benefits guide includes information about:

- Benefits basics, such as who is eligible and when coverage is effective
- The online enrollment system and how to use it
- Your benefit options
- Other benefits MSHA offers
- Important federally required notices

Important Reminders

This Benefits Guide contains important information about MSHA Benefit plans effective from July 1, 2017 – June 30, 2018.

All information in this guidebook is subject to change without notice. Please refer to the MSHA Benefits Site (found on the Pulse Intranet page) for additional information and useful links.

Discuss the benefit choices with your covered family members.

Complete enrollment online in the HR & Payroll Service Center. Newly eligible team members must enroll within 30 days of the date you become eligible.

Team Members currently covered may make changes to their elections by completing open enrollment from April 17 - April 30, 2017. Changes will be effective July 1, 2017.

If you do not complete open enrollment, your current elections will continue 7/1/2017 – 6/30/2018, except contributions to flexible spending accounts and health savings accounts.

Once you have made your elections, you cannot change benefits until the next annual Open Enrollment unless you have a qualified life event.

Eligiblity

Who Is Eligible

You are eligible to participate in the MSHA benefit plans if you work at least 30 hours per week or more, and are classified in a benefit eligible position.

When Coverage Begins

Coverage is effective the 1st of the second calendar month following date of employment in a benefit eligible position. For example, a team member hired into a benefit eligible position in January will have benefits effective March 1st.

If an eligible team member is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all his or her Covered Dependents will be deferred until the date the Employee is Actively at Work.

If you are a current team member who experiences a Qualified Life Event, your benefit changes are effective the 1st of the month following notification of event and receipt of required documents. (See section on Mid-Year Changes).

Dependents

If you are eligible for benefits you may insure your spouse and children (ages birth up to 26) under the medical, dental, vision, dependent life and family AD&D (accidental death and dismemberment) policies.

Duplicate Coverage

If you and your spouse both work for Mountain States Health Alliance and are both eligible for benefits:

You can each be covered as a team member or as a dependent, but not both.

If each of you is covered as a team member, your dependent children may be covered by either of you, but not by both.

What is a Spousal Surcharge?

A Spousal Surcharge is an additional charge for a spouse to be covered on MSHA's medical plan when he/she is eligible for their own employer-sponsored coverage.

If your spouse…	Is enrolled in the MSHA medical plan…
Is eligible for his or her employer's medical coverage, whether or not they are enrolled	You will pay the surcharge
Employer does not offer medical coverage or your spouse is not eligible for medical coverage	You will not pay the surcharge
Is self-employed and has no coverage available	You will not pay the surcharge
Is not employed	You will not pay the surcharge
Also works at MSHA, in a benefit eligible position	You will not pay the surcharge

Enrollment

Enrolling in benefits is simple through the online enrollment system – just follow the steps below:

1. If you are at a MSHA facility, open Internet Explorer and access the MSHA home page. Then click on "HR & Payroll Service Center" on the left hand side.
Read and accept the disclaimer – you may need to maximize your page or scroll down to see the entire page.

2. If you are at home, go to www.mountainstateshealth.com then locate the "Physicians & Team Members" heading (at the top right) and scroll to "HR & Payroll Service Center" under "Team Members"

3. Enter your user ID and password. Your user ID is your Network Sign-on and your password is the last four digits of your Social Security number and the four digits of your birth year (eight numbers in total).

4. Select "Benefits", then "New Hire Enrollment". (Or select "Open Enrollment" if you are selecting your annual enrollment for July 1st). The system will walk you through each of your benefit options, prompting you to make elections.

5. Once you have made your elections, you will see the Summary Page. Review your benefit elections, and if everything is correct, click on "Continue", wait for the e-mail prompt. You can also email your benefit summary to your work or personal email.

6. For life events, proof of event must be provided within 30 days of the event. Fax documents to (423) 262-4703 or email HR4U@MSHA.com.

IMPORTANT REMINDER

If you do not enroll within your 30-day enrollment period, you must wait until the next Open Enrollment, unless you have a qualifying event.

Making Mid-Year Changes

Qualified Life Events

Choose your benefits carefully, because they will stay in effect for the entire plan year – from July 1, 2017 through June 30, 2018. However, you may change (add or delete) your covered dependents, enroll in, or cancel coverage within 30 days of a Qualified Life Event.

To make changes, use the "Life Events" section on the HR & Payroll Service Center online enrollment system. You must make the changes and provide required documentation within 30 days of the Qualified Life Event. Changes are generally effective the first of the month after notification and documents received. Changes resulting from birth or adoption are effective the date of the event providing enrollment and documentation is received within 30 days of the event.

A Qualified Life Event is a change in your personal situation that results in the gain or loss of eligibility for a MSHA insurance plan. The benefit change must be consistent with the type of qualified event.

What Is A Qualifying Event?

- Marriage or Divorce
- Birth, Adoption or Legal Custody
- Death of a Spouse or Dependent
- Commencement or Termination of Spouse's Employment with Health Care coverage
- Major Changes in Coverage Under another Employer plan

Proof of Qualified Life Event Verification should be scanned to HR4U@msha.com or fax (423) 262-4703. Please provide within 30 days of the event.

How to Enroll in Voluntary Plans

Eligibility is the same for other benefits; a team member hired during the month has 30 days to enroll and their coverage will begin the first of the second month after they were hired. Voluntary Individual Whole Life, Critical Illness, Voluntary Disability and Accident plans are available for enrollment during the annual open enrollment period only. All other Voluntary Benefits are available to team members anytime 24/7. Enroll in Auto & Home, Pet, ID Theft, Legal, Purchasing Power, and Retail Benefits at www.enrollvb.com/site/msha.

MEDICAL COVERAGE

MEDICAL

MSHA offers the Platinum, Gold, and Bronze medical plans so that you can choose the one that best meets the needs of you and your family. All three (3) of these plans are High Deductible Health Plans ("HDHP") and qualify to be used with a Health Savings Account ("HSA"). Deciding which plan is best for you is not easy. A variety of resources can be found on the Benefits Site, accessed from the MSHA Intranet Page (Pulse Page).

Features of the Platinum, Gold and Bronze plans:

- Certain Preventive Services are covered at 100%, at no cost to you and charges do not go toward your deductible.
- If you are enrolled in a family plan, the total family deductible must be met before claims are processed with a coinsurance.
- You will pay the lowest co-insurance if you choose to use a MSHA owned facility, physician, pharmacy or one participating with the highest tier.

What is a High Deductible Health Plan?

A High Deductible Health Plan emphasizes preventive care and encourages team members to be accountable for prudent spending of their health care dollars. The plan design requires that you meet an upfront deductible before most benefits are paid, except for certain preventive services and maintenance drugs (visit the MSHA Benefits Site for the list).

Once you meet your deductible, you will pay coinsurance until your out of pocket maximum is reached. When you use MSHA facilities your coinsurance is less. Once you reach your out of pocket maximum, the plan pays 100%. This limits your overall costs if you were to have a catastrophic medical event.

Enrollment in a High Deductible Health Plan allows you to also enroll in a Health Savings Account. An "HSA" is an individually owned bank account where you can save tax- free dollars to pay for eligible health care expenses. Once money is in your HSA, it is yours to keep. If you do not need to spend it on qualified medical expenses, you can save it.

Over the years, your HSA balance can grow and can even be used to help you meet medical expenses when you retire. See page 11 for enrollment requirements and more information on an HSA.

REVIEW YOUR MEDICAL PLAN OPTIONS ON THE FOLLOWING PAGES

MEDICAL COVERAGE

Anew Care is an Accountable Care Organization (ACO) comprised of healthcare practitioners and partners that have come together to provide the community with exceptional healthcare, greater value for every dollar spent on health & wellness services and better results as measured by the member/patient experience.

Integrated Solutions Health Network, LLC (ISHN) is a regional PPO network serving Mountain States Health Alliance. ISHN consists of approximately two thousand physicians in Northeast Tennessee, Southwest Virginia, and Western North Carolina.

Online directories are available to search for in-network doctors, hospitals, and providers. Directories can be located the MSHA Benefits Site (found on the Pulse Intranet page) or by visiting www.bcbst.com/msha and click on the member materials tile.

	Platinum Plan	Gold Plan	Bronze Plan
Bi-Weekly Premiums			
Team Member Only	$45.00	$85.00	$42.15
Family[1]	$65.00	$115.00	$450.00
Health Savings Account (Annual Company Contributions)[2]			
Team Member Only	$600.00	$600.00	$0.00
Family	$1,200.00	$1,200.00	$0.00

1. Spousal Surcharge – Team Members will be required to make an additional bi-weekly contribution of $75 to cover a spouse under MSHA's medical plans if the spouse is eligible to enroll in an employer-sponsored medical plan.
2. Company HSA contributions are made 1/2 in July and 1/2 in January. Contributions are prorated for mid-year enrollments.

		Platinum Plan	Gold Plan	Bronze Plan
Eligibility		Benefit Eligible Team Member must be Tobacco Free	All Benefit Eligible Team Members	All Benefit Eligible Team Members
Tiers	Tier 1	AnewCare	(1A) MSHA / (1B) ISHN	ISHN
	Tier 2	ISHN & BCBST Blue Network S	BCBST Blue Network S	BCBST Blue Network S
	Tier 3	Out-of-Network & Wellmont	Out-of-Network & Wellmont	Out-of-Network & Wellmont
Deductible	Tier 1	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$4,000 Individual / $8,000 Family**
	Tier 2	$1,500 Individual / $3,000 Family	$2,000 Individual / $4,000 Family	$5,500 Individual / $10,000 Family**
	Tier 3	$1,500 Individual / $3,000 Family	$2,000 Individual / $4,000 Family	$5,500 Individual / $10,000 Family**
		Tier 1 & 2 share same deductible	Tier 1 & 2 share same deductible	Tier 1 & 2 share same deductible
Out-of-Pocket	Tier 1	$3,000 Individual / $6,000 Family	$3,000 Individual / $6,000 Family	$6,350 Individual / $12,700 Family**
	Tier 2	$6,000 Individual / $10,000 Family**	$6,000 Individual / $10,000 Family**	$6,350 Individual / $12,700 Family**
	Tier 3	$20,000 Individual / $20,000 Family**	$20,000 Individual / $20,000 Family**	$20,000 Individual / $20,000 Family**
Preventive Care	Tier 1	100%, No Deductible	100%, No Deductible	100%, No Deductible
	Tier 2	100%, No Deductible	100%, No Deductible	100%, No Deductible
	Tier 3	No Benefits	No Benefits	No Benefits
Office Visits & Physician Charges	Tier 1	90% after deductible	(1A) 85% / (1B) 85% after deductible	70% after deductible
	Tier 2	70% after deductible	70% after deductible	70% after deductible
	Tier 3	30% after deductible	30% after deductible	30% after deductible
Facility Charges	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	80% after deductible	75% after deductible	70% after deductible
	Tier 3	30% after deductible	30% after deductible	30% after deductible

** No individual may exceed $6,550 in out of pocket expenses.

		Platinum Plan	Gold Plan	Bronze Plan
Tiers	Tier 1	AnewCare	(1A) MSHA / (1B) ISHN	ISHN
	Tier 2	ISHN & BCBST Blue Network S	BCBST Blue Network S	BCBST Blue Network S
	Tier 3	Out-of-Network & Wellmont	Out-of-Network & Wellmont	Out-of-Network & Wellmont
Deductible	Tier 1	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$4,000 Individual / $8,000 Family
Pre & Postpartum / Maternity Care / Facility & Physicians	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	75% after deductible	75% after deductible	70% after deductible
	Tier 3	30% after deductible	30% after deductible	30% after deductible
Mental Health Inpatient / Outpatient	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	75% after deductible	75% after deductible	70% after deductible
	Tier 3	30% after deductible	30% after deductible	30% after deductible
Chiropractic Services (Six (6) visits per plan year)	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	80% after deductible	80% after deductible	70% after deductible
	Tier 3	0%	0%	30% after deductible
Durable Medical Equipment	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	80% after deductible	80% after deductible	70% after deductible
	Tier 3	20% after deductible	20% after deductible	30% after deductible
ER Facility (True Emergency)	Tier 1	90% after deductible	(1A) 90% / (1B) 90% after deductible	70% after deductible
	Tier 2	90% after deductible	90% after deductible	70% after deductible
	Tier 3	90% after deductible	90% after deductible	30% after deductible
ER Facility (Non-Emergency)	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	75% after deductible	75% after deductible	70% after deductible
	Tier 3	25% after deductible	25% after deductible	30% after deductible
Home Health Care	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	75% after deductible	75% after deductible	70% after deductible
	Tier 3	20% after deductible	20% after deductible	30% after deductible
Occupational, Physical and Speech Therapy	Tier 1	90% after deductible	(1A) 90% / (1B) 50% after deductible	70% after deductible
	Tier 2	50% after deductible	50% after deductible	70% after deductible
	Tier 3	0%	0%	30% after deductible
X-Ray/Labs/MRI/CT/ PET	Tier 1	90% after deductible	(1A) 90% / (1B) 80% after deductible	70% after deductible
	Tier 2	70% after deductible	70% after deductible	70% after deductible
	Tier 3	25% after deductible	25% after deductible	30% after deductible

Prescription Drugs*	Platinum Plan		Gold Plan		Bronze Plan	
Pharmacy	MSHA	Non-MSHA	MSHA	Non-MSHA	MSHA	Non-MSHA
Maintenance (no deductible)	100%	90%	90%	80%	70%	70%
Non-Maintenance (deductible applies)						
Preferred (Generic or Brand)	90%	80%	90%	80%	70%	70%
Non-Preferred (Generic or Brand)	80%	70%	80%	70%	70%	70%

- Visit the MSHA Benefits site for a listing of Maintenance Drugs, Preferred (Generic or Brand), and other information.

TERMS YOU NEED TO KNOW

Co-insurance:

A percentage of medical plan costs that you pay after your deductible is met.

Deductible:

A fixed dollar amount that you pay before the plan will begin paying benefits.

Out-of-pocket Maximum:

The maximum you will pay for your benefits until treatment is covered at 100%.

In-network:

Doctors, hospitals, and other providers with whom the medial plan has an agreement to care for its members. Covered team members and dependents have lower out-of-pocket costs when using in-network providers

Out-of-network:

Care received from a doctor, hospital, or provider with whom the medical plan does not have an agreement. Covered team members and dependents pay more to use out-of-network providers.

Allowed amount:

The maximum amount on which payment is based for covered health care services. This may also be called "eligible expense" or "negotiated rate". If you use an "in-network provider" you will not be responsible for the difference between the billed amount and the allowed amount.

Primary Care Physician:

"PCPs" are Family Practitioners, Internists, Pediatricians, OB/GYNs, Nurse Practitioners, or Physician Assistants.

Preventive Care

Preventive Care is medical treatment for early detection to prevent illness or injury. Services must be coded as preventive care by an in-network physician to be covered in full by MSHA medical plans. Your PCP may request certain labs, procedures, or follow up based on your health history which may or may not be paid at 100%.

Preventive services include the following, based on age, sex, and family history:

- Well Baby Exam
- Well Child Exam
- Adult Routine Physical Exam
- Well Woman Exam
- Immunizations, as recommended by the CDC
- Routine Mammography, starting at age 35
- Screenings for Vision and Hearing, performed by Physician during Routine Exam
- Screenings for Cervical Cancer
- Screenings for Prostate Cancer, starting at age 50
- Screening for Colorectal Cancer, starting at age 50
- Certain Lab Tests designated as Preventive, such as Basic Metabolic Panel and Lipid Panel

Provision of the Platinum plan:

In order to maintain eligibility in the Platinum plan, Team Members must attest to being Tobacco Free for the plan year.

MSHA – Owned Pharmacies

MSHA owns several retail pharmacies. By filling your prescription in these pharmacies you can receive lower pricing on your prescription needs. These pharmacies are conveniently located in or near our hospital facilities and also provide delivery service for your convenience.

Consider what a Mountain States Pharmacy has to offer:

- Competitive pricing – lower Co-insurance than using non-MSHA pharmacies
- Convenience of a designated MSHA team member number (423-232-9857) to arrange for transfer, reorder or delivery of prescriptions
- Free delivery to MSHA facilities on a routine schedule
- Mail order and online ordering
- Dollars spent at MSHA pharmacies support MSHA and keep system benefit costs low
- Payroll deduction available for your convenience

Mountain States Pharmacy Locations Include:
Johnson City Medical Center Main Lobby (423) 431-2140
Johnston Memorial Hospital Cancer Center Lobby (276) 258-1990
525 N. State of Franklin Road Johnson City, TN 37604 (423) 926-6154
1657 E. Stone Drive Kingsport, TN 37660 (423) 247-2126
96 Fifteenth Street Norton, VA 24273 (276) 679-4452

Healthy Maternity

If you're expecting, Healthy Maternity is for you.

The Healthy Maternity Management Program from BlueCross BlueShield of Tennessee offers one-on-one maternity support for moms-to-be, as well as unlimited access to pregnancy-related materials online.

Healthy Maternity benefits include:

- Free Medela dual electric breast pump with program enrollment by the 21st week of pregnancy
- Personalized, confidential health advice from a maternity nurse
- Helpful prenatal information and online pregnancy resources
- Guidance on how to make the most of your health plan
- Details about your baby's immunizations

Enrolling is Easy

You can enroll as soon as you learn you're pregnant.

Enroll online by visiting bcbst.com and logging in to BlueAccess, choosing the "My Health & Wellness" tab and clicking on Healthy Maternity, or by calling (800)818-8581 (Case Management prompt).

For more information about Healthy Maternity:

Visit www.bcbst.com/Healthy-Maternity

Call our maternity nurses at 1-800-818-8581 (Case Management prompt) Monday - Friday, 8 a.m. to 7 p.m. ET.

Employee Assistance Program (EAP)

The MSHA Employee Assistance Program (EAP) provides you and your family with confidential mental health and substance abuse services through Mountain States Psychiatry. MSHA provides this coverage at no cost. The EAP Program covers nine (9) free counseling and/or medication management visits per plan year. Additional visits require a $25 co-pay.

You are eligible for coverage under the EAP if you are:

- A benefit-eligible team member; or
- A dependent of an eligible team member who is covered by MSHA medical plan.

The EAP is designed to help you deal with problems such as:

- Depression, anxiety and stress
- Crisis counseling
- Parent/child or teen concerns
- Marital difficulties
- Adjustment or coping difficulties
- Gastric bypass pre-surgery psychological evaluations
- Alcoholism and drug abuse

Confidential

All contact with the EAP representatives is strictly confidential. EAP representatives may not reveal the identity of those who call or the nature of the problems to MSHA or anyone else without specific written consent. MSHA will receive summary reports from the EAP to evaluate the effectiveness of the program, but no one's identity will be revealed in these reports.

To schedule an appointment:

Johnson City Office
508 Princeton Commons
Suite 403
Johnson City, TN 37601
(423) 302-3480

Or Call the Respond Crisis Hotline:
1-800-366-1132
Before 8 am, after 5 pm, or on weekends.

For More Information

If you have questions about the services covered, contact EAP at (423) 302-3480 during business hours.

IMPORTANT REMINDER

Feel free to contact the EAP regardless of the nature of your problem. No restrictions apply to the problems you may bring. However, the EAP will not intervene with problems directly related to your job such as raises, promotions and terminations. You should discuss these types of issues with your area manager.

Amwell Telehealth

What is Amwell?

Amwell is a faster, easier way to see a doctor. You can have video visits with a doctor anytime. It's easy to use, private, and secure. It's free to enroll and the cost per visit is $39.

Amwell offers:

Your choice of trusted, U.S. board-certified doctors Video visits using the web or mobile app Consultation, diagnosis—even prescriptions (when appropriate)

Amwell can be used any time, day or night. It's perfect when your doctor's office is closed, you're too sick or busy to see someone in person, or even when you're traveling.

What can doctors treat on Amwell?

On Amwell you can take care of most common issues like:

- Colds
- Sinusitis
- Flu
- Pinkeye
- Fever
- Ear Infection
- Rash
- Migraines
- Abdominal pain

What is the cost?

Doctor visits on Amwell are just $39.

How does this apply to my insurance?

Amwell visits are totally separate from your insurance plan. They do not apply to your deductibles or out of pocket costs. You can pay with any credit card, including your Health Savings Account.

When Would I Use Amwell?

- I should probably see a doctor, but can't fit it into my schedule
- My doctor's office is closed
- I feel too sick to drive
- I have children at home and don't want to bring them with me
- It's difficult for me to get a doctor's appointment
- I'm on business travel and stuck in a hotel room

How do I Sign-up?

There are 3 easy ways to sign up:

- Download the iOS or Android App by searching "Amwell"
- **Sign-up on the web at www.msha.amwell.com (not accessible through Internet Explorer)**
- Sign-up by phone, call 1-855-818-DOCS
  Enter Service Key: MSHA
  to get the Mountain States Health Alliance rate

Questions & Assistance

If you have any other questions, please call or email our support team at 1.855.818.DOCS (1.855.818.3627) or support@americanwell.com

Can I use Amwell when I'm traveling?

Amwell is great when you're on the road for vacation or work. Telehealth is available in most states, but some states do not allow telehealth or prescriptions. For a full list, visit: http://info.americanwell.com/where-can-i-see-a-doctor-online

Who Are The Doctors?

Clinical services on Amwell are provided by Online Care Group – the nation's first and largest primary care group devoted to telehealth. Doctors on Amwell:

- Average 15 years experience in primary and urgent care Are US Board Certified, licensed and credentialed
- Have profiles, so you can see their education and practice experience
- Are rated by other patients, so you can review and select the doctor that meets your needs

How do I add my spouse?

Your spouse should create a separate account to enroll.

How do I add a child to my account?

Parents and guardians can add their children who are under age 18 to their account and have doctor visits on their behalf. Enroll yourself first and then add your child or dependent to your account.

What do I do if I have a child over 18 who is still on my health insurance?

They should enroll as an adult and create their own separate account.

Health Savings Account

Health Savings Account ("HSA") is a tax-favored savings account that allows the accountholder to save and pay for qualified health care expenses tax-free. You can use funds in your HSA to pay for out-of-pocket expenses not covered by your health plan, as well as other qualified medical expenses.

To open and contribute to a HSA you:

- Must be enrolled in an HSA compatible health plan (any of the MSHA medical plans)
- Cannot be covered by a non-HSA compatible health plan
- Cannot be enrolled in any type of Medicare, (Part A included)
- Cannot be claimed as a dependent on another person's tax return
- Cannot have a spouse with a Flexible Spending Account that can be used for your medical expenses.
- If you have specific questions about your eligibility for an HSA, please call the HR4U Hotline at (423)431-HR4U(4748).

Benefits of a Health Savings Account:

- It is an individually owned bank account
- You and MSHA can make tax-free contributions to the account*
- The funds in the account roll over every plan year
- You can keep the account after you leave MSHA or retire and the money is always tax-free as long as you use it for qualified healthcare expenses
- The money in your account can grow with investment earnings on a tax-free basis. Any amount over $2,000 can be invested in multiple fund options
- You can change your contribution amount at any time throughout the year
- Your funds are easily accessed with your Optum Bank MasterCard
- You will receive monthly statements showing your account balance, investment information, and earnings
- You can use the funds in your account to pay for qualified healthcare expenses for any of your tax dependents
- Individual account holder is responsible for the monthly account fee of $1.75 (deducted from account balance) until balance reaches $5,000

*MSHA makes contributions if enrolled in the Platinum and Gold plans.

Qualified Healthcare Expenses Includes, but not Limited to:

- Doctor's fees
- Dental treatment
- Prescription drugs
- Eyeglasses, contacts, contact solution and vision exams
- Hospital services
- Hearing aids Chiropractors Lab work, x-rays
- Over the counter medicines with a doctor's prescription
- Nursing home services
- Long term care insurance
- COBRA premiums

For a full list of qualified healthcare expenses please visit www.irs.gov/pub/irs-pdf/p502.pdf

HEALTH SAVINGS
ACCOUNT

IMPORTANT REMINDER

Both employer and employee contributions count toward the annual IRS maximum.

Annual Contribution Limits are set by the IRS for each calendar year.

FOR MORE INFORMATION

Call (844)326-7967 or visit www.optumbank.com

FLEXIBLE SPENDING

ACCOUNT

IMPORTANT REMINDER

Expenses paid through the Dependent Care FSA reduce the amount available under the federal childcare tax credit. To learn whether the Dependent Care FSA or tax credit is most beneficial to you, talk to your tax advisor.

For flexible spending accounts, the IRS defines "incurred" as the date the medical care is provided, not the date when the participant is formally billed, charged for, or pays for care. Any claims incurred during the plan year must be submitted for payment by September 30th of the following plan year.

FOR MORE INFORMATION

If you have questions about the Pre-Tax Spending Accounts, call Optum Bank at:
(800)243-5543 or visit
www.optumhealthfinancial.com

Flexible Spending Accounts

A Flexible Spending Account enables you to contribute Pre-tax dollars to use for healthcare and/or dependent day care expenses. Team members can enroll in these benefits even if they are not enrolled in the medical plans (may not enroll in the Medical Spending Account if enrolled in the HSA).

The Medical Spending Account – contribute between $104 and $2,600 per plan year; and/or

The Dependent Care Spending Account – contribute between $104 and $5,000 per plan year.

How the Account Works:

- Estimate your spending needs for the plan year of July 1, 2017 – June 30, 2018.
- Make your election to participate during Open Enrollment or when newly benefit eligible.
- Contribution amount cannot be changed during plan year without qualified life event.
- Claims incurred in one (1) plan year must be submitted for reimbursement by September 30th of the following plan year.
- Individual account holder is responsible for the monthly administrative of $4.00. This fee will be collected via payroll deduction.

Medical Spending Account

Any healthcare expenses qualifying under the internal Revenue Code for income tax purposes also qualify for reimbursement through the Medical Spending Account. If you use the account for these expenses, you cannot take an income tax deduction as well. Eligible expenses include, but are not limited to:

- Deductibles, coinsurance and co-pays—for medical, dental, pharmacy and vision care
- Amounts you pay in excess of plan limitations
- Amounts you pay in excess of annual or lifetime benefit maximums
- Expenses not covered or not fully covered by your plan
- Certain over-the-counter medications

Dependent Care Spending Account

Any expenses qualifying for a Federal Child and Dependent Care Tax Credit for income tax purposes also qualify for reimbursement through the Dependent Care Spending Account. If you use the account to reimburse yourself for eligible expenses, you cannot take the Federal Tax Credit as well. Eligible expenses include those services provided inside or outside your home while you work by anyone other than your spouse or your dependents to care for eligible dependent children (under age 13) or dependents who are physically or mentally unable to care for themselves for whom you contribute more than half of their support.

Getting Access to Your Funds

If you enroll in the Flexible Spending Account, you will be issued a payment card to use when paying for eligible expenses. The card is accepted the same as a debit card at doctors' offices, medical facilities, hospitals, pharmacies and qualified merchants.

Dental

All of the dental plan options pay benefits for eligible dental services and supplies. You may see any provider that participates with Delta Dental Premier or Delta Dental PPO network. If you go to an in-network dentist you cannot be charged more than the contracted fee and you can receive a deeper discount therefore stretching your annual maximum further.

Preventive / Diagnostic Care

Preventive and diagnostic care services are covered in full under all dental options. Eligible services include and apply toward the annual maximum limit:

- Exams
- Cleanings
- Routine X-rays
- Wisdom teeth extraction

Basic Care

A percentage of basic care expenses is covered by each of the dental options, after you meet an annual deductible. Eligible services include:

- Fillings
- Root Canals
- Extractions (including wisdom teeth)

Major Care

A percentage of major care expenses is covered by Option 3 only, after you meet an annual deductible. Options 1 and 2 do not provide benefits for major care services. Eligible services include:

- Caps and crowns
- Bridgework
- Dentures
- Implants

Orthodontic Care

A percentage of orthodontic care expenses is covered by Options 2 and 3. Option 1 does not provide benefits for orthodontic care services. Option 2 covers eligible expenses for children under age 19, while Option 3 covers eligible expenses for yourself or any dependent, regardless of age.

DENTAL COVERAGE

FOR MORE INFORMATION

To locate a dentist go to www.deltadentaltn.com or call (800) 223-3104

Bi-Weekly Premiums	Option 1	Option 2	Option 3
Team Member Only	$7.82	$9.83	$17.08
Team Member + 1	$12.07	$23.59	$25.97
Family	$20.00	$29.45	$54.85

Coverage	Option 1	Option 2	Option 3
Annual Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Annual Maximum Limit	$500 per person	$1,000 per person (excludes orthodontics)	$2,000 per person (excludes orthodontics)
Preventive / Diagnostic Care	Plan pays 100%, no deductible	Plan pays 100%, no deductible	Plan pays 100%, no deductible
Basic Care	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Care	Not covered	Not covered	Plan pays 50% after deductible
Orthodontics	Not covered	Plan pays 50% (for children under age 19)	Plan pays 50% (any age)
Lifetime Maximum Per Person	Not covered	Up to $1,000 per person	Up to $2,000 per person

VISION COVERAGE

IMPORTANT NOTE

No ID cards are issued by VSP; simply contact a VSP Choice Doctor or other provider and tell them you are a team member of MSHA and that you have VSP vision benefits. The provider will do the rest for you, it's that simple.

FOR MORE INFORMATION

Locate the provider directory at www.vsp.com/go/mountainstates healthalliance.com or by calling VSP at (800) 877-7195

Vision

MSHA offers vision insurance through VSP. The doctor network is called VSP Choice. WellVision Exam focuses on your eye health and overall wellness.

Option 1 (with a VSP doctor)	Option 2 (with a VSP doctor)
Eye Exam • $10 copay every plan year Prescription Glasses ($10 co-pay on lenses every 12 months) • Single vision, lined bifocal, lined trifocal lenses • Polycarbonate lenses for dependent children • UV protection now included Frames (every 24 months) • $150 allowance for a wide selection of frames • 20% off the amount over your allowance - OR - Contact Lens Care (No co-pay on lenses every 12 months) • $130 allowance for contacts and the contact lens exam (Fitting and evaluation)	Prescription Glasses ($10 co-pay on lenses every 12 months) • Single vision, lined bifocal, lined trifocal lenses • Polycarbonate lenses for dependent children • UV protection now included Frames (every 24 months) • $150 allowance for a wide selection of frames • 20% off the amount over your allowance - AND - Contact Lens Care (No co-pay on lenses every 12 months) • $130 allowance for contacts and the contact lens exam (Fitting and evaluation) - OR - Second Pair Coverage • This enhancement allows you to get a second pair of glasses or contacts, subject to the same co-pays as your first pair benefit.

The plan provides coverage for non-VSP Providers as follows. Visit vsp.com for details.			
Exam	Up to $45	Lined trifocal lenses	Up to $65
Single vision lenses	Up to $30	Frame	Up to $70
Lined bifocal lenses	Up to $50	Contacts	Up to $105

Bi-Weekly Premiums	Option 1	Option 2
Team Member Only	$2.99	$4.42
Team Member + 1	$6.52	$9.09
Family	$10.32	$13.76

Disability Insurance

Short Term Disability

Short Term Disability insurance pays a percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury (excluding on-the-job injuries, which are covered by workers compensation insurance). You must be under the care of a physician to receive benefits. When you have a qualifying disability, * you must first satisfy the elimination period before the plan will begin paying benefits.

Feature	Option 1	Option 2
Elimination Period	29 days for a covered accident or sickness	14 days for a covered accident or sickness
Benefit Amount	60% of your basic weekly earnings up to $800/week	60% of your basic weekly earning up to $800/week
Maximum Benefit Duration	26 weeks (6 months)	26 weeks (6 months)

*** Pre-existing conditions are not covered for a disability caused or contributed to by a pre-existing condition or medical/surgical treatment unless, on the date you become disabled, you have been continuously insured under MSHA policy for at least 12 months.**
For newly enrolled, pre-existing conditions means a mental or physical condition or symptoms for which you have (a) consulted a physician, (b) received medical treatment or services, or (c) taken prescribed drugs or medications at any time during the 180-day period just before the effective date of your STD under the MSHA group policy.

Long Term Disability

Long Term Disability insurance provides you with income for an extended period, by paying a portion of your salary. MSHA pays the full cost of Option 1, or you can elect Option 2 for an additional cost and higher coverage. When you have a qualifying disability, you must first satisfy the elimination period before the plan will begin paying benefits. During the first two years of disability, "disability" means you are not able to perform all the "material" duties of your occupation. After benefits have been paid for two years, disability means the inability to perform all of the material duties of any occupation for which you are, or may become, qualified based on your education, training or experience.

Elimination Period

The time you must be out of work due to a qualifying disability before the plan will pay benefits.

Feature	Option 1 (MSHA Provided)	Option 2 (Additional Cost)
Elimination Period	180 days of disability from accident, injury or illness	180 days of disability from accident, injury or illness
Benefit Amount	50% of your basic monthly earnings up to $1,000/month	60% of your basic monthly earnings up to $6,000/month
Maximum Benefit Duration	The longer of your SSNRA (social security normal retirement age) or one year.	The longer of your SSNRA (social security normal retirement age) or one year.

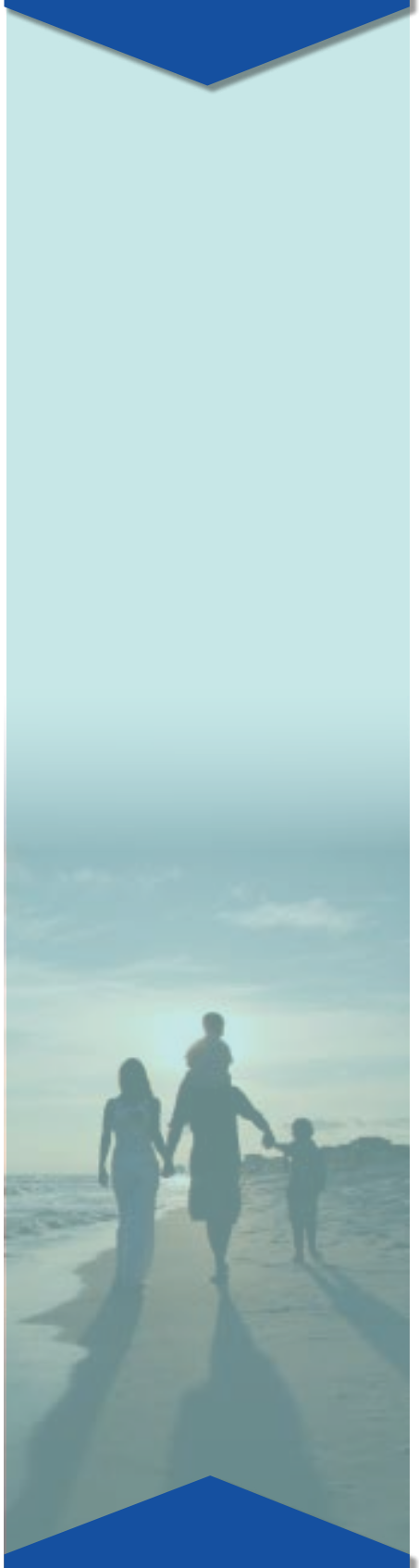
DISABILITY COVERAGE

IMPORTANT NOTE

The benefit amount you receive from the STD/LTD plan will be reduced by disability benefits you receive from Social Security or other sources.

Premiums paid for Disability Plans are pre-tax and therefore earnings received as STD or LTD payments are taxable per IRS regulations.

LIFE AND AD&D
INSURANCE



Life and AD&D Insurance

Planning for your family's financial wellbeing can bring you peace of mind. Life and Accidental Death and Dismemberment insurance can provide financial support to your beneficiaries. MSHA pays the full cost of your Basic Life and AD&D coverage through Reliance Standard. You may purchase additional coverage to meet your needs.

Feature		Benefit
Basic Life Insurance	MSHA Paid	One (1) times your annual salary up to $50,000.
AD&D Insurance	MSHA Paid	One (1) times your annual salary up to $50,000 paid in the event of your death due to an accident or to you in the event of dismemberment due to an accident.
Supplemental Life Insurance	Team Member Paid	Up to three (3) times your base annual salary up to a maximum of $1,000,000 when combined with your basic life amount. Proof of good health will be required for an amount more than $400,000.
Spouse Life	Team Member Paid	Spouse amounts: $15,000, $25,000 or $50,000.
Child Life	Team Member Paid	Dependent amounts: $5,000, $10,000 or $15,000.
Supplemental AD&D Insurance (Team Member Only or Family)	Team Member Paid	Up to 10 times your annual salary to a maximum of $700,000. Spouse: 50% of employee benefit; 40% if children are covered. Children: 15% of employee benefit; 10% if spouse is covered.

You have the following options for Life and AD&D coverage:

Reductions Due to Age

Once you reach age 70, your benefits will be reduced as indicated below.

Basic Life & AD&D: 50% of the original amount.

Supplemental Life: 50% of the original amount.

Evidence of Insurability (EOI)

Proof of good health must be submitted to Reliance Standard prior to coverage beginning if...

Supplemental Life:

- You elect an amount that is more than $400,000; or increase your coverage amount after your initial enrollment.

Dependent Life:

- You choose coverage for your spouse after your initial enrollment period, or increase your spouse's coverage beyond $15,000.

Long Term Care

Long term care is the type of assistance needed if you are unable to care for yourself because of a prolonged illness or disability – from help with daily activities at home to skilled nursing care in a nursing home.

As a participant in the plan, you can receive benefits for eligible long term care services provided by family members, home care agencies, senior centers, adult day care centers, traditional nursing homes and continuing care retirement communities.

If you enroll within 30 days of when you are first eligible, you will be covered on a "guaranteed" basis. This means you do not need to submit proof of good health to be covered, but you must complete the LTC enrollment form found at the end of the enrollment process. Complete the form and mail directly to UNUM. If you enroll at a later date, you will be subject to individual medical underwriting and must complete the Evidence of Insurability form. Your spouse must complete a statement of good health form, regardless of when you enroll him or her.

Cost of Coverage

Your cost for coverage is based on the "insurance age" – the age at which you purchased coverage. So, the younger you are when you purchase this coverage, the lower your premiums. This insurance is also portable, which means that if you leave MSHA, you can continue this coverage at the same insurance rates paid as a team member

Benefit Features	Option 1	Option 2
Facility Monthly Benefit	$2,000	$2,000
Home Monthly Benefit	$1,000	$1,000
Facility Benefit Duration	3 Years	6 Years
Home Benefit	50%	50%
Lifetime Maximum	$72,000	$144,000
Elimination Period	90 Days	90 Days
Home Care Level	Professional	Total

LONG TERM CARE
INSURANCE

IMPORTANT NOTE

Long Term Care requires enrollment form to be filled out and mailed to UNUM within 30 days of being a new hire. Application for spouse requires enrollment form and Evidence of Insurability.

Election of LTC after the 30 days of being a new hire require enrollment form and Evidence of Insurability for policy with UNUM. Forms can be printed at the end of the enrollment process.

FOR MORE INFORMATION

Please contact Unum at 800-227-4165

VOLUNTARY BENEFITS

Enrollment for these benefits is available within 30 days of hire or during open enrollment.

FOR MORE INFORMATION

Call the Voluntary Benefit Center at (877) 454-3001 during the hours of 8:00 AM - 7:00 PM EDT Monday - Friday or log in at www.emrollvb.com/msha

Voluntary Benefits

Whole Life with Long Term Care

Unum's Whole Life Insurance is designed to pay a death benefit to your beneficiaries but it can also build cash value you can use while you are living.

Cash value at a guaranteed rate of 4.5%*. Once your cash value builds to a certain level, you can borrow from the cash value or use it to buy a smaller "paid-up" policy with no more premiums due.

If you are diagnosed with a medical condition that limits life expectancy to 12 months or less, you can request up to 100% of the benefit amount, to a maximum of $150,000. Your spouse and dependents have this option as well.

Policy is portable if you leave or retire from the company. Coverage for dependents is available.

Short-Term Disability

Short Term Disability provided by Colonial Life can help offset your income if you become disabled. Your income is the financial security that helps protect your family and lifestyle. If a serious accident or illness prevented you from working, would you be able to continue covering everyday living expenses?

Replaces a portion of your income if you become disabled because of a covered accident or covered sickness.

You can use the benefits to help pay for mortgage or rent payments, utility bills, food, clothing, medical costs not covered under other plans, travel and lodging for treatment.

Benefits are paid directly to you, unless you specify otherwise.

Benefits are paid regardless of any other insurance you may have with other insurance companies.

You may choose the amount of disability benefits to meet your needs, subject to income requirements and existing disability coverage.

The coverage is portable; you can take it with you if you change jobs or retire.

Group Critical Illness with Cancer

Group Critical Illness Insurance, provided by Aflac, plan can help with the treatment costs of covered critical illnesses, such as:

- Cancer
- Heart Attack
- Stroke

The plan helps you focus on recuperation instead of the distraction and stress over the costs of medical and personal bills.

You receive cash benefits directly (unless otherwise assigned)

Use cash to help pay bills related to treatment or to help with everyday living expenses.

Group Accident

Group Accident provided by Aflac can help offset expenses should you or a covered family member have an accident. After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you through the many stages of care:

Initial emergency treatment

- Hospitalization
- Follow-up treatments
- Physical therapy

Helps with out-of-pocket costs that arise when you have a covered accident such as a fracture, dislocation, or laceration.

Voluntary Benefits

Home & Auto

Through a special arrangement with Travelers, you have access to a benefit that could save you money. The Travelers Auto and Home Insurance Program offers several advantages, including:

Special team member savings on auto , home and renters insurance

- Money-saving discounts
- Convenient payroll deduction
- Free, no-obligation quotes from licensed insurance professionals
- Year-round enrollment

ID Commander ID Theft Protection

Once every three seconds, someone becomes a victim of identity theft. Protect yourself and family members with proactive solutions from ID Commander.

- Advanced Identity Monitoring + Alerts
- $1 Million Identity Theft Insurance*
- Guaranteed Full-Service Identity Restoration
- 24/7 Live Lost Wallet Assistance
- Advanced Antivirus / Antispyware Software
- Identity Health Resource Center

Legal

Protect your family's future with LegalGUARDsm. You work hard to make the right choices for your loved ones, especially when it comes to legal matters. Get the peace of mind you want and the protection you need with a LegalGUARD Plan.

Being a LegalGUARD member saves you time and costly legal fees. But most importantly, it gives you confidence and provides coverage for home and residential, financial and consumer, estate planning and wills, auto and traffic, and family.

Purchasing Power

When cash is not an option, discover a better way to buy. Whether your computer crashes or washing machine breaks down, the need for a major purchase can happen when we least expect it. If you can't spare the upfront cash for these kinds of surprises, Purchasing Power can help.

- Brand name computers, electronics, appliances, furniture and more
- Automated payments deducted from your paycheck
- No upfront cash or credit check required
- Pay over time

Create your free account or login at www.MSHA.PurchasingPower.com

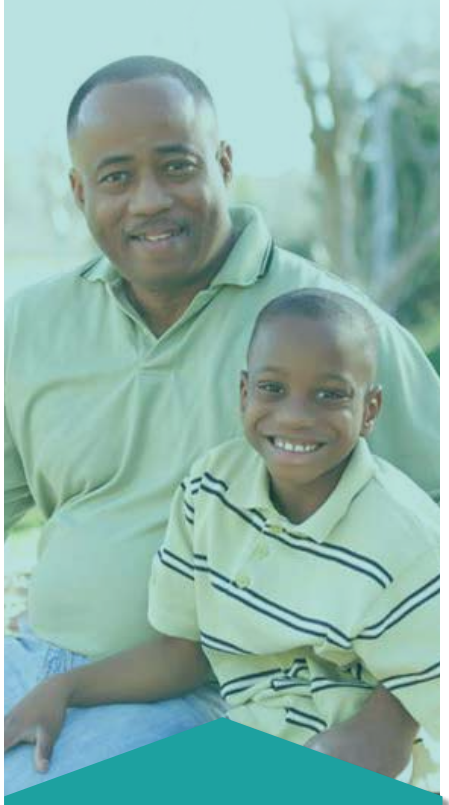
Pet Insurance

Pet insurance from PetFirst Healthcare is the smart way to budget for unexpected vet bills for your dogs and cats. Freedom to use any veterinarian nationwide – including emergency care clinics and specialists. Policies reimburse you based upon what you pay at the veterinarian – not what we think you should have paid

Call PetFirst at (866) 937-7387 or enroll online at www.petfirst.com/msha.

VOLUNTARY BENEFITS

Enrollment for these benefits is available to Team Members through out the plan year.

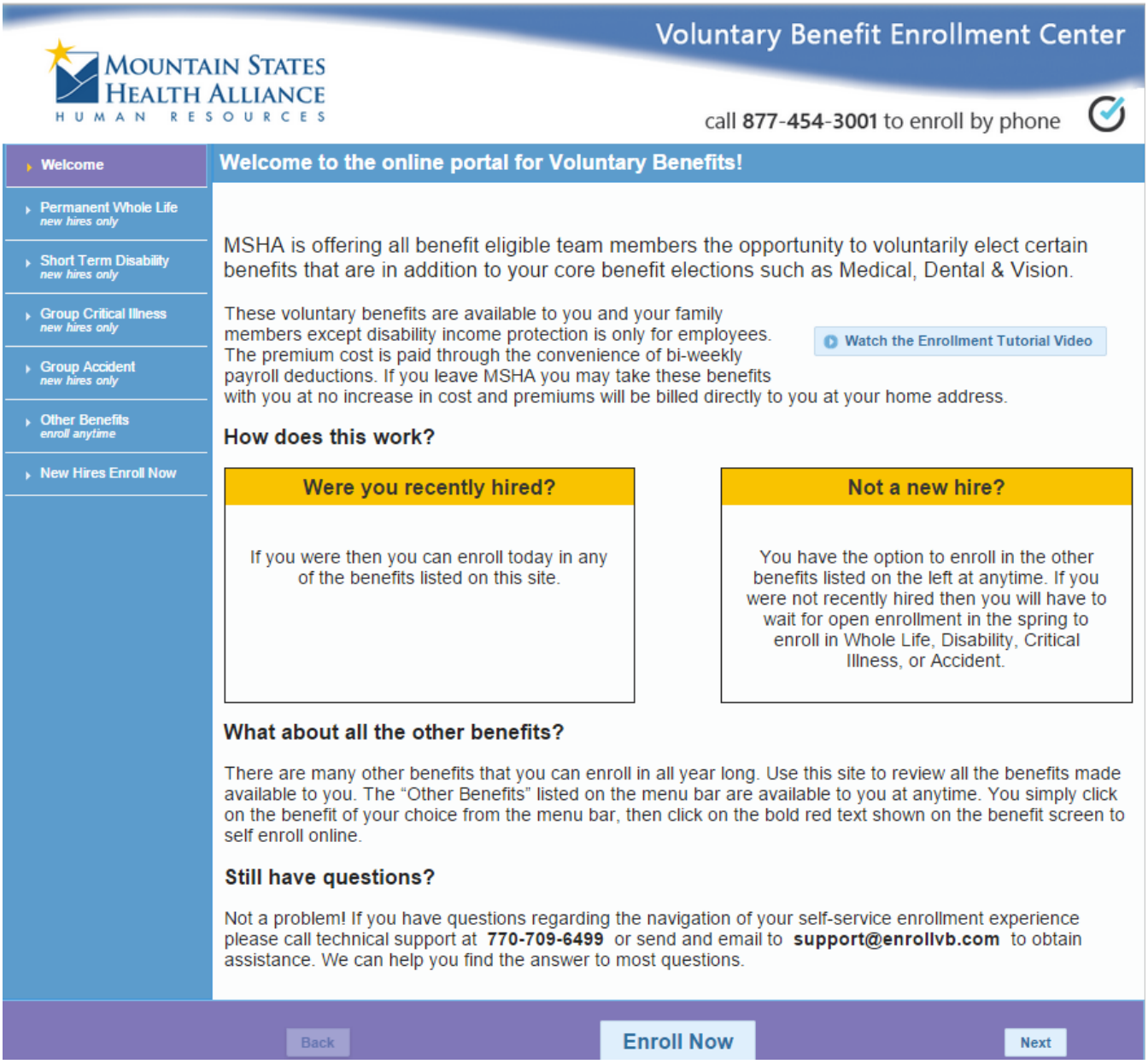


ENROLLVB INFORMATIONAL PORTAL

ENROLLVB Informational Portal

EnrollVB provides information for all voluntary benefits, plus toll free customer service number if you prefer to speak with a representative.

- Learn more about the products available
- Enroll in the products that meet your lifestyle and needs
- Log in at www.enrollvb.com/msha
- Call the Voluntary Benefit Center at (877) 454-3001 during the hours of 8:00 AM – 7:00 PM EDT Monday – Friday



Retirement Plans

Team Member Contributions

Eligible Team Members, age 21 and above, can begin contributions to their retirement plan through Lincoln Financial Group from their hire date. Contributions can be made on a pre-tax or ROTH after-tax basis up to the IRS annual limits. Catch-up contributions are also available for team members age 50 and over.

There is an auto enrollment feature where eligible new hires who do not make an election will be automatically enrolled at 1% pre-tax deferall rate in the plan. Participants will still retain the ability to change their deferral election at anytime.

Employer Contributions

All employer contributions are accrued each pay period and submitted to Lincoln at least annually.

MSHA 401(k) Plan

Team Members become eligible for a 3% employer contribution after one (1) year & 1,000 hours worked. Contributions begin on the next entry period, either January 1st or July 1st.

MSHA also provides a 1%-3% employer discretionary matching contribution based on years of service. This matching contribution is subject to a six year vesting schedule. Team members must work 1,000 hours in a plan year to achieve one year of vesting.

BRMMC 401(k) Plan

Team Members become eligible for a 3% employer contribution after one (1) year & 1,000 hours worked. Contributions begin on the next entry period, either January 1st or July 1st.

NCH 401(k) Plan

Team Members become eligible for a 3% employer contribution after one (1) year & 1,000 hours worked. Contributions begin on the next entry period, either January 1st or July 1st.

APP 403(b) Plan

For this plan only, there is no minimum age requirement for Team Members to begin contributions to their retirement plan, but Team Members must be age 21 and above to become eligible for a 3% discretionary employer contribution after one (1) year & 1,000 hours worked. Contributions begin on the next entry period, either January 1st or July 1st.

APP also provides a 1% matching contribution if the team member defers at least 3% of contribution.

RETIREMENT PLANS

Saving for retirement is important, and Mountain States is committed to offering team members a high quality retirement plan. This allows you to save money on a tax-deferred or after-tax basis and may include an employer contribution.

Lincoln Financial Group also provides participants access to electronically manage your plan. Participants are able to check their account balance, change investment elections, and stop/start or increase/decrease contributions using the Lincoln website. In addition, Lincoln provides a toll-free help desk system to assist participating team members. The number for the desk is (800) 234-3500. Lincoln representatives are available to MSHA team members for group, on-site, or individual consultations. Topics can range from initial enrollment to investments to distributions. A consultation can be set up by calling (423) 431-1615 or by going to www.lfg.com.

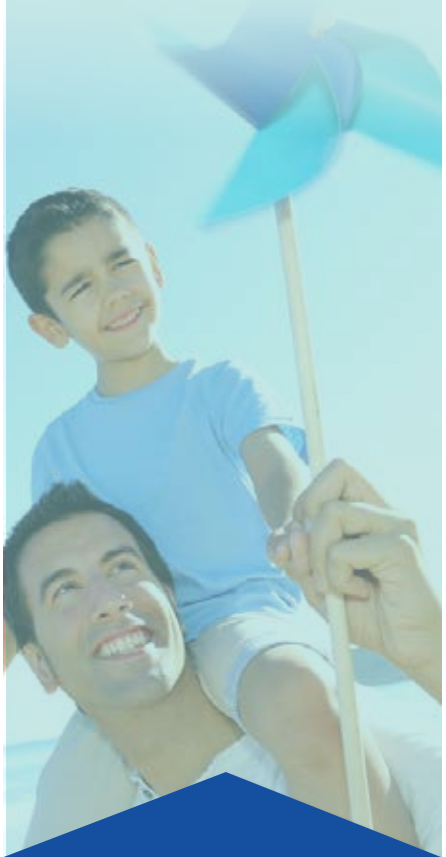
OTHER MSHA BENEFITS

FOR MORE INFORMATION

To find out more about these programs, contact HR4U Hotline:

(423) 431-HR4U (4748)

HR4U@msha.com



Other MSHA Benefits

Credit Union

You are eligible to become a member in the credit union immediately upon employment with MSHA. A credit union is operated as a service and benefit for team members and is located at JCMC, Franklin Woods, and North Point. ATMs are located at several locations throughout the service area.

Discounts

MSHA offers a variety of discounts at area venues, including the cafeteria, local movie theaters and Biltmore House. For a complete listing, refer to the HR page on the MSHA Intranet Site.

Fitness Centers

Several fitness centers in Tennessee and Virginia offer membership discounts to MSHA team members and their families. Please refer to the Fit4Life page on the MSHA Intranet Site for a complete list and details.

MSHA University

All facilities offer programs sponsored by MSHA University to provide you with developmental opportunities in many professions and occupations.

Leaves of Absence

MSHA will comply with all the requirements of the Federal Family and Medical Leave Act, with State and Federal Maternity Leave statutes governing veterans and members of the armed forces. MSHA also offers other forms of Leaves of Absence. For more information on those, please refer to policy HR-200-045, Leaves of Absence.

Other MSHA Benefits

Time Accrual Plans

As an MSHA team member, you will accrue hours to use for paid leave in two separate banks.

Major Medical Leave

The Major Medical Leave (MML) Bank consists of hours to use for absences due to serious personal illness or accidents. Team Members accrue eight (8) days each year, based on working 80 hours per pay period.

Hours are prorated for part time team members and hours worked less than 80 hours per pay period. Hours are accrued at the same rate regardless of years of service. You may begin using accrued MML hours after six (6) months of employment in a benefit eligible position.

MML is paid beginning with the 33rd hour of absence due to illness or immediately when hospitalized or for outpatient surgery, chemotherapy, radiation therapy or dialysis.

Paid Time Off

The Paid Time Off (PTO) Bank consists of hours to use for vacation, holidays, personal and incidental sick days. PTO will accrue based on paid hours up to 80 per pay period as follows:

Years of Service	**Paid Hours** (Max Days/YR)	**Option 2** (Based on 80 Worked Hours)
1 – 5	168 (21 days)	6.47
6	176 (22 days)	6.77
7	184 (23 days)	7.08
8	192 (24 days)	7.39
9	200 (25 days)	7.70
10	208 (26 days)	8.00
11	216 (27 days)	8.31
12	224 (28 days)	8.62
13	232 (29 days)	8.92
14	240 (30 days)	9.23
15	248 (31 days)	9.54

PTO hours are prorated for part time team members and hours worked less than 80 per period.

You may begin using accrued PTO hours after three months of employment in a benefit eligible position.

REQUIRED NOTICES

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see below for more details, and be sure to give this notice to your Medicare-eligible dependents covered under the Mountain States Health Alliance group health plans.

Important Notice from Mountain States Health Alliance About Your Prescription Drug Coverage and Medicare - CREDITABLE

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Mountain States Health Alliance has determined that the prescription drug coverage offered by the Mountain States Health Alliance Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Mountain States Health Alliance coverage will not be affected. See the Contact listed below for an explanation of your plan benefits including the prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Mountain States Health Alliance coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Mountain States Health Alliance and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mountain States Health Alliance changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be

required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	April 17, 2017
Sender:	Mountain States Health Alliance
Contact--Position/Office:	HR4U Hotline
Address:	3135 Peoples Street Johnson City, TN 37604
Phone Number:	423-431-4847

Women's Health and Cancer Rights Act

This communication is to provide notice as required under the federal Women's Health and Cancer Rights Act, effective October 21, 1998. Please review this information carefully.

As a Plan participant or beneficiary of the Mountain States Health Alliance Health Plan, if you or a covered dependent elects breast reconstruction in connection to a mastectomy, coverage will also be provided for:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided after consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

This notice is provided to you for informational purposes, no action is required on your part.

Please keep this information with your other group health plan documents. If you have any questions regarding this notice, please contact Member Services at the number found on your Medical ID Card.

Newborns' and Mothers' Health Protection Notice

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

Special Enrollment Rights Notice

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within[30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates their employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 or 31 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility.

ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALABAMA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

OR

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

OMB Control Number 1210-0137 (expires 10/31/2016)

Notice of Privacy Practices

The Mountain States Health Alliance Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at (423) 431-HR4U (4748).

Continuation Coverage Under COBRA Notice

This notice applies to everyone with healthcare coverage under the Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

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

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

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

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

When is COBRA continuation coverage available?

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

events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

HR4U Hotline
3135 Peoples Street
Johnson City, TN 37604
423-431-4847

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Mountain States Health Alliance

HR4U Hotline

3135 Peoples Street

Johnson City, TN 37604

423-431-4847

Wellness Program - ADA Notice

Fit for Life is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of enrollment in Platinum Plan for being Tobcacco Free and completing the HRA. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive enrollment in the Platinum Plan.

Additional incentives may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HR4U at 423-431-4748.

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

Protections from Disclosure of Medical Information

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HR4U at 423-431-4748.

Wellness Program - Notice of Reasonable Alternative Standard

Notice of Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at HR4U at 423-431-4748 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notes

Notes

Summary

This summary offers an overview of benefits offered at Mountain States Health Alliance (MSHA). The information should not be construed as a promise or guarantee of benefits or a contract of employment. MSHA reserves the right to modify, amend, suspend or end a plan at any time. If a conflict exists between the information provided in this summary and actual plan documents or policies, the documents or policies will govern. Fees are subject to change as plan costs change and/or employee elections change. See your official plan documents for specific details.

Availability of Summary Health Information

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format.

The SBC is available at on the MSHA Benefits page and at www.bcbst.com/msha A paper copy also is available free of charge by calling 423-431-HR4U (4748)

MOUNTAIN STATES HEALTH ALLIANCE

HR4U
Tel: (423)431-HR4U(4748)
Fax: (423)262-4703
HR4U@msha.com