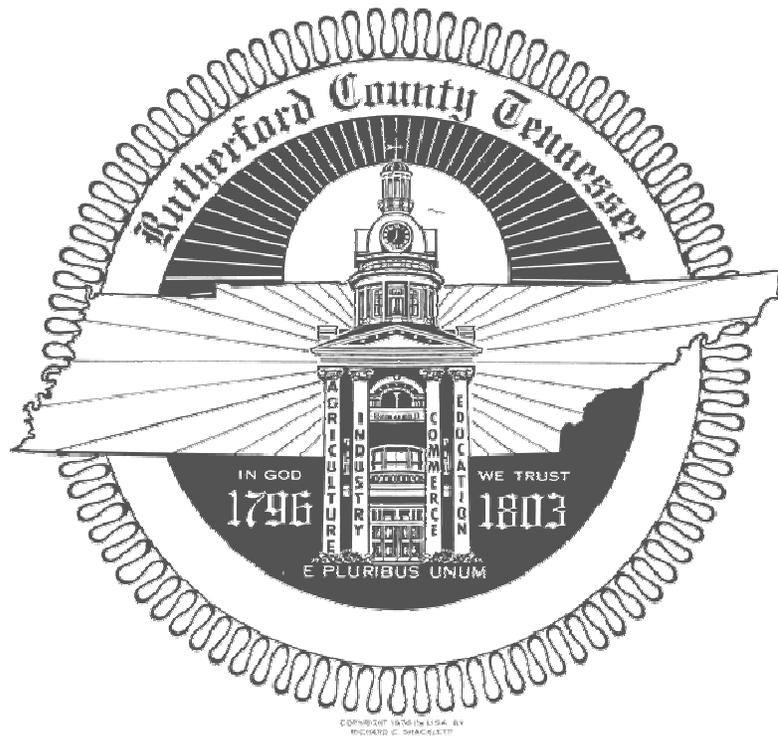


RUTHERFORD COUNTY GOVERNMENT



EMPLOYEE BENEFIT PLANS

Rutherford County Government Active Employees
January 2008

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This handbook does not outline every limitation or exclusion of the County-sponsored plans. The Plan Documents are the legal publications that define eligibility, enrollment, benefits and administrative rules. Copies of the Plan Documents can be obtained from the Insurance Department or from the Insurance Department's web site,
www.rutherfordcountyttn.gov/insurance/index.htm

The information contained in this handbook is accurate at the time of printing; however, the County Commission may change the plans at their discretion. The benefits described in this handbook cannot be modified by any oral statements.

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What Is This Information And Why Do I Need It?

Employee Assistance Program (EAP)
is a confidential counseling and referral service for all full-time employees and their dependents, regardless of whether you are enrolled in health coverage.

This *Benefits Handbook* has been provided to help you understand what benefits are available to you as a County Employee. Familiarize yourself with topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

If you meet the eligibility requirements listed on page 11, you will have the following benefits available to you:

- Health Insurance
- Vision Insurance
- Onsite Medical Clinic
- Dental Insurance
- Employee Assistance Program
- Flexible Benefits
- Basic Term Life and Basic Special Accident Insurance
- Optional term Life Insurance
- Leave Time
- Retirement

In addition, all full-time and part-time employees receive the benefits of:

- Wellness Program*
- Worker's Compensation

**Some aspects of the program are only available to those enrolled in the health plan.*

Flexible Benefits
or Section 125 plan is a benefit plan that allows participants to re-direct some of their earnings into a customized spending account. Flexible benefits allow you to pay for medical and dependent care expenses which can be paid with tax free money

Regardless of which benefits you select, the eligibility section of this handbook applies to you.

The Insurance Department is responsible for administering and/or overseeing all components of the group insurance coverage.

The County's healthcare options are self-insured which means claims are paid from funds controlled by the County which consists of employee premiums and the County's contributions.

Words or phrases that may be unfamiliar to you, and are not explained in the text, are defined in the side margin. We hope you will find this information helpful, useful and easy to understand. Please contact the Insurance Department if you have comments or suggestions related to this publication or if you require this publication in an alternative format.

Who Governs The Group Insurance Program?

Benefits and premiums are recommended by the County Insurance Committee. Members are:

- County Mayor;
- three County Commissioners;
- one member from the Rutherford County Education Association;
- three at-large members;
- four members who are employees of Rutherford County to include one member from the School Board;
- two members from the County General;
- and one member from the Highway Department.
- One of the County General members shall be an employee from the department with the largest number of insured employees. The employee members from the School Board, County General, and Highway Department must be enrolled in the Rutherford County health insurance plan.

- The Finance Director, Human Resources Director, and Insurance Director shall serve as ex-officio non-voting members.

The County Insurance Committee serving as plan administrator may recommend to: (1) change or end any coverage offered through the County's group insurance program, (2) change or discontinue benefits, (3) establish premiums, and (4) change the rules for eligibility at any time, for any reason. Their recommendations are forwarded to the County Commission who makes the final determination.

Telephone Numbers You May Need

Services

CareHere Onsite Medical Clinic Schedule primary care and health risk assessments at no cost to you! www.carehere.com	1-877-423-1330 24 hrs per day/7 days per week
Employee Assistance Program Receive emotional, legal, and financial counseling at no cost to you! www.horizoncarelink.com <i>Login ID: Rutherford</i> <i>Password: Eap</i>	1-866-252-4468 24/7 Counselors are available
Health Information Line Get medical advice, access audio and web medical libraries at no cost to you!	1-800-564-9286 24/7 Nurses are available to give advice

Vendors

CIGNA (Health and Dental Insurance) 24/7 claims, eligibility, enrollment info, provider directories, along with medical advice at www.mycigna.com	1-800-244-6224 7am to 7pm CST, M-F
CompBenefits (Vision Insurance) Eligibility, enrollment info, provider directories at www.mycompbenefits.com	1-800-856-3676
Hartford (Life Insurance) USable Life (Flexible Benefits) Download claim forms and get valuable information at www.selectdataservice.com	1-888-563-1124 1-888-698-1429 8am to 5pm CST, M-F Fax: 1-888-877-4747

Administrators

Insurance Administration www.rutherfordcounty.org/hr	898-7715
County General Human Resources www.rutherfordcounty.org/hr	494-4480
Board of Education Human Resources Tennessee Consolidated Retirement System	893-5815 x22007 1-877-681-0155

Member Privacy

The County group insurance program considers your protected health information (PHI) private and confidential. In accordance with the federal Health Insurance Portability and Accountability Act (HIPAA), policies and procedures are in place to protect such information against unlawful use and disclosure. PHI is individually identifiable health information. This includes demographics such as age, address, e-mail address and relates to your past, present or future physical or mental health condition. We are required by law to make sure your PHI is kept private.

When necessary, your PHI may be used and disclosed for treatment, payment and healthcare operations. For example, your PHI may be used or disclosed, including, but not limited to:

- In order to provide, coordinate or manage your healthcare
- To pay claims for services which are covered under your health insurance
- In the course of the operation of the County group insurance program to determine eligibility, establish enrollment, collect or refund premiums, and conduct quality assessments and improvement activities
- To coordinate and manage your care, contact healthcare providers with information about your treatment alternatives
- Conduct or arrange for medical review, auditing functions, fraud and abuse detection, program compliance, appeals, right of recovery and reimbursement/subrogation efforts, review of health plan costs, business management and administrative activities
- To contact you with information about your treatment or to provide information on health-related benefits and services that may be of interest to you

To obtain a copy of the Health plan's privacy notice describing in greater detail the practices concerning use and disclosure of your health information, visit our web site or you may obtain a copy from the Insurance Department.

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Who's Eligible?

To be eligible for the Active Employee County sponsored group benefit plans (Health Insurance, Onsite Medical Clinic, Flexible Benefits, Group life) you must belong to one of the following categories.

- Full-Time Employees and Elected Public Officials
- A part-time or seasonal employee is eligible for coverage who work at least thirty (30) hours per week, at least thirty-six (36) weeks of the year, and has been employed for at least one (1) continuous year
- Interim teacher is eligible for coverage who has worked in one (1) specific position for at least one hundred (100) continuous days in a given year

How Do I Pay For Coverage?

Non-Returning Board of Education employees

BOE employees pay their annual premiums in 10 month increments. Employees who do not return the following school year will have their insurance terminated at the end of August.

The insurance premiums deducted from the paycheck you receive at the end of each month include payment for your health, life, and voluntary insurance coverages. These deductions pay for the current month's coverage. Premiums are not prorated. The Insurance Department can provide you with information regarding your current premiums.

Unlike other County employees, Board of Education employees pay their annual premiums in 10 month increments. Premiums are not collected in July and August. Employees who do not return the following school year will have their insurance terminated at the end of August.

The County contributes approximately 80% of the cost of your health insurance premiums. Your premium equates to the other 20% of its cost. If on an approved leave and no longer receiving compensation from the County, you must arrange to make payment for your premium contributions. Contact the Insurance Department for premium payment information.

The County pays the full cost of providing employees with \$30,000 basic term life insurance and basic special accident insurance. You are given the opportunity to purchase additional life insurance on yourself and your dependents. The employee is responsible

for the cost of additional insurance beyond the amount provided by the County.

The plans permit a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled retroactive to the date you last paid a premium with no provision for reinstatement of coverage. To obtain health coverage again, you would have to wait for the annual open enrollment period.

To obtain life coverage again, you will have to provide evidence of insurability.

What Types Of Health Coverage Are Available?

- Single: Covers employee only
- Family: Covers employee, spouse and all eligible dependent children

When Does Coverage Begin?

You have 31 days from the first day of employment to submit your enrollment application. Coverage begins on the first day of the month after your first day of employment. If you fail to enroll in health coverage by the end of your enrollment period, you will only be eligible by satisfying one of the special enrollment provisions on page 17 or by applying for coverage during the next open enrollment period.

A dependent's coverage is effective on the same date as yours unless newly acquired.

Newly acquired dependents will become effective on the date they were acquired if you have family coverage. You may also choose to have coverage effective the first day of the following month if you are changing from single to family coverage.

Coverage for an adopted child begins when appropriate documentation reflecting legal obligation of support of such child is submitted to the Insurance Department. See complete definition of dependents on page 14.

Part-time employees will be effective the first day of the month after attaining full-time status if you have completed one full calendar month of employment. Application must be made within one full calendar month after becoming eligible.

Interim teachers must apply within one full calendar month after meeting the 100 continuous days' requirement.

You will receive an identification card at your home address within four weeks after the effective date of your coverage. You may call CIGNA to request additional cards.

Preexisting Condition Clause

Preexisting condition shall mean a condition for which a covered person received treatment or advice during the six-month period immediately prior to coverage with the County's plan. Both of the County's healthcare options apply a preexisting condition clause.

If you join the health plan when you are first eligible (see page 12) the plan will exclude coverage for preexisting conditions for your first 6 months on the health plan.

If you do not join the plan when you are first eligible, but later join as a Late Enrollee (see pages 17-20), the plan will exclude coverage for preexisting conditions for your first 18 months on the health plan.

The preexisting condition clause does not apply to services received at the onsite medical clinics. All enrolled individuals can receive treatment at the Clinics, even if their condition is considered preexisting.

The preexisting condition clause does not apply to pregnancy, newborns or adopted children or children placed for adoption. Also, if you are enrolling (as a new hire) or transferring during the annual enrollment transfer period and have had health coverage without a 63-day lapse between prior health coverage, the six-month preexisting condition clause will be waived.

Employees and dependents who did not have previous health coverage, or if the prior coverage has been terminated for more than 63 days, will be required to satisfy the six-month preexisting condition requirement. Treatments for conditions determined to be preexisting shall not be considered eligible expenses until coverage has been in force for six months.

Newly hired eligible employees and their dependents will be required to furnish a Certificate of Coverage letter (letter on former employer or insurance carrier letterhead) stating they had prior coverage, the names of participants enrolled and the date the coverage terminated. This letter should be provided to the Insurance Department and is required in order to be exempt from the preexisting requirements. There cannot be a lapse of coverage longer than 63 days. If the newly hired employee does not have the letter when first enrolled, they may provide the letter at a later date and the insurance administrator can change their coverage to reflect that preexisting should not apply.

What If I Need To Change My Coverage?

To make a change in your coverage (add or terminate a dependent, etc.), contact the Insurance Department and request an enrollment/change application. Return the completed form to the Insurance Department. The eligibility requirements for dependents listed on pages 14-15 apply.

What Dependents Are Eligible?

- Your spouse (legally married)
- Natural or adopted children (regardless of where they live)
- Stepchildren, foster children, children for whom you are the legal guardian or for whom you have legal custody. Such children must be unmarried, be declared and legally qualify as a Dependent on the Employee's federal personal income tax return filed for each year of coverage, maintain his/her principal place of residence with the Employee, and not have reached age 19 or 25 if a full-time student at an educational institution. (As for stepchildren, in the event of a court decree which gives one parent financial responsibility for medical and/or dental expenses, the parent as stated in the decree will have first responsibility for medical and/or dental expenses. Appropriate and legal documentation will be required to determine order of payment for medical and/or dental claims.)
- Adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption — the obligation may be determined by court records, federal income tax records or other appropriate documentation as determined by the Insurance Committee or its representative.

- Foster children are considered eligible if medical expenses are not covered by another group coverage or by the agency through which the child was placed. The placement is to be for a minimum of 25 days per month and expected to exceed one year. Application to cover the child is to be submitted 30 days prior to the child's placement.

Should a change in your dependent's eligibility status occur, notify the Insurance Department to terminate coverage.

All dependents must be listed by name on the appropriate enrollment/change application. Benefits are not provided for dependents not listed on this form. A dependent can only be covered once within the same plan.

Unmarried dependent children are eligible for coverage through the last day of the month of their 24th birthday. Dependent children between the ages of 19 and 24 must be a full-time student. Proof of a dependent's eligibility may be required.

Full-time Student – One who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period

Incapacitated children (mentally or physically disabled and incapable of earning a living) may continue health or dental, if applicable, coverage beyond age 18 (or 24 if a full-time student) as long as the incapacity existed before their 19th birthday (or 25th birthday if covered as a full-time student) and they were already insured under the County's group insurance program. The child must meet the requirements for dependent eligibility previously listed. **A request for extended coverage must be provided to the Insurance Department within 31 days of the dependent's 19th or 25th birthday.** Additional proof may be required periodically. Approval of the incapacitation request is determined by the claims administrator for your health insurance company. Coverage will not continue and will not be reinstated once the child is no longer incapacitated.

What Dependents Are Not Eligible?

- Ex-spouse (even if court ordered)
- Married children, regardless of age
- Parents of the employee or spouse
- Step children who do not reside with you
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)

- Live-in companions who are not legally married to the employee

How Do I Add Dependents To My Coverage?

An enrollment/change application must be completed within 30 days of the date a dependent is acquired. The “acquire date” is the date of birth, marriage, change of student status, or, in case of adoption, the legal obligation and support of such child. Changes in type of coverage (single to family) are effective on the first day of the month in which the dependent was acquired or, if requested, the first of the following month. If you maintained family coverage on the date the dependent was acquired, the effective date may be retroactive to the dependent’s acquire date even if beyond the 30 day enrollment period.

An employee’s child named under a qualified medical support order must be added within 30 days of the court order, if a court so stipulates.

If you have single coverage and do not notify the Insurance Department within 30 days of acquiring a dependent, the new dependent can only enroll if they meet one of the special enrollment provisions listed on page 17 or by applying during the annual open enrollment period.

If dependents are added while you are on single coverage, you must request family coverage for the month the dependent was acquired in order for claims to be paid. This change in type of coverage is also retroactive and you must pay for family coverage for the entire month in which the dependent is insured.

How Do I Terminate A Dependent’s Coverage?

To remove a dependent from your coverage, complete an enrollment/change application and return it to the Insurance Department. (Check with your insurance administrator to make sure your dependent is no longer eligible for coverage.) When you request cancellation, a dependent’s coverage will terminate on the last day of the month in which the form is signed. In the case of

ineligibility, the dependent is covered until midnight on the last day of the month that the ineligibility occurs. For adopted children, coverage terminates upon the termination of legal obligation. In the event of a divorce for any reason other than irreconcilable differences, your spouse cannot be removed from coverage until the divorce is final. **All claims paid for ineligible dependents will be recovered. As the head of contract, you are responsible for reimbursing the plan for incorrect claims payments.**

You can change your type of coverage by completing an enrollment/change application. Keep in mind that deleting a dependent may make you ineligible for family coverage.

To verify claim payments are paid only for eligible dependents aged 19–24, the health insurance vendors are required by the County to request annually a verification form of student status. Claims cannot be paid until the form is returned to the vendor.

The Insurance Department reserves the right to request documented proof of eligibility of dependents. Failure to provide the requested proof will result in suspension of the dependent's coverage until such proof is provided.

If the dependent becomes ineligible, it is your responsibility to notify the Insurance Department.

What If I Don't Enroll In Health Coverage When First Eligible?

If you do not elect health coverage for yourself and/or your dependents when first eligible (see page 12) and you later decide to enroll, you and/or your dependents will not be allowed to enroll until the annual open enrollment period. Open enrollment is conducted during November with requested changes in coverage to be made effective January 1.

Anyone who does not enroll when first eligible is considered a "Late Enrollee". Late Enrollees are subject to an 18-month preexisting condition exclusion (see page 13).

Special Enrollment Provisions

The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made

for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse. The required documentation must be submitted to the Insurance Department and coverage applied for within 30 days of loss of health coverage.

Employee NOT currently enrolled acquires a new eligible dependent (spouse, newborn or adoptee)

- Copy of the birth certificate, marriage certificate or adoption documents

Death

- Copy of death certificate and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended

Divorce

- Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Legal separation

- Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing the names of covered participants, date coverage ended and the reason why coverage ended

Loss of eligibility (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause)

- Written documentation from the employer or insurance company on company letterhead providing names of covered participants, date coverage ended and the reason for the loss of eligibility

Loss of coverage due to exhausting lifetime benefit maximum

- Written documentation from the insurance company on company letterhead providing names of covered participants, date coverage ended and stating that lifetime maximum has been met

Loss of TennCare (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis)

- Certificate of coverage from TennCare stating that coverage has been or will be terminated

Termination of employment (voluntary and non-voluntary)

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

The reduction in the number of hours that caused loss of eligibility

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Employer's discontinuation of contributions to the spouse, ex-spouse or dependent insurance coverage (total contribution not partial)

- Written documentation from the employer on company letterhead providing names of covered participants and verifying the employer's discontinuation of total contribution toward health insurance coverage. The effective date of coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month or subsequent month following approval by the Insurance Department; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period.

What Is The Annual Open Enrollment Period?

During the fall of each year you have the opportunity to transfer your existing County group health insurance coverage if you are currently enrolled, or to enroll in health insurance if you or your eligible dependents are not currently covered. Benefit information is mailed to your home address and you should review this information carefully to make the correct decision for you and your family. If you decide to transfer to another healthcare option, coverage will be effective on the following January 1, and you must remain enrolled in that healthcare option until the next year.

You may also enroll in the optional insurance plans, and enroll in medical and/or dependent care savings accounts.

How Do I Terminate Health Coverage?

If you wish to terminate insurance coverage, you must

- Complete an enrollment/change application
- Return the completed application to the Insurance Department **before** the day the termination is to be effective

A dependent's insurance will be canceled on the last day of the month when he/she becomes ineligible for coverage. It is your responsibility to notify the insurance department if your dependent no longer meets the dependent eligibility rules.

When canceled, either voluntarily or by work hours being reduced below the eligibility requirements (i.e., going full-time to part-time), insurance coverage ends at midnight on the last day of the month for which you paid your premium. All forms must be completed by the last day of the month to terminate coverage for the following month. For example, if you do not want coverage for the month of December, you must cancel the coverage in writing by the end of November. You cannot cancel coverage for the month of December once the month begins. ***Most employees pay their premiums on a pre-tax basis, please check with the Insurance Department before canceling coverage.***

Any insurance continued for an ***incapacitated dependent child*** ends when he/she is no longer incapacitated, or at the end of the 31-day period after any requested proof is not furnished.

In the event of an employee's death, covered dependents may be eligible to continue coverage through an extension of coverage (see page 28).

What If I Have Other Insurance?

If you are covered under more than one insurance plan, benefits will be coordinated for reimbursement if you follow the guidelines for your medical plan. At no time should reimbursement exceed 100 percent of charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, should you have other health coverage as the head of contract (not dependent coverage) for yourself, the oldest plan is considered your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage

through his or her employer, that coverage would be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage.

The health insurance providers have the right to subrogate claims. This means they can recover any payments made as a result of injury or illness caused by the action or fault of another person, or lawsuit settlement from payments made by a third party insurance company. ***This would include automobile or homeowners insurance, whether yours or someone else's.*** You are required to assist in this process.

The plans require an annual verification of other coverage. This information must be returned to your health insurance provider in order to process claims. Claims will not be processed until this information is received.

On the Job Injuries

The plan will not be responsible for expenses for injuries or illnesses occurring in conjunction with employment.

What Can I Expect If I Terminate Employment?

Your insurance coverages will cancel automatically when your employment is terminated and this information is provided to the Insurance Department. You will receive a COBRA notification to continue your health coverage, if eligible, and optional life insurance conversion notices, if applicable, at your home address. ***Make sure your correct address is on file with the Insurance Department and payroll/personnel office.***

How Do I Continue Coverage?

You may be able to continue medical (if eligible) and/or dental coverage under the Consolidated Omnibus Budget Reconciliation Act, a federal law referred to as COBRA. This law allows

employees and eligible dependents whose medical insurance would otherwise terminate, to continue the same medical benefits for specific periods of time under certain conditions. Covered individuals may continue the medical insurance if **all** of the following conditions are met:

1. Coverage is lost due to one of the “qualifying events” outlined on pages 23-24.
2. Covered individuals are not insured under another group medical plan as an employee or dependent. (This restriction is waived if you or your dependent enrolls in another group medical plan that has a preexisting condition clause, and a condition exists that is not covered by the other plan.) In this situation, you must provide the following to the Insurance Department:
 - A letter from the new employer or claims administrator explaining that plan’s preexisting condition clause and how long it applies
 - A letter from your physician stating your preexisting condition

The COBRA Administrator will send a COBRA notification packet to your home at the address on file after being notified there has been a termination of coverage (after all leave has been used) because of one of the qualifying events described below. You or your eligible family member will then have 60 days from the date of the COBRA notification packet to return your application to the Administrator. Coverage will be reinstated immediately if premiums are returned with the application. Please make sure your correct home address is on file with the Insurance Department. If you do not receive your notification letter within 30 days after your insurance terminates, you should contact the Insurance Department.

You or one of your family members must notify the Insurance Department if a dependent wants to continue coverage under COBRA because:

- Of your divorce from that spouse
- The dependent child is no longer eligible for medical or dental coverage because of a loss of dependent status under the plan

How is a COBRA Event Reported?

When one of these two circumstances (divorce or loss of dependent status) occur, you or your dependent has 60 days from

the date of the qualifying event or the date the insurance will terminate due to the qualifying event (whichever is later), to notify the Insurance Department.

Failure to notify the Insurance Department within 60 days of the loss of coverage will eliminate any rights to COBRA continuation. The Insurance Department will only accept written notification and will supply you with a “COBRA Event Notice” form for completion.

The COBRA Administrator will then send your dependent the COBRA enrollment packet to your address. Restrictions for returning the enrollment form (when premiums must be paid and other provisions) are outlined in the COBRA packet. Failure to report a dependent becoming ineligible to continue coverage within 60 days of the loss of eligibility will result in the dependent not being offered the opportunity to continue coverage under COBRA as their 60-day eligibility period will have lapsed.

There may also be a requirement for you to notify the Insurance Department in the event of a disability determination by the Social Security Administration. Additional information regarding disability extensions is provided further in this section.

How Long Does COBRA Last?

If you qualify for COBRA, the maximum length of time coverage may continue is based on which qualifying event causes your loss of medical coverage.

Qualifying Events for Employees

You may continue your single or family medical coverage for a ***maximum of 18 months*** if coverage is lost due to one of the following qualifying events:

- Employment is terminated for any reason other than gross misconduct
- Work hours are reduced below 30 hours
- Changes in your job appointment make you ineligible for coverage (example: changing to a part-time position)

Qualifying Events for Dependents

Dependents may also continue their medical or dental coverage under COBRA for ***18 months*** based on the events listed for employees. Furthermore, dependents may continue medical or dental coverage for an ***additional 18 months***—maximum of 36

months—if coverage is lost due to one of the qualifying events listed below.

- Your death
- Your divorce from your spouse
- You become entitled to Medicare prior to enrolling in COBRA (the 36-month period is retroactive to the date of Medicare entitlement)
- Your dependent child is no longer eligible as a dependent (married, in the armed forces on a full-time basis, over age 24 unless meeting qualifications for incapacitation, etc.)

A child born to, or placed for adoption with you during a period of COBRA continuation coverage is also eligible for continuation of coverage provided coverage is requested within the 60-day time period.

How Much Are COBRA Premiums?

COBRA premiums are equal to 102 percent of the total monthly premium. (Total monthly premium includes employee and employer contributions.) Premiums are not prorated. When your coverage through COBRA ends, you may be eligible to convert to a private, direct-pay plan with your health provider.

If you or your dependents are on an 18-month COBRA extension and were disabled when you originally lost coverage or within 60 days of when you or your dependent's coverage started, you and your dependents may continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payments after the 18th month. In order to qualify, an award letter from the Social Security Administration (SSA) must be sent by the COBRA participant to the Insurance Department within 60 days of your receiving SSA's disability letter. You will be notified if the additional 11 months are approved.

When Does COBRA Coverage End?

Any COBRA coverage ends on the earliest of the following:

- The required premium is not paid by the due date
- You or your dependents become insured under another group health plan after the date you elect COBRA coverage under this plan. (However, your COBRA coverage will not be terminated if, on the date you obtained the other coverage, the other group health plan contained a preexisting condition)

clause that applies to, or is not otherwise satisfied by, you or your dependent by reason of the provisions of HIPAA. Please contact the Insurance Department if you believe this applies or if you have questions).

- You or your dependent becomes entitled to Medicare after the date you elect COBRA coverage under this plan
- Coverage has been extended for up to 29 months due to a disability and there has been a final determination during the 11-month extension period that the individual is no longer disabled
- On the last day of the appropriate 18-, 29- or 36-month period

Note: It is your responsibility to share this explanation of COBRA benefits with your covered dependents.

What If I Go on Leave?

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees to take up to 12 weeks of leave during a 12- month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to receive County support of your health insurance premium. Initial approval for family and medical leave is at the discretion of each department head and the human resources department. Employees must have completed a minimum of 12 months of employment and worked 1,250 hours in the 12 months immediately preceding the onset of leave. Leave may be paid, unpaid, or a combination of paid and unpaid leaves depending on the circumstances of the leave.

Under current County policy, the employee pays a portion of the health care premium. While on paid FMLA leave, the County will continue to make payroll deductions to collect the employee's share of the premium. In addition, individuals will continue to accrue annual and sick leave benefits as long as they are on paid leave.

While on unpaid FMLA leave, the employee must continue to make his or her share of the premium either in person or by mail. The payment must be received in the Insurance Office by the 10th day of each month. If the payment is more than 30 days late, the

employee's health care coverage may be dropped for the duration of the leave.

If the employee contributes to a life insurance or disability plan, the employer will continue making payroll deductions while the employee is on paid leave. While the employee is on unpaid leave, the employee may request continuation of such benefits, and pay their portion of the premiums. If the employee does not continue these payments, the County may discontinue coverage during the leave. If your health benefits are terminated because of failure to pay premiums, such benefits will be restored as of the date you return from [FMLA] leave.

See your employee handbook for the detailed Family Medical Leave policy.

Leave Without Pay – Insurance Continued

If you choose to continue coverage while on an approved leave of absence, you will be responsible for the total monthly premium (**employee and employer share**) once you have been without pay for one full calendar month. You will need to contact the Insurance Department to arrange premium payment. The maximum period for a leave of absence is one (1) year. At the conclusion of the one year of leave, you must immediately report back to work for a period of no less than six full calendar months to be eligible for an additional year of insurance continuation under the leave without pay category. If you do not immediately return to work upon the expiration of the leave of absence, coverage is terminated and COBRA eligibility will not apply.

Leave Without Pay – Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. You may reinstate coverage when you return to work. ***If your coverage is canceled for nonpayment while on a leave of absence, it cannot be reinstated unless you qualify for one of the special enrollment provisions.***

To Reinstate Coverage After Your Return

Within 31 days of your return to work, you must submit a completed enrollment/change application to the Insurance Department, enrolling in the same health option you had previously. If you do not enroll within 31 days of your return to work, you can only re-enroll by meeting one of the special enrollment provisions or through the annual open enrollment process. The following guidelines apply:

If returning within six months

- No waiting period, coverage is effective the first of the following month after returning to work
- Preexisting condition does not apply

If returning after six months

- Must wait one full calendar month before coverage is effective
- Must satisfy the six-month preexisting condition clause (page 13) unless employee provides a certificate of coverage letter reflecting other coverage while on leave and there has not been a 63-day lapse

If you and your spouse are both insured with the County's group insurance program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract.

To transfer coverage, submit an enrollment/change application to suspend your coverage. Your spouse would submit an enrollment/change application to change to family coverage and add you as a dependent. The Insurance Department must be contacted to coordinate this change and to transfer deductibles and out-of-pocket expenses.

Leave Due to a Work-Related Injury

If you experience a work-related injury or illness, contact the Insurance Department about how this will affect your insurance. It is your responsibility to keep insurance premiums current until you return to work.

What If I Retire?

All covered employees who meet the qualifications may continue medical insurance at retirement for themselves and covered eligible dependents. The retiree, if eligible to continue, must enroll in order to add their dependents.

To continue coverage as a retiree, you must submit an application to continue coverage within one full calendar month from the effective date of your retirement. An individual cannot be classified as a retiree and maintain active coverage as an employee in the same plan.

How Do I Qualify to Continue Health Coverage?

You qualify to continue health coverage if:

- You are at least 55 years of age and have 15 years of service with the County prior to retirement and have been covered under the group medical plan for a continuous 5 year period prior to retirement
- You are at least 62 years of age and have 10 years of service with the County prior to retirement and have been covered under the group medical plan for a continuous 5 year period prior to retirement
- You have 30 years of service with the County prior to retirement, regardless of your age, and have been covered under the group medical plan for a continuous 5 year period prior to retirement

What If I Don't Qualify?

Retired employees who cannot continue health insurance coverage because of the service requirements previously listed may convert to a private direct payment plan or may be eligible to continue coverage through COBRA. Eligibility requirements for COBRA can be found on page 22. You may be eligible to continue your optional life programs on a direct-bill basis.

What Happens To My Covered Dependents If I Die?

If You Are an Active Employee

Your covered dependents may continue health coverage with the County's group insurance program for six months at the cost of the active employee's monthly contribution. After that, they may continue health coverage under COBRA guidelines for a maximum of 36 months as long as they remain eligible. Dependent optional life insurance coverage, if applicable, will terminate at the end of the month of the death of the employee; the dependents may be eligible to convert the life insurance to a direct-pay basis.

If You Are a Covered Retiree

Dependents may continue to be covered as long as they continue to meet eligibility guidelines.

If You Die in the Line of Duty

Your covered dependents will be allowed to remain on the County's health plan for up to 24 months at the cost of the active employee's monthly contribution. After that, they may continue health coverage under COBRA guidelines for a maximum of 36 months as long as they remain eligible. Dependent optional life insurance coverage, if applicable, will terminate at the end of the month of the death of the employee. Dependents may be eligible to convert the life insurance to a direct-pay basis.

If You Are Covered Under COBRA

Your covered dependents may continue health coverage under COBRA guidelines if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

HEALTH PLAN

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What Are The Distinguishing Features Of Each Healthcare Option?

PPO – A health insurance option where members chose a network provider or a non-network provider. Network providers accept a pre-negotiated fee. The participant is typically responsible for 20% of the maximum allowable charge and an annual deductible.

When a patient utilizes a non-network provider, the participant is typically responsible for 40% of the maximum allowable charge and any amounts above the maximum allowable charge.

The County provides two Preferred Provider Organization health plans from which to choose. These plans are identical in coverage except for their deductibles and out-of-pocket maximums.

Preferred Provider Organization (PPO) Option 1

\$250 individual/\$500 family in-network deductible
\$1550 individual/\$3100 in-network out-of-pocket maximum

\$450 individual/\$900 family non-network deductible
\$3050 individual/\$6100 non-network out-of-pocket maximum

Preferred Provider Organization (PPO) Option 2

\$500 individual/\$1000 family in-network deductible
\$2300 individual/\$4600 in-network out-of-pocket maximum

\$900 individual/\$1800 family non-network deductible
\$4600 individual/\$9200 non-network out-of-pocket maximum

What Will the Health Plan Cover?

The County's Health Plans cover medical treatments and services provided by recognized medical providers as outlined in the Plan

Document. This handbook provides a summary of those benefits but does not outline every limitation or exclusion of the County-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. Copies of the Plan Document can be obtained from the Insurance Department or from the Insurance Department's web site, www.rutherfordcounty.org/hr.

How Much Will I Have to Pay For Medical Care?

In-Network and Non-Network Services

Our Plans use a Preferred Provider Organization ("PPO"). The PPO is a list of medical providers that have met quality standards, agreed to discounted rates, and have signed contracts where they agree to write-off certain non-covered items such as charges over the maximum allowable amounts listed in their contract. By using PPO providers, you help the County control their health cost while securing a better value for yourself.

PPO providers are reimbursed at a higher percentage (80%) than non-network providers (60%). In addition, non-network providers can charge you for services non-covered by the health plan.

Deductibles and Coinsurance

Most services are subject to annual deductibles that have to be satisfied before benefits are paid. Only the cost for covered services can be applied toward satisfying the deductible.

Our plans have individual and family deductibles. Family deductibles are twice the amount of the individual deductible. The family deductible serves as a cap which limits the employee deductible cost if he covers more than one dependent on the health plan.

Our plans have different and lower deductibles for network providers than for non-network providers.

Common Accident Deductible

If two or more covered members of your family are injured in the same accident, only one of the members' deductibles will have to be satisfied. The largest applicable deductible will be taken.

Out of Pocket Maximums

Once you reach a certain amount of out-of-pocket expenses (your deductible plus your coinsurance) in a calendar year the plan will provide 100% reimbursement for your covered services through the end of the year.

Copayments for preventive care do not apply to the out-of-pocket maximum.

Our plans have different and lower out-of-pocket maximums for network providers than for non-network providers.

Pharmacy Benefits

Our plan covers medically necessary prescription medications that:

- Have been approved by the Food and Drug Administration
- Have been prescribed by a licensed physician
- Have been dispensed by a licensed Pharmacist
- Are not available for purchase without a prescription (over-the-counter)

Erectile Dysfunction medication is covered at a limit of 8 pills per month.

Prescription drugs are not subject to the deductible and as listed above, have a separate out-of-pocket maximum from the other health benefits. Drugs are reimbursed based on their classification. Your share (copay or coinsurance) of these drugs is:

- Generics \$5.00 (\$15.00 Mail-order)
- Preferred Brand 20%
- Non-Preferred Brand 35%

To get a list of what Brand drugs are considered Preferred go to www.mycigna.com and follow the links to the prescription drug list. You may also contact CIGNA customer service for this information at 1-800-244-6224.

Pharmacy Out-of-Pocket Maximum

Pharmacy has a separate out-of-pocket maximum from the medical. The pharmacy out of pocket maximums are:

- \$1000 per individual
- \$2000 per family

Lifetime Maximum Benefit

Our health plan will provide for up to \$2,000,000 in benefits over a covered members' lifetime.

Schedule of Benefits

After the deductible has been satisfied, the plan will pay the following services at the described percentages until the out-of-pocket maximums have been met.

Service	In-network	Non-network
Physician Office visit	80%	60%
Lab work at Physician office	100% Not subject to deductible	60%
Preventive Care	\$20 Copay	Not Covered
Hospital Care	80%	60%
Physical/Occupational Therapy	80%	60%
Ambulance Services	80% - all services considered in-network	
Chiropractic Care	No network provided. 26 visits annually, \$17.50 per visit Separate \$150 deductible	
Pre-admission testing	100%	60%
Second Surgical Opinions	100%	60%
Home Health	100%	60%
Skilled Nursing Facility	80%	60%
Diabetes Training	100%, limited to \$125 per session, 2 sessions per lifetime	
Mental Health Inpatient	80% 60 day annual limit	None
Mental Health Outpatient	80% 50 visit annual limit	None
Substance Abuse Inpatient \$50,000 lifetime maximum (Inpatient & outpatient)	80% 2 programs per lifetime \$10,000 annual limit	None
Substance Abuse Outpatient	80% \$2000 annual limit	None
Prescription Drugs	Generics - \$5.00 Copay (\$15.00 Mail-order) Preferred Drugs – 20% Non-Preferred Drugs – 35%	

How Does the Plan Control Cost?

In order to control cost, our health plan uses various strategies.

Preferred Provider Network

All Providers in our Network agree to discounted fees and to abide by certain quality standards. These arrangements insure better quality of care at better rates.

Preadmission Certification/Authorization

Before you enter a hospital for an elected admission or before you receive certain outpatient tests or procedures, information has to be sent to our Claims Administrator for review and approval. If you use a network provider, it is his responsibility to get the proper authorizations, and you will be held harmless if he fails to do so.

If you go out of the network, it is your responsibility to get care authorized. If you fail to get an inpatient admission authorized, you will have to pay an additional \$500 in your medical expenses. In addition, if your stay is not considered medically necessary, you will be liable for the entire admission.

Medical Necessity Review

The health plan only provides for medical services, treatments or supplies that are considered medically necessary. To be eligible for benefits, the care needs to be

- Provided or under the direction of a hospital or physician
- Consistent with the symptoms or diagnosis of the person's medical condition
- Appropriate according to the standards of good medical practice
- Not solely for the convenience of the patient, physician or hospital
- And the most appropriate care that can be safely administered

Our Claims Administrator routinely reviews care to make sure we cover only medically necessary treatments. If you use a network provider, it is his responsibility to provide only medically necessary care or to advise you if the treatment would not be covered by the health plan. You will be held harmless if he fails to do so.

If you go out of the network, it is your responsibility to insure that the care you receive is considered medically necessary. If you have a question regarding a treatment you should contact CIGNA to verify coverage.

Are There Any Special Benefits?

Case Management

In cases where the patient's condition is expected to be or is of a serious nature the Plan Administrator may at its discretion arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. Alternative care will be determined on the merits of each individual case.

Chiropractic Care

Chiropractic Care is covered up to a maximum of 26 visits per year. The maximum payable per visit is \$17.50 and the charges are subject to a separate deductible of \$150.

The Chiropractic Care deductible is separate from the regular Plan Calendar Year Deductible. The Chiropractic Care deductible does not count towards the regular Plan Calendar Year Deductible nor does the regular Plan Calendar Year Deductible count towards the Chiropractic Care deductible.

Diabetes Training

Diabetes Education is covered at 100% without a deductible. The total reimbursement for a session is limited to \$125, and payment is limited to two (2) sessions per lifetime.

Home Health Care

Skilled Services provided by a Home Health Care Agency are covered by the Plan. These services include nursing care, therapy, oxygen and its administration and diagnostic services.

Hospice

Benefits for Hospice Providers will be provided for services related to the care of a terminally ill Patient (where life expectancy is six (6) months or less). Benefits will be paid at 100%, not subject to the Deductible amount, provided the diagnosis of terminal illness is certified by the Covered Person's primary or attending Physician.

Pre-Admission Testing

Necessary x-ray and laboratory tests done in connection with and before admission to the Hospital for scheduled surgery will be reimbursed at the 100% (not subject to the deductible) when performed by Network Providers.

Preventive Care

In order to encourage early detection and prevention, the health plan provides for routine physicals, well child visits and other routine preventive care tests and immunizations for a \$20 copayment. You must use PPO providers to access this benefit. Preventive care is not covered when provided by non-network providers. These copayments do not apply to your out-of-pocket maximum.

Maternity Care

Benefits are payable for pregnancy-related expenses on the same basis as for disease.

Under Federal Law, our health plan cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours or ninety-six (96) hours as applicable. In any case, our plan does not require that a provider obtain authorization for lengths of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

Healthy Babies Program

It's never too early to start taking care of a baby and our health plan believes in being very proactive in helping babies be healthy

– moms, too. That's why as soon as your doctor says, "*Congratulations, you're expecting,*" you can enroll in the Healthy Babies® Program.

As a participant in Healthy Babies, you'll have opportunities for education and support through your entire pregnancy – and after.

Special features of Healthy Babies include:

- Support from a registered nurse case manager for moms and babies with special health care needs. These nurses are just a toll-free call away and can provide you with education on risk factors as well as offer access to services that can help you have a healthy delivery and baby.
- Free educational materials from the March of Dimes®, a recognized source of information on pregnancy and babies.
- Round-the-clock access to a valuable toll-free information line staffed by experienced registered nurses.
- And once your baby arrives, CIGNA HealthCare continues to provide access to the services you'll need for the first few days.

Enrollment in Healthy Babies is as easy as calling the toll-free number on your CIGNA HealthCare ID card, 1-800-244-6224.

Medical Emergencies

Emergency services are medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

When faced with a medical emergency you need go to the nearest provider who can provide the care you need. In the case of medical emergencies, non-network providers will be reimbursed at network levels. Ambulance services are always paid at the network level.

We realize that sometimes people will use emergency rooms for non-emergent care. ***If you use an emergency room to treat non-life threatening conditions, you will have to pay an additional \$100*** deductible per occurrence to help offset the higher cost of this provider. In addition, if you have received services at a non-network provider, it will be reimbursed at the non-network rate.

Second Surgical Opinions

Benefits will be provided for second surgical opinions and related diagnostic tests obtained within three (3) months of the first opinion.

If the second surgical opinion conflicts with the first opinion, benefits will be provided for a third opinion and related diagnostic tests.

Second and third surgical opinions must be given by a Physician who is not in the same medical group or practice as (a) the Physician who initially recommended the surgery or (b) the Physician who rendered the second or third surgical opinion.

Second Surgical Opinions are paid at 100% and are not subject to the deductible when performed by Network Providers.

Skilled Nursing Facilities/Rehabilitation Facilities

Confinements to Skilled Nursing or Rehabilitation Facilities are covered at the network levels and limited to 100 days per calendar year.

What Are the Behavioral Health Benefits?

Treatment of mental and nervous conditions and charges for alcoholism or chemical dependency treatments are paid at 80% after your deductible is satisfied as long as you use a network provider. No benefits are provided for care received by non-network mental health providers. Any Covered Medical Expenses for mental and nervous disorders or alcoholism or chemical dependency treatment will not be included in determining the maximum "cash out-of-pocket expenses", nor will such charges ever be paid at 100%.

In addition to the Behavioral Health benefits provided under the Medical plan, the County provides counseling through the Employee Assistance Program at no charge to employees and members of their household see pages 56-58.

Mental Health Benefits

In-Network Mental Health inpatient stays are payable at 80% limited to 60-days per year.

In-Network Mental Health outpatient treatments are payable at 80% limited to 50 visits per year.

Substance Abuse Benefits

In-Network Substance Abuse inpatient stays are payable at 80% limited to \$10,000 per year.

In-Network Substance Abuse outpatient visits are payable at 80% limited to \$2,000 per year.

All benefits for Substance Abuse treatments (inpatient and outpatient) are limited to \$50,000 per member's lifetime.

How Is Incorrect Information Handled?

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. Eligibility requirements for employees and dependents are covered in detail in this book.

If your covered dependent(s) becomes ineligible, it is your responsibility to inform your insurance preparer and complete an enrollment/change application within one full calendar month of that dependent losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, even if you are under court order to continue to provide coverage. If there is any kind of error in your coverage or an error affecting the amount of your premium, it is your responsibility to notify your insurance preparer. Any refunds of premiums are limited to three months from the date a notice is received by the Insurance

Department. Claims paid in error for any reason will be recovered from the employee.

Fraud, Waste and Abuse

Financial losses as a result of fraud, waste or abuse have a direct effect on you as a plan member. When fraudulent claims are paid or benefits provided to an individual that is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your health care. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or participant fraud. You can help prevent fraud and abuse of the plan by working with us to fight those individuals who engage in fraudulent activities.

How You Can Help

- Pay close attention to the Explanation of Benefits (EOB) forms sent to you when a claim is filed under your contract and always call the toll-free number on the reverse side of your identification card to question any charge that you do not understand — this will prevent providers from billing for services not provided to you or your dependents or misrepresenting the date of service, the amount charged or the type of service provided. ***If you discover (as confirmed by CIGNA) that an over-billing has occurred, you can receive 50% of the recovery amount up to a maximum of \$500.***
- Report anyone who permits a relative or friend to “borrow” his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who fabricates claims or alters amounts charged on claim forms
- Please contact the Insurance Department to report fraud, waste or abuse of the plan. All calls are strictly confidential.

What If a Mistake Was Made in Paying My Claim?

- If you believe an error was made in processing your claim

- If you have a question about your health coverage
- If you are unsure if a claim has been filed, or
- If you have a question regarding a dependent's eligibility

First call CIGNA at 1-800-244-6224. If they are unable to answer your questions, contact the Insurance Department at 615-898-7715.

Is There an Appeal Process?

Claims Appeal

Before initiating a health claims-related appeal, you should first contact the insurance company to get an explanation of the claims payment. If you are unable to resolve your issue, you may then request an appeal.

Appealing to the Insurance Company

Our insurance company has their own internal appeals process that must be followed prior to appealing to the County. Your first step is to contact CIGNA at 1-800-244-6224.

Administrative Appeal

You may also request a review of administrative issues, including certain decisions made on behalf of the plans. To file this type of appeal, provide the Insurance Department a letter detailing the circumstances of your situation. Your correspondence will be reviewed and you will receive a written response to your request.

Appealing to the Plan Administrator

This level of appeal is available to you if you have already been through the internal appeals process offered by your insurance company without a satisfactory resolution.

The appeal should be in the form of a letter (from the employee) detailing the events leading to the denial of the insurance claim. Copies of all correspondence and explanation of benefits relating to the claim should accompany the letter. Also include any other documented information, such as names of personnel you have talked with, dates of the communications, physicians' statements, etc. It is very important that you provide a phone number or email address where you can be reached during business hours so that

you can be contacted with questions or information about your appeal. The deadline for filing an appeal is two years after claim rejection.

Appeal Review

When the Insurance Department receives your information, it will be thoroughly reviewed to determine the exact nature of your appeal. The majority of requests for appeals require additional review by the insurance company. The appeals coordinator will request that the insurance company provide (in writing) the criteria used in making its determination of benefits. The average review takes approximately 30 days to complete. Some cases take longer depending on whether additional information is needed, the response time for the requested information and the complexity of the medical condition.

Some cases may also require review by an independent medical consultant. The determination to request such a review will be made by the appeals coordinator.

Many appeals are resolved during this review phase of the process. If, however, your appeal is not resolved, it may be scheduled for presentation to the Staff Review Committee.

Staff Review Committee

The Staff Review Committee is composed of employees within County government selected by the Insurance Committee. The Staff Review Committee meets as needed to review appeals that have not been resolved. Prior to the Staff Review Committee meeting, you will be furnished with a copy of your case file and will have the opportunity to notify the Insurance Department if you feel that any information in the file is incorrect or incomplete. You may make a personal presentation to the Staff Review Committee, or your appeal can be reviewed based on the written record. After the Staff Review Committee has heard your appeal, their votes are tallied and the results are forwarded to the Insurance Committee.

Insurance Committee

The Insurance Committee receives a written report of each appeal and is advised of the recommendation from the Staff Review Committee's meeting. After reviewing the written appeals, each Committee member votes individually by written ballot and returns the ballot to the Insurance Department. If the majority of the Committee votes that they agree with the decision of the Staff Review Committee, the decision will stand. If, however, the majority of the Committee votes for an additional review of the

case, it will be scheduled for presentation at a second meeting. If your appeal is scheduled for a second meeting, you will again be given the opportunity to make a personal presentation. You may make a personal presentation at this level even if you did not appear at the first meeting, or your case can be reviewed on the written record. You will receive written notification of the outcome of your appeal after all the Committee votes have been returned. It normally takes about two weeks (from the date of the first appeals meeting). The decision of the Committee is final and is the last step in the administrative appeals process.

VISION

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What is the Vision Plan?

Rutherford County has purchased a vision plan for all active employees who are enrolled in the medical plan. It is added automatically, and there is no additional premium for this coverage charged to you. This plan is provided by CompBenefits, and is a network-based plan.

You may choose the eye care professional of your choice. To receive the highest level of benefits, you and your dependents must select an eye care provider from CompBenefits' list of participating eye care providers. When you select a participating eye care provider, your out-of-pocket costs for covered eye care services are limited to the copayment amounts shown on your Schedule of Benefits.

What Services are Available?

Vision examinations – Each insured is eligible for a comprehensive eye examination which shall include: 1) personal and family ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) papillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect recording cup disc ratio, blood vessel status and any abnormalities; 7) cover test; 8) tonometry; 9) refraction; 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. One such service will be covered in any 12 month period.

Materials – Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such materials will be covered, together with certain services as necessary. Services include but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses – One pair of prescription lenses once in any 12 month period.

Frames – One new frame once in any 24 month period. The VisionCare Plan Network Provider will show the Insured the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the

amount the Plan covers, the Insured is responsible for the difference in cost.

Contact lenses when necessary – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and /or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any 12 month period and only if prior authorization is obtained from the Plan. The Copayment is waived.

Contact lenses when elective – Benefits include: (1) The cost of an annual vision examination, subject to the Copayment; and (2) the cost of contact lenses, any fitting costs and follow-up visit to a maximum of \$105.00, not subject to the Copayment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any 12 month period.

How Much Will It Cost Me?

Copayment – An Insured's Copayment is:

- | | |
|-----------------------|------|
| 1. Vision Examination | \$10 |
| 2. Materials | \$15 |

Allowance – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule:

Vision Examination	\$35
Single Vision Lens	\$25
Bifocal Lens	\$40
Trifocal Lens	\$60
Lenticular Lens	\$100
Contact Lenses (elective)	Exam+ \$105
Contact Lenses (medically necessary)	\$210
Frame	\$40

How Do I Schedule an Appointment?

Call to schedule an appointment with a CompBenefits participating provider and give your name, ID number, group number and the name of the group. The ID number and group number can be found on your CompBenefits ID card. After scheduling the appointment, the provider's office verifies your eligibility and benefits before performing the exam. There are no forms for you

to complete. You simply pay the participating provider for any applicable copayments and any extra costs for services and materials not covered by you at the time the services are rendered.

If you choose to receive covered services from a provider other than a CompBenefits participating provider, your benefits are based upon the allowances shown above. You must pay the provider in full at the time the services are rendered and then submit to us an allowance as shown in the Schedule of Benefits, and any services or materials NOT covered under your plan.

How Do I Get Questions Answered?

Should you have questions about your vision plan, you can call CompBenefits at 1-800-865-3676, or go online at www.mycompbenefits.com

ONSITE MEDICAL

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What Are The Onsite Medical Clinics?

One of the benefits of being enrolled in the County's Health Plan is the ability to receive services from the Onsite Medical Clinics. The Clinics are run by an independent Company, CareHere. They are located around the County and provide primary care exclusively to County employees and their dependents that are enrolled in the Health Plan.

The Clinics are staffed by highly qualified Physicians and Nurse Practitioners with experience in the areas of Primary Care, Family Practice and Women's Health.

In order to minimize waiting and increase time with the physician, office visits are by appointment only. Walk-in visits are not available at this time.

Clinic Locations and Hours

Blackman Elementary – Mornings (Mon-Sat) 586 Fortress Blvd – Murfreesboro – Portable closest to the playground

Blackman Elementary – Afternoons (Mon-Fri) 586 Fortress Blvd – Murfreesboro – Portable closest to the playground

Murfreesboro Health Dept – Afternoons (Wed & Fri) 100 West Burton, Murfreesboro

Rock Springs Middle School – Mornings (Mon & Thurs) 3301 Rock Springs Rd, Smyrna – Go in school's front entrance and go to the main school office

Stewarts Creek Elementary – All day (Mon & Wed) 200 Red Hawk Pkwy, Smyrna (Walk-ins also accepted)

Stewarts Creek Elementary – Tues Afternoons, 200 Red Hawk Pkwy, Smyrna (Walk-ins also accepted)

Walter Hill School – Mornings (Tues & Fri) 6309 Lebanon Pk – located at the left-most side of the building

Walter Hill School – Afternoons, 6309 Lebanon Pk - located at the left-most side of the building

GYN Exam Day – Women 18 & Older ONLY – Walter Hill School

Times and Locations are subject to change, go to www.Carehere.com or call 1-877-423-1330 for the most current schedule.

What Services Are Available?

Primary Care

Acute and chronic conditions can be treated at the Clinics, and the “appointment only” policy insures prompt treatment with little to no wait. The Clinic providers can treat you for conditions such as:

- Colds, flu, sore throat
- Respiratory infections
- High blood pressure
- Arthritis
- Allergies
- Diabetes
- Asthma
- And more

Pharmacy

Many generic medications are also available at the Clinics. If available, you can get up to a 30-day supply (90-day supplies available for established patients).

Health Risk Assessments

CareHere provides each employee a free annual Health Risk Assessment (HRA). This HRA is an in-depth analysis of over 30 key lab measurements indicating high cholesterol, diabetes, liver functions, chemistry levels, nutrition, or prostate cancer.

From a simple blood draw and health questionnaire, you will receive a detailed report explaining your results with color-coded graphs to help you better understand your scores.

Armed with this report, you and your physician can review your health risks in detail, prepare a plan of action, if necessary, and track trends over time that are essential to healthy living.

Do not eat for at least 12 hours before your HRA appointment
- you may drink water or coffee without sugar.

Within 2 weeks of your blood draw, you will receive your personalized HRA Report. Schedule a new appointment at CareHere to review your report with a member of the Clinic’s Medical Team.

Health Coaches

Trained “Health Coaches,” contact every patient with abnormal lab results revealed in Health Risk Assessments or routine onsite lab work.

If needed, Health education materials will be sent to members based on medical assessment, condition(s), and receptivity. For high risk patients, case managers stay in regular contact with individual patients to monitor progress. CareHere works hard to coordinate case management with the members' physicians for optimal coordination and effective collaboration.

How Much Will It Cost Me?

Care from the onsite clinic is provided at no cost to members of the Health Plan.

How Do I Schedule An Appointment?

- From the internet you can schedule an appointment at: www.CareHere.com
- Click "Members Only".
- Login and enter your user name and password
 - First-time registrants should sign in using the Access Code: **RC486**
- Or, if you do not have internet access, you may call the 24 hour appointment line at **1-877-423-1330**.

For more information about the On-site Medical Program please visit www.rutherfordcounty.org/hr

DENTAL

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What Are The Distinguishing Features of Each Dental Option?

The County provides two Preferred Provider Organization dental plans for our Active employees. These two options are illustrated below:

Benefit	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50 per individual up to \$150 per family	\$100 per individual up to \$300 per family	\$50 per individual up to \$150 per family	\$50 per individual up to \$150 per family
Calendar Year Maximum (Class I, II, and III)	\$1,000 per covered individual	\$1,000 per covered individual	\$1,000 per covered individual	\$1,000 per covered individual
Class I – Preventive and Diagnostic	100%, no deductible	80%, no deductible	100%, no deductible	100%, no deductible
Class II – Basic Restorative	80%, after deductible	60%, after deductible	80%, after deductible	80%, after deductible
Class III – Major Restorative	50%, after deductible	40%, after deductible	50%, after deductible	50%, after deductible
Class IV - Orthodontia	50%, after separate \$50 deductible	40%, after separate \$100 deductible	50%, after separate \$50 deductible	50%, after separate \$50 deductible
Orthodontia Lifetime Maximum	\$1,000	\$1,000	\$1,000	\$1,000

What Will the Dental Plan Cover?

Class I expenses include: Oral exams, cleanings, bitewing x-rays, fluoride applications, sealants, and space maintainers (limited to non-orthodontic treatment).

Class II expenses include: Full mouth x-rays, panoramic x-rays, emergency care to relieve pain, fillings, and oral surgery – simple extractions.

Class III expenses include: Oral surgery – all except simple extractions, surgical extraction of impacted teeth, anesthetics, major periodontics, minor periodontics, root

canal/therapy, relines rebases and adjustments, repairs – bridges, crowns, inlays and dentures, crowns, dentures, bridges, and histopathologic exams.

Class IV expenses include: Orthodontia.

This is not a full listing of benefits or exclusions, please refer to the Summary Plan Description on the Rutherford County website for detailed information. That web address is: www.rutherfordcounty.org/hr

How Much Will I Have To Pay For Dental Care?

Payment for a service delivered by a Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Illustration above. The covered person is responsible for the balance of the Contracted Fee. Payment for a service delivered by a non-Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the provider's actual charge.

How Do I Get Questions Answered?

If you have questions regarding the Dental Plan, you can call CIGNA at 1-800-244-6224 or go online at www.mycigna.com to get answers.

EMPLOYEE ASSISTANCE PROGRAM

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What is The Employee Assistance Program?

The Employee Assistance Program (EAP) is a confidential counseling and referral service for all full-time employees and their dependents, regardless of whether you are enrolled in health coverage. Retirees covered under a County-sponsored plan are also eligible. The EAP can handle problems related to

- emotional • financial • stress
- family • mental health • family/marital
- workplace • substance abuse • chronic illness
- grief • legal • elder care

Workshops and seminars are offered to employees on a regular basis at locations across the County. Others are available upon request.

What Services Are Available?

- **24-Hour Member Advocate Line**—Members have 24/7 live access to master’s level Member Advocates for telephonic consultation, provider referral, and appointment scheduling assistance with specialists for legal, financial, or clinical issues. **1-866-252-4468.**
- **Goal and Success Planning Consultation**—Consultation and resource services to assist employees and families in achieving personal success and well-being.
- **Personalized Resource Materials**—Reinforcement for each consultation by providing members with informative materials, including educational literature that address the special needs of the employee as identified through the phone consultation.
- **Assessment and Counseling**—Rutherford County’s employees and their family members may receive short-term, in-person counseling sessions for assessment, problem solving, and referrals to additional resources.
- **National Network**—Nationwide coverage from anywhere in the United States, with more than 18,000 contracted and credentialed providers in our network.
- **HorizonCare™ Online**—Horizon’s website offers content, self-assessments, interactive tools, and educational guides.
www.horizoncarelink.com
 - *Login id: Rutherford - Password: Eap*

- **Legal Consultation Services**— This most frequently-utilized non-clinical service offers guidance to members seeking legal advice for issues such as will preparation, divorce, automobile accidents, elderly parent care, and other legal-related concerns.
- **Financial Consultation Services**—Members are able to receive assistance in managing inheritance or estate taxes, retirement fund rollovers or transfers, debt consolidation, and general tax or investment questions.
- **Telephonic Follow Up**—Horizon provides personal follow-up contact with each member to ensure the services provided are appropriate to the member's counseling needs and are satisfactory.
- **Telephonic WorkLife Services**—Our WorkLife services target the life event issues most people experience at some point. We offer expert resources to assist your employees in finding appropriate resources for childcare, elder care, adoption, and other personal matters requiring careful research and detailed information. **1-866-252-4468**
- **HorizonCare™ Online Plus**—Easily accessible online EAP and WorkLife resources in one web-based application, giving members the power to access the information they need at the time and place most convenient.
 - www.horizoncarelink.com
 - *Login id: Rutherford - Password: Eap*
- **Worklife Services** - The WorkLife programs provide employees with convenient, confidential access to qualified specialists who can help address a variety of work-life issues, including but not limited to:
 - Child Care
 - Elder Care
 - Pet Care
 - Adoption
 - Education
 - Daily Support Services

Management Consultation and Referral

The management consultation and referral process offers managers and supervisors around-the-clock, year-round access to a team of master's-level clinicians to help address employee disciplinary matters or work performance issues.

How Do I Access Services?

All services are strictly confidential and can be accessed by calling the contracted vendor who is available 24 hours a day, 365 days a year. The counselor who takes your call will ask you some questions and refer you to a provider based on the information you provide.

How Much Does It Cost?

You and your eligible dependents may receive unlimited counseling sessions at no cost to you. If it is determined that you need greater assistance than through EAP, you will be referred to your insurance provider's mental health and substance abuse benefits.

WELLNESS PROGRAM

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What Is Get RutherFIT?

Get RutherFIT, Rutherford County's employee wellness program, is designed to encourage employees to achieve a healthy and physically fit lifestyle. The Get RutherFIT Program strives to see that you and your families will become good health care consumers and adopt healthier lifestyles which will help you enjoy a productive and fulfilling life. As a County employee you can participate in many great activities throughout the Get RutherFIT program; and if you are covered by the County's Health Insurance Plan you could win a variety of prizes.

“Wellness Wisdom” Health Topic Presentations

Periodically there are “Wellness Wisdom” sessions offered for County employees. Examples of some topics include hypertension, health and stress, and general diet, nutrition, and weight.

Annual Health Fair

Each summer, Rutherford County holds an annual health fair at no cost to its employees. At this fair you can:

- Get a variety of health assessments
 - Test your cholesterol
 - Check for diabetes
 - Check your blood pressure
 - And receive screening for other medical concerns such as bone density, body mass, skin cancer and more
- Get valuable information regarding various health and wellness topics
- Learn more about local health care providers
- WIN VALUABLE PRIZES
- And enjoy free food!

Bi-Annual CPR & AED Training

The County encourages its employees to be prepared and trained to help others in times of need. The County sponsors sessions for CPR and AED training throughout the year. The courses are intended to provide a general understanding of CPR and AED procedures and are free for all County employees.

Rutherford County's Biggest Loser Program

The County also encourages its employees to be physically fit and have a healthy weight. The Biggest Loser program is designed to help individuals that want to lose weight do so in a competitive yet supportive program. Participants compete against each other to lose the most weight (by percentage of weight loss). Participants in this program are provided with temporary memberships to fitness centers, nutritional counseling, oversight by a CareHere physician, weekly support meetings, and educational materials to aid them in weight management. Prizes are awarded throughout the program with the biggest loser being awarded the grand prize. Participants are selected on an application basis. The Human Resources Department will notify employees when applications are being accepted. Unfortunately not all applicants will be selected to participate in the program due to the limited number of slots available.

What Is The Wellness Discount Card?

Each employee on the Health Insurance Plan receives one Wellness Discount Card. The Card offers discounts to various health, fitness, and wellness related businesses in Rutherford County. There are also several restaurants that have offered discounts on their cuisine. Whether you enjoy gardening, playing sports, working out, pampering yourself, or eating right, this card should have something for you!

What Health Screenings Are Available?

CareHere provides each employee a free annual Health Risk Assessment (HRA). This HRA is an in-depth analysis of over 30 key lab measurements indicating high cholesterol, diabetes, liver functions, chemistry levels, nutrition, or prostate cancer.

From a simple blood draw and health questionnaire, you will receive a detailed report explaining your results with color-coded graphs to help you better understand your scores (see page 46).

Is Preventive Care Covered?

In order to encourage early detection and prevention, the health plan provides for routine physicals, well child visits and other routine preventive care tests and immunizations for a \$20 copayment. You must use PPO providers to access this benefit. Preventive care is not covered when provided by non-network providers. These copayments do not apply to your out-of-pocket maximum.

How Can I Get Free Medical Advice?

The CIGNA HealthCare **24-Hour Health Information Line (1-800-564-9286)** is always available—day or night—for **personal and confidential** information on a wide range of health-related topics. You can either speak directly with a registered nurse, or listen to prerecorded information.

When you call the 24-Hour Health Information Line, you'll have two options:

1. **Speak directly with a registered nurse.**
A specially trained team of nurses is on duty around the clock. The nurse will ask you a few questions about your symptoms and situation, then direct you to the type of care that should make you more comfortable.
2. **Listen to recorded information in the audio library.**
You can listen to tapes on [topics](#) ranging from aging and women's health to nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can listen to as many tapes as you'd like.

Can I Access Health Information on the Internet?

myCIGNA.com helps those enrolled in the medical plan manage health care benefits and provides access to WebMD's suite of health information and decision support tools.

Through **myCIGNA.com** you can:

- Access your claim payment history
- Check on your eligibility and enrollment information
- Order new id cards
- Get valuable information about your health plan
- Find out where you can get the best deal on your prescription medications

And access WebMD health tools and resources including:

- A Health Risk Assessment offered through WebMD Health Quotientsm. Get recommendations and information about lifestyle changes, self-care and medical care.
- Drug Comparison Tool--Research and compare drugs used to treat specific conditions. Review drug prices, side effects and drug interactions using WebMD sm.*
- Use your secure WebMD smHealth Record to store health information, identify potentially harmful drug interactions, prepare for a doctor appointment and track your health status.
- Your Well Being newsletter-- Helpful tips and information about your health and your plan.
- Hospital Comparison Tool - Compare hospitals based on specific illnesses or procedures. Response based on your needs or preferences from Select Quality Care^{sm*}
- Healthy Rewards ® Member Discount Program. Save up to 62% off a variety of health and wellness products and services. Simply provide ID card information and pay the discounted fee.

What Are We Doing to Help Expectant Mothers?

As a mother-to-be, there are proven steps you can take now to help improve the well-being of your child. The **Healthy Babies**® program gives you information and support to help you and your baby—from prenatal to post-delivery.

Here are some features of the Healthy Babies program:

- Easy enrollment. Just call the number on your CIGNA HealthCare ID card **1-800-244-6224** or the CIGNA HealthCare 24-Hour Health Information Line **1-800-564-9286** to enroll at any time during your pregnancy.
- Free educational materials from a recognized source of information on pregnancy and babies—the March of Dimes.
- Round-the-clock access to a valuable health information line staffed by experienced registered nurses. You can also access audio tapes with information about prenatal care, Caesarean sections, postpartum blues and other topics of interest by calling **800.564.8982**.
- Support from a registered nurse case manager for mothers and babies with special health care needs.
- Post-delivery support and services. We'll continue to support you and your baby, even after your baby arrives. And you'll be able to choose from a wide selection of participating pediatricians and family doctors to provide your new baby's medical care.

What About Stress Management?

Stress can make you feel frustrated, anxious or unable to concentrate. It can result from situations at work and at home as you strive to handle difficult decisions or manage many obligations. It can also have a negative impact on you both mentally and physically. But when stress takes the enjoyment out of life, that's when you may need help.

Help can be found with the iCanRelax Stress Management Program through CIGNA. This program offers a combination of telephonic and online coaching.

To enroll in the program call toll-free **1.800.809.9598**, Monday through Friday 8 AM – 8 PM EST. Your personal health coach will contact you once you have enrolled to conduct a stress risk assessment, which includes overall health and stress-related questions.

How Can I Get Help With Quitting Smoking?

Making the choice to stop using tobacco can be tough. It requires learning to think differently, and changing your daily routine. It means understanding your obstacles and gaining the support to overcome them.

Now there's the new CIGNA Quit Today tobacco cessation program that can help you become and remain tobacco-free. Simply call **1.866.417.QUIT (1.866.417.7848)** to enroll.

Support and motivation are essential as you work toward a tobacco-free life. CIGNA Quit Today pairs you with a dedicated wellness coach who helps you evaluate if you're ready to quit.

If you choose to quit, your coach will help you develop a personalized strategy. At key milestones, you and your coach will work through any obstacles and refocus your efforts, if necessary.

As a participant in the tobacco cessation program, you will receive the following resources:

- A toolkit that includes a printed CIGNA Quit Today workbook, a relaxation CD, and support materials tailored to your needs.
- Optional small group telephone support sessions.
- Nicotine replacement therapy including an 8-week supply of the patch or a 12-week supply of gum at no cost to you when ordered through CIGNA Tel-Drug Home Delivery Pharmacy.
- Support line available 7 days a week, 24 hours a day.

FLEXIBLE BENEFITS

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What are Flexible Benefits?

A Flexible Reimbursement Account or Section 125 plan is a benefit plan that allows participants to re-direct some of their earnings into a customized spending account. The benefit of this plan is that the plan is set up in accordance with Section 125 of the Internal Revenue Service code so the benefits can be paid with tax free money. A Section 125 plan is completely income tax free; no Federal Income Tax, and no Social Security or Medicare Tax.

The County offers 3 types of Flexible Reimbursement Accounts: Pre-Tax Premium Payments; Medical Reimbursement Accounts; and Dependent Daycare Accounts

Pre-Tax Premium Payments

The Pre-tax Premium Payment Program allows full-time County employees to pay health insurance premiums before income or social security tax is deducted. Pre-tax premiums reduce an employee's taxable income because they are deducted before taxes are withheld.

How Do I Enroll in This Program?

Enrollment in the Pre-tax Premium Payment Program is automatic. However, if you don't want to participate, you may complete a waiver form. This form must be signed and submitted before the end of each year. Detailed information can be obtained through the Insurance Department.

Are There Any Limitations to This Program?

Once enrolled in the Pre-tax Premium Program, Internal Revenue Service (IRS) rules do not allow your election to be changed for one year. This means you cannot cancel your coverage during the year, unless you experience a family status change like death, divorce, birth or adoption of a child, or a job change by you or your spouse. You must first have any such event approved through the Insurance Department. Any change you make must be relative to your family status change and reported within 30 days of the event.

Medical Flexible Reimbursement Accounts

A Medical Flexible Reimbursement Account allows you to set aside part of your salary each pay period on a pre-tax basis to pay for the out-of-pocket medical, dental, and vision care expenses not covered by your health benefits plan. There is no minimum to the amount you set aside, and the maximum is \$5,000 annually.

Eligible Expenses

The following is a partial list of expenses that are reimbursable tax-free with a Medical Flexible Reimbursement Account:

- Deductibles, co-pays, and other eligible expenses not covered by insurance
- Prescription drugs and medical supplies
- Over-the-counter drugs that are medically necessary like allergy medications, aspirin, or antacids
- Dental services, orthodontics, and dentures
- Eye surgery, glasses, contacts and contact lens solutions
- Weight-loss programs if prescribed by a physician for a medical condition
- Chiropractic services
- Psychiatric care and psychologist's fees
- Smoking-cessation programs

Medical Flexible Reimbursement vs. Claiming Expenses on a 1040

Unless your itemized medical expenses exceed 7.5% of your adjusted gross income, you cannot claim them on your IRS Form 1040. But you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Flexible Reimbursement Account.

Dependent Care Reimbursement Accounts

The Dependent Care Reimbursement Account allows you to set aside a maximum of \$5,000 in pre-tax dollars per calendar year to pay for eligible dependent care expenses.

Eligible Expenses

Dependent care expenses are eligible for reimbursement if they meet the following criteria:

- The annual amount submitted for reimbursement does not exceed the lesser of your income or your spouse's income.
- The expenses are necessary to enable you to work.
- Your dependent is under age 13 or physically or mentally incapable of caring for himself or herself.
- Your dependent is eligible to be claimed as a dependent on your Federal Income Tax Return.
- Your payments are not made to a person you claim as a dependent.
- If the services are provided by a dependent care center that provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

Note: When filing your Federal Income Tax Return you will be required to supply the name, address and taxpayer identification number of the dependent care provider.

Reimbursement Account Rules

Because reimbursement accounts offer tax advantages, the IRS places certain restrictions on these accounts.

- You cannot transfer money between accounts.
- You cannot change the annual amounts without an approved qualifying mid-year event.
- **You must use the full amount in the account each plan year, or lose it. The "Use it or lose it" rule means if you don't use all of the money in your account, you cannot get a refund or roll it over into the next plan year. For this reason, it's important that you set up your annual**

Flexible Reimbursement Accounts only for predictable expenses to be incurred during the plan year.

Who is Eligible to Participate?

All employees who are eligible for the County Health Benefits Program participate. Enrollment in the County Health Benefits Program is not required.

How Does the Reimbursement Account Work?

- First, estimate how much money you'll spend from during the plan year for expenses which qualify for reimbursement. Your contribution to the account must be less than the maximum amounts allowed for each account.
- Once you've enrolled in an account, each pay period the amount you allocate to your Reimbursement Account is taken out of your pay before taxes are calculated and withheld. The money you set aside for your account is tax-free.
- During the plan year, when you pay for eligible expenses, you will be reimbursed for them with the tax-free money you have set aside in your Reimbursement Account by simply filing a Reimbursement Request Form with the supporting documentation.

Enrollment Period

Each year you must re-enroll in the account, even if you wish your total annual contribution for the new plan year to remain the same. You will be given opportunity to enroll during the fall open enrollment period.

Coverage Period

If you enroll in a Reimbursement Account during Open Enrollment, your period of coverage is the same as the plan year. The plan year is the calendar year plus 2.5 months (ex: January 1st, 2007 through March 15th, 2008). If you enroll after the plan year begins, your period of coverage begins on the effective date of your coverage (which will always be the first of the month) and ends on the last day of the plan year.

If you terminate employment or become ineligible to participate in the program, your Medical FRA will end the last day of the month

unless you elect to extend participation in the Medical Reimbursement Account through the end of the plan year.

If you stop your participation in a Medical FRA due to a qualifying mid-year event, the account will end the last day of the month following receipt of a completed election form.

How Do I Get Reimbursed?

When you enroll, you will have the option of either using a debit card or filing claims for reimbursement.

Flex Stored Value Cards (debit cards) eliminate the "lag time" in claims reimbursement. Rather than paying the provider for eligible expenses with a personal check and then faxing the receipts to have your reimbursement check mailed to you, just swipe your Flex Stored Value Card and you're done. Flex Stored Value Cards are debit cards that you use just like a major credit card.

If filing a claim for reimbursement, you can go to www.selectdataservices.com and download a copy of the claim form and directions. Forms are also available in the Insurance Department. You may submit a form anytime you incur reimbursable expenses during the plan year and up to three months after the end of the plan year. Forms may be faxed to the vendor for reimbursement.

For Medical Reimbursement Accounts, you will be reimbursed from your account for the total amount of the qualifying expenses claimed, up to your plan year election (as long as the expenses were incurred during your period of coverage).

For Dependent Care Reimbursement Accounts, you will be reimbursed from your account up to your existing balance.

Are There Other Coverages Available?

Disability, medical indemnity, and cancer policies are available on a voluntary basis through USABLE.

LIFE INSURANCE

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What Life Insurance Coverage is Available?

To be eligible for the various life and special accident insurance programs, you must meet the eligibility guidelines listed on pages 11 (employees) and 14 (dependents). In addition, children are not covered until 15 days of age.

Basic Term Life and Accidental Death & Dismemberment Insurance

EMPLOYEE BASIC LIFE AND ACCIDENTAL DEATH

The County provides, at no cost to the active full-time employees, \$30,000 of basic term life and \$30,000 of basic special accidental death and dismemberment (“AD&D”).

The face amount of coverage is reduced by 35% at age 65, 15% at age 75, and 20% at age 80.

RETIREE BASIC LIFE

If you meet the eligibility requirements to continue health insurance when you retire, you may also be able to purchase basic life insurance at the group rates. Retirees are eligible for \$25,000 of coverage up to age 65; \$10,000 in coverage up to age 70. This insurance is not available after age 70.

Premiums are billed annually and payable to the Insurance Department.

Additional Life Coverage

These programs are available on a contributory basis for employees and dependents (spouse and children) whether or not they participate in health coverage. For guaranteed-issue coverage, the employee must enroll during the first full month of employment with the County. If optional life coverage is not elected at that time, the employee may only apply at a later date by furnishing satisfactory evidence of insurability.

SPOUSE BASIC LIFE

Employees may purchase basic life insurance on their spouse in increments of \$5,000 up to a total of \$25,000. The premiums are constant and do not increase with employee age.

CHILD BASIC LIFE

You can also purchase life insurance on your eligible dependents (see dependent eligibility rules on page 18) for a face value of either \$5,000 or \$10,000. Premiums are collected on a per family basis, meaning that your premium amounts do not increase with the number of children you have. One premium covers all children in the family. Children are not covered until 15 days of age.

EMPLOYEE OPTIONAL TERM LIFE & ACCIDENTAL DEATH COVERAGE

Employees may elect up to five times annual base salary (subject to a maximum of \$500,000), but evidence of good health is required for the amounts greater than \$150,000. Coverage is purchased in \$10,000 increments and premiums are based on the employee's age. This is 5-year level term coverage. It increases when the employee reaches age 25, 30, 35, etc....

SPOUSE OPTIONAL TERM LIFE & ACCIDENTAL DEATH COVERAGE

If the employee has purchased optional term life for him/herself, Spouse Term life insurance is also available. Spouse Life can be purchased in \$5,000 increments up to 50% of the face value that has been purchased for the employee. Evidence of good health is required for the amounts greater than \$50,000.

This is 5-year level term coverage. It is based on the employee's age, not the spouse's age. It increases when the employee reaches age 25, 30, 35, etc....

What Does Accidental Death & Dismemberment Coverage Provide?

Several of our policies have an Accidental Death and Dismemberment rider ("AD&D"). This additional benefit doubles the value of your life insurance coverage if you die in an accident. In addition, the dismemberment coverage provides benefits if you survive an injury, but lose the use of a body part.

SEAT BELT BENEFIT

If you suffer a loss while in an automobile and wearing a seatbelt, an additional benefit of the lesser of 10% or \$10,000 will be provided.

If a seat belt benefit is payable, an additional 5% up to \$5,000 may also be provided if the person was positioned behind an air bag.

When Can I Purchase Additional Life Insurance?

NEW HIRES

New hires have 31 days from the date they are first eligible for coverage (see eligibility on page 11) to purchase guaranteed issue life insurance.

NEWLY ACQUIRED DEPENDENTS

Employees can purchase guaranteed issue Spouse basic life and optional life within 31 days of their marriage. They can also add dependent coverage within 31 days of acquiring their first dependent child.

LATE APPLICANTS WITH EVIDENCE OF GOOD HEALTH

During the fall annual enrollment period time, you can apply to purchase additional life insurance coverage, but you will have to submit evidence of good health. The insurer will review your application and make final determination regarding your eligibility.

DEPENDENT CHILDREN

Dependent Child coverage can be added during the annual enrollment period without need for evidence of good health.

What Happens if I Become Disabled?

If you become totally disabled before age 60 and your disability lasts for at least 9 months, you can qualify for a waiver of premium. You must provide proof of your disability within one year of your last day worked. Once approved, your coverage will

continue without payment of premiums up to age 65 as long as you remain totally disabled.

Premium for your dependents' coverage will also be waived. Coverage for your dependents will terminate when your policy terminates.

All premiums must be paid and kept current until the disability waiver is approved. Contact the Insurance Department for assistance with waiver of premium applications.

If I Become Terminally Ill Can I Access my Life Insurance?

If you or your dependent is less than 60 years of age and have more than \$10,000 in coverage you can request up to 80% of your life insurance proceed prior to your death. You must present documentation of being diagnosed with a terminal illness with a life expectancy of less than 12 months.

What if I Die While Traveling?

If death occurs outside your state of permanent residence, a repatriation benefit will be provided for the transportation of the body or its preparation for cremation. The benefit will be no greater than 5% of the coverage or \$5,000.

Who Can Help My Beneficiaries?

Grief, legal and financial counseling is available for beneficiaries at no charge through our carrier.

Call **1-800-411-7238**, 24 hours per day/7days a week to talk to professional counselors.

Free unlimited phone contact, and 5 face to face sessions are available.

In addition, the beneficiaries may be able to receive additional help through our Employee Assistance Program. Call 1-866-252-4468

PAID & UNPAID LEAVE

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What Types of Leave Are Available?

Rutherford County provides various types of paid and unpaid leave for its employees. Each type of leave is explained in greater detail below. Most types of leave require an employee to fill out an Employee Request for Leave Form.

Administrative Leave with Pay

A non-punitive suspension of the work day with pay, usually given to protect Rutherford County. Employees do not request administrative leave. The department head / constitutional officer or designee determines when administrative leave is appropriate or is necessary.

Annual Leave

The annual leave for employees of Rutherford County, Tennessee shall be as follows:

- a) Up to five years of employment - one day per month (7.5 hours for those on 37.5 hour workweek or 8 hours for those on a 40 hour work week) with a maximum accumulated days of thirty (30).
- b) Five to ten years of employment - one and one-half days per month (11.3 hours or 12 hours) with a maximum accumulated days of thirty-six (36).
- c) Ten to twenty years of employment - one and three-quarter days per month (13.2 hours or 14 hours) with a maximum accumulated days of thirty-nine (39).
- d) Twenty plus years of employment - two days per month (15 hours or 16 hours) with a maximum accumulated days of forty-two (42).

Employees shall be paid for annual leave days up to but not exceeding the allowed maximum accumulated annual leave days indicated above when employees retire or leave their employment in good standing. Any annual leave days which are earned and exceed the maximum number of accumulated days allowed for annual leave shall automatically expire and be lost for annual leave purposes but will be converted to sick leave days. (Note: Elected officials do not accrue annual leave. Ambulance Personnel working 24 hour shifts will be given 24 hours personal leave time per month. This is in lieu of holidays and vacation days.)

Bereavement Leave

Rutherford County provides up to three (3) days paid leave to travel and attend the funeral following the death of an employee's immediate family member. Immediate family includes parents, spouse, children, siblings, mothers or fathers-in-law, daughters or sons-in-law, sisters or brothers-in-law, grandparents, grandparents-in-law, grandchildren, foster families, and step families. If an employee finds it necessary to be off longer than three (3) days, or to be off for the death of an individual not included in this policy, they may use sick leave first followed by annual leave if approved by their supervisor. Personnel working 24-hour shifts will be given one shift off for bereavement leave.

Civil Leave – Jury Duty, etc.

It is desirous for all employees to fulfill their duty to serve as members of juries or to testify when called in both Federal and State courts. Therefore, the following procedures shall regulate when an employee is called for jury duty or subpoenaed to court.

1. The employee will be granted civil leave when the employee is subpoenaed or directed by proper authority to appear in Federal or State court as a witness or juror.
2. The employee will receive his regular compensation during the time he is serving on jury duty.
3. If the employee is relieved from court or jury duty during working hours, the employee must report back to his employer.
4. The above provisions concerning compensation for time in court do not apply if the employee is involved in private litigation. On these occasions the employee must take annual leave, compensatory time or leave without pay.

Disaster Leave

A County employee who is a certified disaster service volunteer of the American Red Cross may be granted leave from work with pay for a period not to exceed fifteen (15) work days (or 120 hours) in each fiscal year to participate in specialized disaster relief services for the American Red Cross. The employee shall be released from work for this function upon request of the American Red Cross for the services of that employee, and upon the approval of the county department head / constitutional officer and the County Mayor. Upon return from leave, the employee shall provide the department head / constitutional officer with a copy of their deployment evaluation from the American Red Cross

documenting their service. The County shall compensate an employee granted leave under this section at the employee's regular rate of pay for those regular work hours during which the employee is absent from the employee's work. This leave shall not affect the employee's regular leave status.

Holiday Leave

Rutherford County will observe the following holidays: New Year's Day, Martin L. King, Jr. Day, Presidents Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving (2 Days), Christmas (2 Days), and County Elections (primary or general elections). Rutherford County will also add an additional day at Christmas or New Year's Day if the State of Tennessee provides another day for the same holiday. This notification may be made late in the year. At the beginning of each calendar year, the County Mayor's Office will distribute a memorandum instructing employees as to the dates on which such holidays will be observed, should the actual holiday fall on a weekend. (Note: Ambulance Personnel working 24 hour shifts will be given 24 hours personal leave time per month. This is in lieu of holidays and vacation days.)

Leave of Absence

Leave of absence is leave without pay and may be granted by an employee's department head / constitutional officer when an employee must be absent from duty beyond the amount of accrued annual leave and sick leave (if applicable). Leave of absence may be granted for job-related education, extended illness or disability, or any other reason deemed appropriate by the department head / constitutional officer not to exceed one (1) year. All annual and sick leave (if applicable) must be exhausted before this request will be approved. No accumulation of sick leave or annual leave benefits will occur during any leave of absence in excess of twenty (20) working days. During leave of absence, employees may retain the same medical coverage but are required to contribute the total amount (the employee and county share of the premium). If the premiums are not received by the due date, coverage may be terminated consistent with applicable law.

Maternity/Paternity Leave

Any employee who has been employed by Rutherford County Government for at least 12 consecutive months as a full-time employee is entitled to four months maternity/paternity leave under the Tennessee Maternity Leave Act. In order to be eligible for this leave, an employee must provide Rutherford County

Government with at least three months advance notice of their anticipated date of departure for maternity leave, the length of the maternity/paternity leave, and their intention to return to full-time employment after the maternity leave has ended. If an employee qualifies for maternity/paternity leave and provides the required notice, the employee will be entitled to receive their prior job or a similar one upon returning to work. If the employee is prevented from giving the three months advance notice because of a medical emergency which requires that the maternity leave begin earlier than originally anticipated, the employee will not forfeit their rights under the Tennessee Maternity/Paternity Leave Act solely because of failure to give the three months advance notice.

An employee, male or female, who is taking leave for the birth, adoption or foster care of a child may use up to thirty (30) work days of sick leave. If both parents are county employees the aggregate of sick leave used for maternity/paternity leave is limited to thirty (30) work days. Employees may then substitute earned annual leave or compensatory time for any additional time off or may take the remaining time off without pay. If the position, however, is so unique that Rutherford County Government cannot, after reasonable efforts, fill the position temporarily, Rutherford County Government will fill the position with another full-time employee, and the employee on leave will not be entitled to reinstatement to their position or a similar one at the end of the maternity leave. In addition, if the employee utilizes maternity/paternity leave to actively pursue other employment opportunities, to include working part-time or full-time for another employer, the employee will not be entitled to reinstatement at the end of the leave.

PLEASE NOTE: Maternity / Paternity leave, as well as other types of leave that meet these eligibility requirements, will run concurrent with the Family and Medical Leave Act.

Military Leave

In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), Rutherford County protects the job rights of individuals who voluntarily or involuntarily leave employment with the County to undertake military service.

A. Full-time employees who are members of any military reserve component will be granted military training leave for such time as they are in the military service on field training or active duty for periods not to exceed fifteen (15) working days (or 120 hours) per calendar year. This time may not be used for weekend drills. Such requested leave shall be supported with copies of the armed forces orders.

Full-time employees who are members of a military reserve unit who have completed their military training duty for the calendar year, and are reactivated for additional training, will be allowed an additional fifteen (15) days (or 120 hours) military leave if the additional military training:

(1) Occurs during the same calendar year; and

(2) Fulfills the employee's military training obligation for the subsequent calendar year.

During such time that the employee is on military training leave, the employee will receive full pay and benefits to which he or she would otherwise be entitled.

B. Full-time employees who are members of any military reserve component, and who are called into active duty as a result of an executive order or during period of armed conflict have additional benefits/requirements as follows:

- Employees will be entitled to receive county pay equal to the difference between their county salary and their military pay for up to 18 months.
- The county will continue to provide family insurance coverage for any family members that are enrolled in the County's health plan for up to 18 months. The County will pay both the employee's and County's share of the premium during this period. However, the employee is responsible for any payments needed to continue any voluntary insurance they have selected.
- If the employee is paid equal or better by the military, the employee will receive county pay in an amount not less than the cost of their monthly family insurance premium.
- Employees will continue to accrue service time towards retirement during any pay period which they receive compensation from the county.
- During the initial 18 month period the employees' sick leave, annual leave, and holiday balances will be frozen and the employee shall retain those days previously earned upon the employee's return from military duty. These periods of absence will not result in any leave charged to the employee unless the employee specifies the desire to be paid for their accrued annual or holiday leave.

- After the expiration of 18 months, the wage continuation, health insurance, and pension accrual shall cease without further notice.
- Employees called to active duty will be required to provide copies of their military orders and some documentation reflecting their military pay to the Finance Department.

(Note: Upon return from Military Leave, employees may apply for up to four (4) years of military service time to be granted towards their retirement in the Tennessee Consolidated Retirement Service. Four (4) years is the maximum time an employee can apply for towards retirement. COBRA rights as provided in Section 1018 and the employee's right to return to work shall remain. Payment under this agreement is not guaranteed for an indefinite period and is subject to review by the county commission to determine the duration.

Sick Leave

All full-time, regular employees accrue sick leave from the date of hire. Each employee shall be entitled to accrue one day of sick leave per month of employment. There is no limit on the number of days that can be accrued. Sick leave may be used for an employee's personal illness, well-care and sick medical appointments. Sick leave may also be used for illness and well-care of an employee's immediate family. Immediate family includes parents, spouse, children, siblings, mothers or fathers-in-law, daughters or sons-in-law, sisters or brothers-in-law, grandparents, grandparent-in-law, grandchildren, foster families, and step families.

When and if an employee is terminated or leaves prior to the vesting of retirement benefits with the County, there shall be no compensation paid or consideration of any kind given for unused sick leave. After an employee is eligible to receive vested benefits in the County retirement plan and upon said County employee's voluntary retirement from the County, any sick leave which the employee has accrued as of the date of retirement shall be credited for retirement service by the County with the Tennessee Consolidated Retirement System. As an example, if an employee upon retirement after twenty years has 240 days of unused sick leave, the employee shall not be entitled to be paid for said sick leave, but the employee shall have said 240 days credited to the employee's retirement account as additional days worked by the employee for credited service retirement purposes. Any unused sick leave on the date of retirement may be credited one month of retirement credit for each twenty (20) days of unused leave. Sick leave is not recognized for retirement purposes until the employee has retired and the sick leave has been certified by the employer.

When possible, employees are expected to schedule planned medical appointments in a manner that minimizes disruption of workflow. Further, employees must use sick leave for its intended purpose. Supervisors will monitor employee use of sick leave for patterns of abuse. Improper use of sick leave will be grounds for disciplinary action up to and including termination of employment.

Time Allowance for Voting

In compliance with Tennessee Code Annotated, Section 2-I-106, all persons entitled to vote in an election held in this state will be allowed reasonable time off to vote, not to exceed two (2) hours. The department head will designate the time the employee may be absent to vote and voting time shall not be counted as time worked for overtime computation.

Can I Donate Unused Sick Days To Help a Co-Worker?

Realizing that catastrophic events occur relating to illness and injury, Rutherford County Government, upon approval, provides for employees to donate sick time to other Rutherford County Government employees. The request to donate sick time must be received and approved by the department head / constitutional officer of the requesting employee, the department head / constitutional officer of the employee to receive the additional sick time, and the Human Resources Department. Donations may not be utilized until all approvals have been met and the affected employees notified. The following parameters must be adhered to for proper submission:

- The recipient must exhaust all of his personal sick time, annual time, and compensatory time prior to utilizing donated sick time.
- The request must be signed by both department heads / constitutional officers of the affected employees. [Failure to follow these routing requirements will result in the request being denied by the Human Resources Department].
- Requests are considered for catastrophic events only [e.g. serious unexpected health conditions to include but not limited to cancer, heart attack, stroke, or serious injury resulting from

an accident]; the determination of a qualifying event will be made by the Human Resources Department.

- No more than 40 hours per year [rolling year calendar] may be donated by any employee.

What is Unauthorized Leave?

If you are not at work during your regular work hours, you must be on authorized leave. This means that your supervisor knows of and has approved your absence. Unauthorized leave is without pay.

You will be considered as having resigned "not in good standing" if you are absent from work without approval for three (3) consecutive work days or two (2) consecutive work days following the expiration of any authorized leave. Keep your supervisor informed of your needs for leave as they arise and they will do their best to grant you leave.

RETIREMENT

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What Retirement Plans Are Available?

Typically, there are two types of retirement plans covering public employees: Defined Benefit Plan and Defined Contribution Plan.

These type plans are summarized below:

Defined Benefit Plan

- Annuity at retirement is based on a set formula.
- The employer bears the risk of investment loss.
- Contributions are not available for loans or withdrawal until termination of employment.
- Benefit payments are for an employee's lifetime.
- Rutherford County Provides a Defined Benefit Plan

Defined Contribution Plan

- The annuity at retirement is based on the retiree's account balance.
- The employee chooses the investments and bears the risk of investment losses.
- Contributions are available for withdrawals or loans; subject to early withdrawal penalties.
- Examples of defined contribution plans: 401(k), 457, 403(b) plans.

What Are My Retirement Benefits?

Rutherford County is a member of the Tennessee Consolidated Retirement System ("TCRS"). TCRS is a trust fund established by the Tennessee General Assembly for the purpose of administering a retirement program for public employees.

All general fund full-time employees are non-contributory to the system. The County government provides this benefit to its employees without out of pocket expense to the employee.

If you were employed by the County prior to June 30, 1987 you may have the option to withdraw your contributed funds on pre-retirement departure from County employment subject to the rules and regulations of the Tennessee Consolidated Retirement System.

Rutherford County employees attain vesting rights with five years of service. Vesting mean you have accrued enough service to guarantee a retirement benefit once the age requirements are met.

Visit <http://www.treasury.state.tn.us/tcrs/> for more information about the Tennessee Consolidated Retirement System.

When Can I Retire?

County employees who are vested in the retirement plan are eligible for the various retirement options:

Service Retirement

An unreduced benefit payable to an employee who has met the requirements for employees who have attained age 60 with vesting rights or completion of 30 years of creditable service at any age.

Highway department employees at any age are eligible for service retirement after completion of 25 years of creditable service.

Early Retirement

A reduced benefit is payable to an employee who retires prior to attaining the requirements for a full service benefit.

To be eligible for early retirement the employee must be age 55 and have 10 years of creditable service.

Disability Retirement

TCRS also provides disability benefits for those members who become disabled prior to meeting the service retirement requirements. There are two types of disability: ordinary and accidental.

Ordinary Disability Benefits

To qualify for Ordinary Disability benefits (a disability because of medical reasons), you must have at least five years of service, be unable to engage in any gainful employment and you must be approved by the TCRS medical panel. After approval, you are subject to periodic re-evaluations until you attain age 60.

Accidental Disability Benefits

To qualify for Accidental Disability benefits, your disability must be the direct result of an on-the-job injury that renders you unable to engage in any gainful employment. There are no minimum service requirements to apply for accidental disability. The disability must

be documented to your last paid day of service; however, you must apply within one year of last paid date or within two years of the injury. You must be approved by the TCRS medical panel. After approval, you are subject to periodic evaluations until you attain age 60.

Can I Contribute to a Retirement Account?

In addition to our defined contribution plan, Rutherford County offers a deferred compensation plan (457b), similar to a 401k, which allows employees to contribute additional funds towards their retirement. These contributions are employee funded and not matched by the County. Nationwide Retirement Solutions administers the plan which is sponsored by the National Association of Counties (NACO). For more information regarding the 457b plan and how you can participate please contact the Human Resources Department.

LONGEVITY PAY

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What is Longevity Pay?

Rutherford County rewards its employees for their continuous years of service with Rutherford County Government. Longevity pay is a discretionary bonus that may be authorized by the Board of Commissioners each year during budget discussions. Each year the County Mayor presents the budget with proposed longevity pay calculated on an employee's complete years of continuous service as of June 30 of the current year. This calculation is made by multiplying the total years of continuous service by an amount, if any, to be approved by the County Board of Commissioners. (On June 28, 2001, the County Commission adopted that full-time employees earn twenty-five (\$25.00) dollars for each year of continuous service without interruption beginning after three (3) years prior to July 1 of the current year.)

Who is Eligible to Receive Longevity Pay?

To be eligible for longevity pay the employee cannot be a temporary or part-time employee. The employee must be considered a full-time employee on July 1 of the current year in order to be eligible for longevity pay and must have been in continuous service without interruption for a period three (3) years prior to July 1 of the current year. An employee using accumulated sick leave, annual leave, or compensatory time on July 1 toward retirement or immediately prior to the start of retirement will not be eligible for longevity pay. Any employee terminating employment between July 1 and December 1 will be paid longevity pay on the final payroll check issued. All other eligible employees will be paid longevity pay on the last pay period of November or first pay period of December depending on how the pay period ends in the current year. Any terminating employee whose last day at work is before July 1 will not be entitled to longevity pay, even though the employee's accrued annual leave, sick leave, or compensatory time would otherwise cause the terminating employee to be on the County's payroll on July 1.

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What Is This Information And Why Do I Need It?

The Workers' Compensation Program for Rutherford County Government is governed by the Tennessee Workers' Compensation Law pursuant to Tennessee Code Annotated, Title 50, Chapter 6. It is a benefits program that provides medical, rehabilitation, income, death and other benefits to employees and dependents due to injury, illness and death resulting from a compensable work-related claim covered by law.

This section contains details about benefits to which an injured employee are eligible under this Workers' Compensation Program, should there be a work-related injury or illness. In addition to these benefits, the injured employee also has certain responsibilities. The benefits and responsibilities are described in greater detail below.

It is unlawful for Rutherford County Government to terminate an employee for reporting a work-related injury. Wrongful termination is not enforceable under Tennessee Workers' Compensation Law.

It is important to know that the Workers' Compensation Law has been modified and amended by the Tennessee Legislature many times. This information is based on the latest amendments to the Law.

Important Facts About the Workers' Compensation Program for Rutherford County

- All employees of Rutherford County Government are covered under the Workers' Compensation Program, including part-time employees.
- Employees are covered from the first day of employment.
- Any employee who suffers a work-related injury or illness, within the meaning of the Tennessee Workers' Compensation Law, is entitled to benefits provided by the Law.
- The Workers' Compensation Program is managed by the Safety Coordinator under the direction of the Insurance Committee.
- Brentwood Services is a third party administrator who oversees compensation services for Rutherford County Government.

Workers' Comp Contacts

Administrators

Safety Coordinator 615-898-7715 (office)
Dan Goode
303 North Church St – Suite 201 615-867-4602 (fax)
Murfreesboro, TN 37130

CCMSI 615-361-0069 (office)
402 BNA Dr. Suite 106 615-360-8336 (fax)
Nashville TN 37217

Panel of Physicians

Concentra
Dr. Jory Simmons 615-895-4855 (clinic)
1203 A Memorial Boulevard
Murfreesboro, TN 37129
Office Hours : 8:00 am to 5:00 pm (Mon – Fri)

Physicians Medical
Dr. Martin Glynn 615-217-7236 (clinic)
1525 South Church Street
Murfreesboro, TN 37130
Office Hours : 8:00 am to 7:30 pm (Mon – Fri)
9:00 am to 4:30 pm (Sat & Sun)

Tennessee Urgent Care Associates (TUCA)
Smyrna Clinic 615-355-1338 (clinic)
1332 Hazelwood Drive
Smyrna TN 37167
Office Hours : 7:00 am to 7:00 pm (Mon – Fri)
8:00 am to 4:00 pm (Sat & Sun)

Antioch (Dover Point) Clinic 615-399-6898 (clinic)
2553 Murfreesboro Road
Nashville, TN 37217
Office Hours : 8:00 am to 7:00 pm (Mon – Fri)
8:00 am to 4:00 pm (Sat & Sun)

How Will My Medical Information Be Treated?

The HIPAA Privacy Rule mentioned on page 8 provides privacy protection for health information. The Privacy Rule prohibits the disclosure of health information for employment-related decisions without the explicit authorization of the individual. However, there are several instances when an employer may be able to obtain health information without individual authorization. Information related to pre- and post-employment drug testing is not considered protected health information (PHI) under the Privacy Rule.

The Privacy Rule does not apply to workers' compensation programs, so information obtained by Rutherford County Government as part of a workers' compensation claim is not protected under the Privacy Rule. In addition, Department of Transportation regulations, the Federal Aviation Administration, and the Federal Highway Administration rules, contain provisions that require doctors and others to disclose health information to employers. Such disclosures are permitted when required by law and become part of an employee's employment file, which is not subject to the Privacy Rule. However, any medical records obtained by Rutherford County Government shall remain confidential and shall not be considered to be public records.

What Is A Work-related Injury, Illness or Death Claim?

An injury, illness or death arising out of and in the course and scope of employment is by definition a compensable work-related claim. This means if employees are injured while performing assigned job duties during assigned work hours, they are covered under the workers' compensation program.

Be aware that not all accidents, which happen at work, would be compensable under the workers' compensation law. What you are doing when the injury occurs may be more important than where you are.

Injuries sustained while engaging in unassigned job duties, during lunch and breaks, are not covered.

Compensation is not available if the injury results from the willful intention of the employee to injure or kill himself, herself or

another employee. Moreover, workers' compensation benefits are not provided for an injury or accident resulting from an employee's willful misconduct or if the injury is due to intoxication from drugs, alcohol or misuses of prescribed medications.

Recreational and social activities are not compensable unless such recreational or social activities are an **expressly required** incident of employment and produce a substantial direct benefit to Rutherford County beyond improvement in employee health and morale that is common to all kinds of recreation and social life.

An injury suffered while going to or coming from work is not an injury arising out of and in the course of employment, whether or not Rutherford County Government provided the transportation and/or if such means of transportation was available for the exclusive personal use by the employee, unless the employee was engaged in a special errand or mission for Rutherford County Government.

An employee who is injured while deviating from the course of his/her employment (horseplay), including leaving the premises of their place of employment, is not eligible for benefits unless such deviation is expressly approved.

Heart attacks and strokes are not considered injuries under workers' compensation unless it is shown by a preponderance of competent and credible evidence, which shall include medical evidence, that the condition was attributable to the performance of the usual work of employment.

What Should I Do If I Am Injured On The Job?

If there is a work-related accident, **immediately notify your supervisor**. Tell your supervisor exactly what happened, how it happened, who saw what happened and whether there was an injury as a result of the accident.

If you are a witness to a work related accident where a fellow employee is injured severely enough that the involved employee cannot notify the supervisor, an attempt should be made to notify the supervisor for the injured employee. This may be as simple as calling the supervisor to report that there was an accident.

The injured employee should report the injury in writing immediately, but no later than thirty (30) days after the injury. Fill out the **First Report of Injury**. Be as specific as possible when reporting the injury by indicating the date of the accident, how the accident occurred, and the nature and extent of the injury. It

should also be noted whether or not medical treatment is required. Prompt notification initiates workers' compensation benefits in a timely manner.

Will There Be Alcohol Or Drug Testing?

As a Drug-Free Workplace, Rutherford County is required to test for the presence of drugs or alcohol in the employee's body in the event of a work-place injury. If an injured employee refuses to submit to a test for drugs or alcohol, the employee forfeits eligibility for worker's compensation medical and indemnity benefits.

What If I Cannot Report My Injury?

If the injury is such that a report cannot be made at that time, immediate medical assistance will be provided and a report will be made for the employee. Others reporting the injury should also be as specific as possible when reporting the accident and the report should be turned over to the supervisor as soon as possible.

May I Go To My Personal Physician For Treatment of My Work-Related Injury?

No. The County has rules about medical treatment for work-related injuries that require the injured employee to seek treatment from an approved physician on the Panel of Physicians. The injured employee has the privilege of choosing one physician from the approved panel and is then required to accept treatment from that physician. Should the injured employee seek treatment by a physician not approved by the County, such medical treatment may not be eligible for payment under workers' compensation benefits.

How Are Medical Conditions Treated?

Medical Emergencies

In a true emergency situation, temporary medical care can be obtained from the nearest emergency location available. Once the

emergency is over, however, treatment must continue with a physician from the approved panel of physicians.

Surgery

Prior to scheduling any major surgical procedures for a work-related injury, except in the case of an emergency, the treating physician will notify the claims adjuster. Once the adjuster has been contacted, the adjuster will work with the physician and/or his/her medical staff to ensure that all the necessary arrangements are made.

MRI or CT Scan

The authorized treating physician or claims adjuster will arrange for these tests.

Prescription Medications

Prescription drugs are covered under workers' compensation. If the employee pays for the prescription, the employee should submit the bill for reimbursement. The employee should fill the prescription at one of the following authorized pharmacies. **When the prescription is given to the pharmacist, please advise the pharmacist to call 1-800-524-0604 to obtain authorization.**

Authorized Pharmacies Are:

Reeves-Sain	Beckman's
Publix	Rexall Drugs
Terrace Pharmacy	LaVergne Drug Walgreens (All Rutherford Locations)
CVS (All Rutherford Locations)	Krogers (All Rutherford Locations)
Eckerd (All Rutherford Locations)	K-Mart (All Rutherford Locations)

Physical Therapy

The authorized treating physician will make the referral for physical therapy. Either the authorized treating physician or the claims adjuster will arrange the visits.

Do I Have to Pay A Portion Of The Medical Cost?

No. All physician's bills and reasonable medical bills are covered if treatment was with an authorized physician. All medical charges are paid according to the Tennessee Fee Schedule. If the medical provider charges above the Fee Schedule, the charges will be reduced to the Fee Schedule and that amount will be paid. **THE INJURED EMPLOYEE IS NOT RESPONSIBLE FOR CHARGES ABOVE THE FEE SCHEDULE.** However, if the employee is billed for those costs, contact the adjuster to assist in getting the charges corrected.

However, the injured employee will be responsible for bill(s) when:

- The injury is found by the court not to be compensable;
- The physician, who was not authorized by the employer at the time the services were rendered, knew that he/she was not an authorized physician; or
- The employee knew the physician was not authorized and it was not an emergency.

Will I Be Contacted About My Work-related Injury?

Yes. Upon verbal or written notice of the injury, the claims adjuster has to make verbal or written contact with the injured employee within two (2) working days to confirm facts of the claim, history of prior claims, work history, wages and job duties. This may include a recorded statement.

The claims adjuster has fifteen (15) days within verbal or written notice of the injury to determine if it is compensable. The injured employee will be notified, verbal or written, on the decision of their claim.

Can I Change My Panel Physician?

Under Tennessee Law, Rutherford County is not required to offer a second panel of physicians or a second opinion.

The injured employee may always seek a second opinion or obtain treatment with any physician at his/her own expense; however, only the diagnosis and/or restrictions of the authorized physician will be followed.

Am I Paid For Work Time Lost To Attend Doctor Visits Or Physical Therapy?

Rutherford County does not pay for work time lost, except for the initial doctor's visit. The employee may use sick, personal or vacation time to attend doctor visits or physical therapy.

What If I Cannot Work Full-time Or Need Light Duty?

Light Duty

If the authorized physician returns the injured employee to work with specific temporary restrictions (light duty) and a job can be provided within the restrictions, the employee **MUST** return to work and attempt the light duty. Failure to report for the light duty will terminate disability benefits.

Part Time

If, during medical treatment and before full recovery, the authorized physician determines that work can only be done on a part-time basis, then the injured employee is eligible for temporary partial disability benefits. The workers' compensation law provides for payment of $66\frac{2}{3}\%$ of the difference between the employee's wage at the time of the injury and the wage that the employee is able to earn while in a partially disabled condition, subject to the statutory maximums.

What If There Is No Light, Restricted or Part-time Work?

If the authorized physician, in the course of treating the compensable injury, determines that the injured employee is temporarily unable to return to work, then the employee is eligible for temporary total disability benefits.

If the authorized physician releases the injured employee to light or restricted duty and there is no light, restricted or part-time work available, then the employee is eligible for temporary total disability benefits.

These benefits are intended to replace part of the income the employee may lose as a result of the compensable injury. **THE INJURED EMPLOYEE MAY NOT USE ACCUMULATED SICK AND/OR ANNUAL LEAVE INSTEAD OF RECEIVING TEMPORARY TOTAL DISABILITY BENEFITS.**

Under TN Workers' Compensation Law, the date of injury and the first seven (7) days following the injury are the waiting period. Compensation begins on the eighth (8th) day of disability "**from work**". **Consult the supervisor about the use of sick time for the seven-day waiting period.**

Benefits are due for each day over the seven (7) day waiting period until the lost time reaches fourteen (14) days. If the lost time goes beyond fourteen (14) days, the employee is eligible for temporary total disability benefits (TTD) for the full period of disability. Temporary total disability benefits will be calculated beginning with the day following the injury and will be paid biweekly. **However, an employee will not be compensated for the first seven days if sick or annual time was used.**

TTD benefits are based on $66\frac{2}{3}\%$ of the gross average weekly wage for the last 52 weeks worked prior to the injury. This is called the weekly compensation rate and is subject to the minimum and maximum rates in effect on the day of the work-related injury.

What If My Disability Becomes Permanent?

If the compensable injury results in a permanent reduction in the employee's ability to perform the work for which they are suited by

education, age and training, then the employee will be eligible for permanent disability benefits.

It is payable based upon a percentage given by the authorized treating physician in accordance with current AMA Guidelines. The percentage is calculated by a formula that contains the number of weeks assigned by the State Board X the percentage rating X the Temporary Total Disability rate. **HOWEVER, NOT ALL INJURIES RESULT IN RATINGS ASSIGNED BY A PHYSICIAN.**

What Other Conditions Are Covered?

Occupational-related Disease

If the disease meets certain tests imposed by law, the employee can be compensated. There must be a causal relationship between employment and the disease. It cannot be a disease that is an ordinary disease of life to which others are exposed.

Re-injury of A Pre-Existing Condition or Injury

The Workers' Compensation Act limits the extent to which an aggravation of a pre-existing condition or injury is compensable. An aggravation of a work-related injury is compensable while the aggravation is the cause of the disability. Once the aggravation resolves and the employee returns to the pre-injury condition, the claim will no longer be compensable.

Repetitive Motion Injury

Repetitive motion injuries are compensable if they arise out of and in the course and scope of employment.

Problems After Reaching Maximum Medical Improvement

Once the claims adjuster is notified, the employee may go back to the authorized treating physician and receive treatment.

What Other Income Benefits Are Available Under Workers' Compensation?

Temporary Partial Disability Benefits

This benefit is payable to an employee when the employee returns to work in a job paying less as a result of a work-related accident. This lost wage amount is $66\frac{2}{3}\%$ of the difference between the employee's average weekly wage before and after the injury. The maximum amount payable cannot exceed the maximum allowed under the law.

Death Benefits

- When an injury results in death, the widow or widower or dependent orphan is entitled to 50% of the deceased employee's average weekly wage, not to exceed the maximum per week.
- If the deceased employee leaves a widow/widower and one or more dependent children, $66\frac{2}{3}\%$ of the deceased employee's average weekly wages, not to exceed the maximum per week, is due.
- If a deceased employee leaves other relatives dependent on the employee for support, compensation may also be payable to those dependents.
- When the deceased employee leaves no dependents, \$20,000 shall be paid to the employee's estate.

Do I Have Other Legal Recourse?

If the injury was caused by the negligence of a third party other than another person who is also an employee of Rutherford County Government, the employee has a right to sue that party. If the employee sues and receives a dollar reward, Rutherford County Government has a right to recover some or all of the cost expended in the employee's workers' compensation claim. This is known as a subrogation lien. The lien would only be recoverable after you had been fully compensated for your loss resulting from your work-related injury.