



City of Memphis Active Employees

Your 2014 Benefits & Enrollment Guide



ACTION REQUIRED (OPEN IMMEDIATELY)

Open Enrollment October 7-18, 2013

“Don’t wait in line, enroll online”

<http://openenrollment.memphistn.gov>

The City of Memphis is pleased to offer a comprehensive benefits package to all full-time employees that is designed to help protect you and your family's health, finances, and lifestyle. This guide not only summarizes your benefits for 2014 but it gives you an overview of all the benefits available to you as a City of Memphis employee. Reviewing the information contained in this guide will help you make informed decisions about your benefit elections.

Health Wellness and Benefits has taken every effort to ensure the accuracy of the information provided in this guide. However, if there is a conflict with any plan or benefits policy, the plan policy will always govern.

City of Memphis reserves the right to amend, suspend or terminate the benefit plans at any time.

Important information for 2014 Open Enrollment:

- The 2014 open enrollment period starts **October 7, 2013** and will end at midnight **October 18, 2013**.
- No waiting in long lines with benefit online enrollment.
- Open enrollment is passive meaning if you choose not to make any changes to your current benefits for Medical, Dental, Vision, or Life Insurance, your current elections will roll over to 2014.
- You **cannot roll over** your current elections for Flexible Spending Accounts (FSAs). You must re-enroll each year in order to continue either of these plans.
- To make benefit changes or to enroll in an FSA for 2014, you must do so during Open Enrollment. You can enroll in one of three ways:
 - *Enroll online through the City's Open Enrollment web portal
 - *Mail your completed enrollment form along with required documentation
 - *Visit one of two Health Wellness and Benefits Offices
- Summaries of Benefits and Coverage (SBCs), as required by the Patient Protection Affordable Care Act (PPACA) are either available online or you can request a hardcopy by calling Health Wellness and Benefits.

Remember you can only make changes during open enrollment unless you have a qualifying life event such as the birth of a child or you get married or divorced. See the Medical Summary Plan Description for complete details of qualifying life events.

What's New for 2014?

- 1) City of Memphis plans are no longer considered Grandfathered under healthcare reform
- 2) Pre-Existing Condition Limits no longer apply to anyone regardless of age
- 3) Dependents covered to age 26 even if the child has access to his/her own employer coverage.
- 4) All copayments, coinsurances and deductibles now apply toward the Out of Pocket (OOP) Maximum
- 5) Coverage for Clinical Trials
- 6) Additional guidance for Women's Preventive Health/Contraceptive Coverage – No Cost Share
- 7) Vitamin D Coverage for prevention of falls in older adults
- 8) Medical Plans – Employee contribution increased to 30%
- 9) Increase in dental premiums
- 10) Increase to ER Copay – Medical Premier Plan Only
- 11) A third medical plan option – the Value Plan
- 12) Notarized documents no longer required; instead you must provide your Oracle employee ID number (located on your ID Badge or your paycheck stub) along with your signature.

HOW TO ENROLL

- ✚ Enrolling online is the ultimate choice for your 2014 enrollment elections. You can view your current benefits, make benefit changes or enroll in the available benefit options. During the open enrollment period, the online system is available 24/7 and can be accessed from work or any computer with internet access. Further, if your online enrollment confirmation states additional information is needed in order to finalize your enrollment, please fax the documentation to 901-636-8486. Remember to keep a copy of your benefits online confirmation statement and if you are faxing information, please keep a copy of your fax confirmation page for your records as well.
- ✚ Mail your completed enrollment form along with any required documentation to City of Memphis, Health Wellness and Benefits, 2714 Union Avenue Ext., 5th Floor, Room 100, Memphis, TN 38112 or 4225 Riverdale Road, Memphis, TN 38141. All mail must be postmarked no later than October 18, 2013. Or you can fax it to 901-636-8486. *NOTE: Please do not submit duplicate information to different enrollment locations. For example, if you submit information to the Riverdale office, do not submit the same information to the Union Ext. Office. Also, if you need to change information previously submitted during this Open Enrollment period, note the changes and submit to the same location.*
- ✚ Visit one of the offices listed above between 8:30 am and 4:30 pm

All 2014 changes will be reflected in your first paycheck in December. Please refer to the rates listed in this guide to determine the correct deductions. You must notify Health Wellness and Benefits immediately but no later than 30 days after your first paycheck in December if there are discrepancies. If you fail to do so, the City may not be able to remedy your problem until you re-enroll during the next open enrollment.

Who is Eligible for benefits?

<i>Eligible</i>	<i>Required Documentation</i>
Regular Full-time employees	N/A
Lawful Spouse of the opposite sex	<ul style="list-style-type: none"> • Copy of Marriage License, • Copy of Social Security Card • Date of Birth
Dependents to Age *26 (child who is married or unmarried and is your biological, legally adopted, or stepchild of you and/or your spouse.) <i>*life insurance plans cover dependents to age 19 (25 if a full-time student).</i>	<ul style="list-style-type: none"> ✓ Copy of Birth Certificate listing you as the parent, or ✓ Copy of the Adoption Agreement, or ✓ Copy of court papers showing custody/guardianship, or ✓ Copy of divorce decree showing the dependent, or ✓ Copy of Qualified Medical Court Support Order (QMCSO) and ✓ Copy of Social Security Card

Your Core Benefit Snapshot

<i>Benefit/Vendor</i>	<i>Funding</i>	<i>Options</i>
Medical (Cigna) Pharmacy (CVS/Caremark)	City Paid – 70% Employee Paid – 30%	Three Options: ❖ Premier ❖ Basic ❖ Value Option
Dental (UHC)	100% Employee Paid	Three Options: ❖ Primary Dental (In-Network Only) ❖ Premier Dental ❖ Basic Dental
Vision (UHC)	100% Employee Paid	Two Options: ❖ Exam and Materials ❖ Materials Only
Flexible Spending Account (FSA) (Cigna)	100% Employee Paid	Two Plan Types: ❖ Medical Spending - \$2500 max ❖ Dependent Care - \$5000 max
Life Insurance – Death Benefit (Standard) *Contributory Life (Lincoln) *Voluntary Life (Lincoln) <i>*Spouse/Dep Cov Available</i>	100% City Paid 67% City Paid/33% Employee Paid 100% employee paid	\$10,000 per FT employee 1.5 times annual salary (\$200,000 max) \$10,000 - \$500,000
Short-Term Disability	100% Employee Paid (Cost: \$.20 per \$10 coverage)	Benefit: 60% of weekly salary up to \$300 maximum weekly benefit for max benefit period of 6 months (including the 30 day waiting period).
Long-Term Disability	100% Employer Paid	Benefit: After 180 days of continuous total disability, 60% of monthly salary.

Medical Plan Options - Comparison Chart/Semi-Monthly Rates

The following are brief highlights of the major plan provisions for the City of Memphis medical plans administered by Cigna Healthcare. You must refer to the Summary Plan Description (SPD) for applicable benefit limits and details regarding the plans. Please note, the Value Plan is a new plan offering for 2014 and is not included in the SPD. Visit Cigna's website (listed in vendor contacts) for a listing of network providers.

	Basic Plan Single: \$81.00 Family: \$171.97		Premier Plan Single: \$87.88 Family: \$177.52		Value Plan Single: \$42.00 Family: \$147.50	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
ANNUAL DEDUCTIBLE	\$ 350 Sgl \$1,050 Fam	\$ 350 Sgl \$1,050 Fam	\$100 Sgl \$300 Fam	\$500 Sgl \$1,500 Fam	\$1,500 Sgl \$3,000 Fam	N/A
CO-INSURANCE (Hospital and Other Services)	You: 10% Plan: 90%	You: 30% Plan: 70%	You: 0% Plan: 100%	You: 40% Plan: 60%	You: 30% Plan: 70%	N/A
ANNUAL OUT OF POCKET (OOP) MAXIMUM	You: \$1,500 sgl/\$3,000 fam	You: \$3,500 sgl/\$7,000 fam	N/A	You: \$3,000 sgl/\$7,000 fam	You: \$3,000 Sgl/\$6,000 Fam	N/A
OFFICE VISIT AND HOSPITAL:						
Primary Care Physician (PCP)/ Specialist	You: 10% after Ded. Plan: 90%	You: 30% after Ded. Plan: 70%	You: \$20 copay PCP/\$40 Spec + Ded Plan: 100%	You: 40% after Deductible Plan: 60%	You: 30% after Ded. Plan: 70%	N/A
Inpatient Hospital Copay per Admission	You: \$100 copay + Ded. + 10% Plan: 90%	You: \$300 copay + Ded. + 30% Plan: 70%	You: \$100 copay + Ded. Plan: 100%	You: \$300 copay + Ded. + 40% Plan: 60%	You: \$100 Copay + Ded. + 30% Plan: 70%	
Urgent Care Copayment	You: \$25 copay + Ded. + 10% Plan: 90%	You: 30% after Ded. Plan: 70%	You: You pay \$30 + Ded. Plan: 100%	You: 40% after deductible Plan: 60%	You: 30% after Ded. Plan: 70%	N/A
*Emergency Room Copayment *Waived if Admitted	You: \$100 copay + Ded. + 10% Plan: 90%	You: 30% after Ded. Plan: 70%	You: \$200 copay + Ded. Plan: 100%	You: 40% after deductible Plan: 60%	You: \$200 copay + Ded + 30% Plan: 70%	N/A
PREVENTIVE CARE:						
*Well Child Office	You: \$0 Plan: 100%	NOT COVERED	You: \$0 Plan: 100%	Not Covered	You: \$0 Plan: 100%	N/A
*Well Adult Visit	You: \$0 Plan: 100%	NOT COVERED	You: \$0 Plan: 100%	Not Covered	You: \$0 Plan: 100%	N/A
*Ded/Copay does not apply						
OTHER CARE:						
Chiropractic Care (limited to 20 visits/cal yr)	You: 10% after deductible Plan: 90%	NOT COVERED	You: \$40 copay + Ded. Plan: 100%	Not Covered	You: 30% after deductible Plan: 70%	N/A
Physical/Speech/Occupation Therapy (limited to 60 days for all therapies)	You: 10% after deductible Plan: 90%	NOT COVERED	You: \$40 copay + Ded. Plan: 100%	You: 40% after plan deductible Plan: 60%	You: 30% after deductible Plan: 70%	N/A
Durable Medical Equipment (DME)	You: 10% after deductible Plan: 90%	You: 30% after deductible Plan: 70%	You: Deductible Plan: 100%	Not Covered	You: 30% after deductible Plan: 70%	N/A
Mental Health/Substance Abuse:	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	Same as office, medical, and hospital care.	NOT COVERED

Prescription Drug Coverage

The City’s pharmacy program is administered by CVS Caremark and is bundled with the medical plan. If you enroll in medical, you are automatically enrolled in pharmacy and cannot opt out of the program. Also, you cannot elect to enroll in pharmacy only.

The Pharmacy benefit includes both retail and voluntary mail order for maintenance drugs prescribed for 90 day therapy. These medications can be purchased at a more reasonable cost to you by offering a three month supply for two months in copayments. See below benefits:

	Generic	*Formulary Brand (PDL-Preferred Drug List)	Non-Formulary Brand
Copays apply after satisfying the \$25 annual deductible			
Retail (30 day supply)	\$10.00 copay	\$20.00 copay	\$40 copay
Retail or Mail Order (90 day supply)	\$20 copay	\$40 copay	\$80 copay
*The preferred drug list is updated quarterly and can be found on Caremark’s website. See vendor contact listing in this guide. Additional pharmacy detail is listed on Benefit’s website.			

Healthcare Surcharges

Spouse Surcharge - \$25 per pay period	Tobacco/Nicotine Surcharge - \$25 per pay period
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In addition to the medical premium, a spouse surcharge and/or tobacco surcharge will apply if you are covering a spouse and/or if you or any of your family members age 16 or over use tobacco or nicotine products.

To have the tobacco surcharge waived, you must complete and sign an affidavit during open enrollment attesting that you, nor anyone in your family age 16 or over is a tobacco or nicotine user. Failure to do so will result in the assessment of the surcharge until you and your appropriate family members can provide negative test results.

The spouse surcharge is assessed if you choose to cover a spouse on your plan who has access to, but opted out of medical coverage through his/her employer. With a signed affidavit, the spouse surcharge is waived if the spouse has no access to medical care or if the spouse is enrolled in his/her employer’s medical plan that pays as primary to the City of Memphis medical plan.

Please refer to the City of Memphis Summary Plan Description (SPD) for full details of the healthcare surcharges. The SPD can be found online or you can contact Health Wellness and Benefits to request a copy.

Important Note: Signed affidavits waiving spouse and/or tobacco surcharges are subject to random audits that can result in disciplinary action including termination of healthcare coverage if findings show document falsification.

Vision Comparison Chart/Semi-Monthly Rates

The City of Memphis vision plans are administered by UnitedHealthcare (UHC). The below chart is a summary of the benefits offered. Visit UHC’s website at www.myuhc.com for a listing of the vision providers or you may contact their customer service at the phone number listed in the vendor contact section of this guide. For complete vision plan details, visit Health Wellness and Benefits website.

	Exam and Materials Employee: \$2.30 Employee + 1: \$4.21 Employee + Family: \$7.15	Materials Only Employee: \$1.70 Employee + 1: \$3.13 Employee + Family: \$5.30
Comprehensive Vision Exam	\$15 Copay (once every 12 months)	Not Covered
Materials (The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses).	\$15 Copay <ul style="list-style-type: none"> • Pair of <u>lenses</u> for eyeglasses (Once every 12 months) • <u>Frames</u> (Once every 24 months) • <u>Contact Lenses</u> in lieu of Eyeglasses (Once every 12 months) 	\$15 Copay <ul style="list-style-type: none"> • Pair of <u>lenses</u> for eyeglasses (Once every 12 months) • <u>Frames</u> (Once every 24 months) • <u>Contact Lenses</u> in lieu of Eyeglasses (Once every 12 months)

Flexible Spending Accounts The Flexible Spending Account (FSA) plans are administered by Cigna Healthcare and offers all City of Memphis regular full-time employees the opportunity to enroll. Enrollment in medical is not required in order to participate in an FSA. Only health care expenses that are considered tax-deductible by the IRS and not covered by insurance are eligible for reimbursement. When you enroll in an FSA plan, you decide in advance how much you would like to set aside from each paycheck before taxes are deducted. For every dollar you contribute to your FSA, you reduce your taxable income by that same amount. You do not pay taxes on the money you set aside. This money is available to you to use all year long to pay eligible expected and unexpected out-of-pocket healthcare or dependent expenses. It is important that you accurately determine anticipated annual expenses because there is a “Use-it” or “Lose-it” policy in effect. There is a grace period in which to use all the funds for the 2014 plan year. Your funds will be forfeited if not used by the end of the grace period. Remember you must enroll and specify each year the amount you would like to allocate for FSA. See the below chart for additional information:

	Healthcare FSA	Dependent Care FSA
You can contribute...	\$200 - \$2,500 annually	\$200 - \$5,000 annually
To reimburse yourself... NOTE: After enrollment, the employee <u>only</u> will receive a debit card that can be used like cash at any vendor that accepts health care debit cards. The card can be used for expenses incurred by the employee, spouse or dependents. OR File a claim for reimbursement	Example of eligible expenses (refer to www.irs.gov , pub 502 for a detailed list): <ul style="list-style-type: none"> ○ Medical expenses including deductibles, coinsurance, copayments ○ Prescription deductibles, copayments ○ Dental expenses ○ Over-the-counter medicines, vitamins and supplements if prescription written ○ Over-the counter health related supplies 	Example of eligible expenses (refer to www.irs.gov , pub 503 for a detailed list): <ul style="list-style-type: none"> ○ Day care and associated expenses for your children under age 13 ○ Dependent care fees for a disabled spouse, child or a tax-dependent parent or elderly person
Plan Year	January - December 2014	January – December 2014
Grace Period	Until March 15, 2015	Until March 15, 2015
Claim Filing Deadline	March 31, 2015	March 31, 2015

Dental Comparison Chart/Semi-Monthly Rates

The chart below is an overview of the dental plans offered by UnitedHealthcare (UHC). Complete plan details can be found online. Please visit UHC’s website, as listed in the vendor contact section of this guide, for a listing of network dental providers.

	Primary Dental Plan Employee: \$8.12 Employee + 1: \$16.14 Employee + Fam: \$29.87		Basic Dental Plan Employee: \$9.26 Employee +1: \$19.04 Employee + Fam: \$27.71		Premier Dental Plan Employee: \$13.93 Employee +1: \$28.66 Employee + Fam: \$41.70	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Individual Ded.	None	None	\$50	\$100	\$50	\$50
Annual Family Ded.	None	None	\$150	\$300	\$150	\$150
Annual Ind Orthodontics Ded.	None	None	\$50	\$100	\$50	\$50
Annual Fam Orthodontics Ded.	None	None	\$150	\$300	\$150	\$150
Maximum Non-Orthodontics <i>(combined for both In Network and Out of Network Services).</i>	\$1500 per person per calendar year	\$1500 per person per calendar year	\$1000 per person per calendar year	\$750 per person per calendar year	\$1000 per person per calendar year	\$1000 per person per calendar year
Maximum Orthodontics <i>(combined for both In Network and Out of Network Services)</i>	\$1000 per person per lifetime	\$1000 per person per lifetime	\$500 annual max; \$1000 per person per lifetime	\$375 annual max; \$750 per person per lifetime	\$500 annual max; \$1000 per person per lifetime	\$500 annual max; \$1000 per person per lifetime
COVERED SERVICES	You Pay	You Pay	Plan Pays	Plan Pays	Plan Pays	Plan Pays
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES						
Periodic Oral Examinations	\$0	100%	100%	80%	100%	100%
Bitewing X-rays	\$0	100%	100%	80%	100%	100%
Complete Series or Panorex X-rays	\$0	100%	100%	80%	100%	100%
Dental Prophylaxis (Cleanings)	\$0	100%	100%	80%	100%	100%
Fluoride Treatments	\$0	100%	100%	80%	100%	100%
Sealants	\$0	100%	100%	80%	100%	100%
BASIC DENTAL SERVICES (Minor Restorative, Endodontics and Oral Surgery)						
Space Maintainers	\$100	100%	80%	60%	80%	80%
Palliative Treatment (Pain Relief)	\$35	\$35	80%	60%	80%	80%
General Anesthesia	\$115	100%	80%	60%	80%	80%
Amalgam Restorations (Fillings)	\$40	100%	80%	60%	80%	80%
Composite Restorations (Fillings)	\$47	100%	80%	60%	80%	80%
Surgical Extractions including Impacted Wisdom Teeth	\$145	100%	80%	60%	80%	80%
Root Canal Treatment	\$235	100%	80%	60%	80%	80%
Scaling and Root Planning	\$70	100%	50%	40%	50%	40%
Periodontal Surgery	\$339	100%	50%	40%	50%	50%
MAJOR DENTAL SERVICES (Including Periodontics)						
Crowns	\$380	100%	50%	40%	50%	50%
Inlays	\$310	100%	50%	40%	50%	50%
Fixed Bridges	\$380	100%	50%	40%	50%	50%
Full Dentures	\$440	100%	50%	40%	50%	50%
Partial Dentures	\$440	100%	50%	40%	50%	50%
Replacement Crowns	\$25	100%	50%	40%	50%	50%
Relining Dentures	\$100	100%	50%	40%	50%	50%
Repairs to Full Dentures	\$65	100%	50%	40%	50%	50%
ORTHODONTIC SERVICES						
Diagnose or correct misalignment of the teeth or bite	50%	50%	50%	40%	50%	50%

Life Insurance

The City of Memphis offers a death benefit to all regular full-time employees at no cost to you. The following options are available for you to purchase additional life insurance coverage for you and your dependents....plan administered by Lincoln Financial Group:

- **Employee Contributory Life** – Coverage amount is based on annual salary and premium cost is shared between you and the City. Guarantee Issue is \$200,000.
- **Spouse/Dependent Contributory Life** – Can elect \$10,000 for Spouse and Dependent children at a monthly cost of \$2.15 and the premium is paid by you; the employee.
- **Employee Voluntary Life** – Can elect \$10,000-\$500,000 in \$10,000 increments. Guarantee Issue amount is the lesser of \$200,000 or 3 times your salary if you are under age 60; \$10,000 if you are age 60-69. Cost is based on age and the amount of coverage elected and is payable by you; the employee.
- **Spouse Voluntary Life** – Can elect \$5,000-\$250,000 in \$5,000 increments. Premium is based on employee's age and the amount of coverage elected for the spouse. There is no cost sharing for this benefit between you and the City.
- **Dependent Voluntary Life** – Dependents can have \$10,000 in coverage at a cost of \$2.00 per month. There is no cost sharing.

NOTE: You can only elect contributory life and/or voluntary life for your spouse and dependents if you are electing the coverage for yourself.

Please refer to Health Wellness and Benefits website for additional Contributory and Voluntary life details as well as the calculation method if selecting more than \$100,000 in Voluntary Life coverage or if you are age 65 or older.

Beneficiary for Life Insurance

Some insurance companies require an original signed beneficiary form in order to pay benefits should you die. Because of this requirement, beneficiary updates are no longer available online. You can however, print the form, complete and return it to City of Memphis Health Wellness and Benefits. Please make sure there is a signed form in Health Wellness and Benefits to ensure the person you planned to designate as your beneficiary receives the proceeds should something happen to you. **Important Note:** If you do not name a beneficiary, your life insurance proceeds will either go to your estate or the insurance company will follow their standard procedure for payouts. It is also important to note that the insurance company **will not make a payment to a minor (anyone under the age of 18)** who is named as the beneficiary. If you intend to list a minor, you should seek advice on estate planning before you complete this step.

Employee Voluntary Life Premiums

Refer to Health Wellness and Benefits website if you are electing more than \$100,000 in coverage or if you are age 65 or older.

AGE	Semi-Monthly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	0.030	\$ 0.30	\$ 0.60	\$ 0.90	\$ 1.20	\$ 1.50	\$ 1.80	\$ 2.10	\$ 2.40	\$ 2.70	\$ 3.00
30-34	0.035	\$ 0.35	\$ 0.70	\$ 1.05	\$ 1.40	\$ 1.75	\$ 2.10	\$ 2.45	\$ 2.80	\$ 3.15	\$ 3.50
35-39	0.045	\$ 0.45	\$ 0.90	\$ 1.35	\$ 1.80	\$ 2.25	\$ 2.70	\$ 3.15	\$ 3.60	\$ 4.05	\$ 4.50
40-44	0.075	\$ 0.75	\$ 1.50	\$ 2.25	\$ 3.00	\$ 3.75	\$ 4.50	\$ 5.25	\$ 6.00	\$ 6.75	\$ 7.50
45-49	0.130	\$ 1.30	\$ 2.60	\$ 3.90	\$ 5.20	\$ 6.50	\$ 7.80	\$ 9.10	\$ 10.40	\$ 11.70	\$ 13.00
50-54	0.190	\$ 1.90	\$ 3.80	\$ 5.70	\$ 7.60	\$ 9.50	\$ 11.40	\$ 13.30	\$ 15.20	\$ 17.10	\$ 19.00
55-59	0.285	\$ 2.85	\$ 5.70	\$ 8.55	\$ 11.40	\$ 14.25	\$ 17.10	\$ 19.95	\$ 22.80	\$ 25.65	\$ 28.50
60-64	0.470	\$ 4.70	\$ 9.40	\$ 14.10	\$ 18.80	\$ 23.50	\$ 28.20	\$ 32.90	\$ 37.60	\$ 42.30	\$ 47.00

Spouse Voluntary Life Premiums

Refer to Health Wellness and Benefits website if you are electing more than \$50,000 for your spouse and if you are over age 65. The spouse premium is calculated on the employee's age. You must elect coverage in order for your spouse (or dependents) to be eligible and the amount cannot exceed 50% of the coverage amount you elect for yourself.

AGE	Semi-Monthly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	0.030	\$ 0.15	\$ 0.30	\$ 0.45	\$ 0.60	\$ 0.75	\$ 0.90	\$ 1.05	\$ 1.20	\$ 1.35	\$ 1.50
30-34	0.035	\$ 0.18	\$ 0.35	\$ 0.53	\$ 0.70	\$ 0.88	\$ 1.05	\$ 1.23	\$ 1.40	\$ 1.58	\$ 1.75
35-39	0.045	\$ 0.23	\$ 0.45	\$ 0.68	\$ 0.90	\$ 1.13	\$ 1.35	\$ 1.58	\$ 1.80	\$ 2.03	\$ 2.25
40-44	0.075	\$ 0.38	\$ 0.75	\$ 1.13	\$ 1.50	\$ 1.88	\$ 2.25	\$ 2.63	\$ 3.00	\$ 3.38	\$ 3.75
45-49	0.130	\$ 0.65	\$ 1.30	\$ 1.95	\$ 2.60	\$ 3.25	\$ 3.90	\$ 4.55	\$ 5.20	\$ 5.85	\$ 6.50
50-54	0.190	\$ 0.95	\$ 1.90	\$ 2.85	\$ 3.80	\$ 4.75	\$ 5.70	\$ 6.65	\$ 7.60	\$ 8.55	\$ 9.50
55-59	0.285	\$ 1.43	\$ 2.85	\$ 4.28	\$ 5.70	\$ 7.13	\$ 8.55	\$ 9.98	\$ 11.40	\$ 12.83	\$ 14.25
60-64	0.470	\$ 2.35	\$ 4.70	\$ 7.05	\$ 9.40	\$ 11.75	\$ 14.10	\$ 16.45	\$ 18.80	\$ 21.15	\$ 23.50

Short Term Disability (STD) – Administered by The Standard

Through the City's core benefit options you can elect Short Term Disability at the time of employment or a later date. You do not have to enroll during open enrollment or wait for a qualifying life event. However, if you enroll after your initial employment eligibility period, you must complete an Evidence of Insurability (EOI) form and coverage is not effective until approved by Standard's underwriters. The Core Benefits section of this guide lists the available benefit.

Long Term Disability (LTD) – Administered by The Standard

After you have completed your initial probationary period with the City of Memphis, you are automatically enrolled in Long Term Disability at no cost to you. Should you become disabled and go out on LTD, you are no longer considered an employee and will be removed from the City's payroll. The Core Benefits section of this guide lists the available benefit.

Employee Assistance Program (EAP) – Administered by CONCERN

Did you know the City offers EAP services to help you manage quality of life issues? This service is paid by the City and is available to you, your dependents or household members even if you are not covered by a City of Memphis medical plan option. Short-term professional assistance is available through CONCERN 24/7 by calling 901-458-4000 or 1-800-445-5011.



WELCOME TO WELLNESS WORKS – The Employees Suite of Wellness Services

Online Health Risk Assessment

REMINDER: Don't forget you can earn a \$50 gift card by completing Cigna's online Health Risk Assessment. Simply complete the assessment including your biometric numbers (i.e.-Blood Pressure, Glucose, Cholesterol, BMI, etc.) between September 1, 2013 and October 31, 2013. All participants are encouraged to complete the online assessment to learn how to become the champion of your own healthcare. However, only employees who complete the assessment will be rewarded the gift card. The cards will be issued in December 2013.

Onsite Clinic

Are you enrolled in the City's Medical Plan? Did you know the City has an onsite Clinic, operated by Methodist Healthcare, to provide wellness and urgent care services? The good news is that if you are enrolled in one of the City's medical plans, you do not have to pay a copayment nor a deductible when visiting the clinic. Plus, the clinic has a limited supply of medications in stock at no cost to you nor your dependents. Your covered dependents will pay a \$15 copayment for the office visit. If you are not enrolled in the City's Medical Plan, this benefit is not available to you. The onsite clinic is located at 2714 Union Ave. Ext., 5th Floor, Room 114 and is open Monday, Wednesday and Friday from 9:00 am to 1:00 pm. You may contact the clinic at 901-636-6010. **NOTE: Take comfort in knowing your medical information is protected by HIPAA privacy laws and is not shared with The City of Memphis.**

24 Hour Nurseline – Cigna

What do you do when your child spikes a fever in the middle of the night? Or when you go jogging and twist your ankle? Don't worry, wonder or wait – whenever there's a question about health just call the Health Information Line and talk directly with a specialist trained as a nurse, 24 hours a day, 7 days a week. Dial the toll-free number on your Cigna ID card and speak one-on-one with a nurse for personalized attention and help answering your health questions.

Onsite Total Wellness Center

Have you been thinking of increasing your physical activity? Dreaming of shedding a few pounds or toning your physique? Stop dreaming and get moving..... For only \$10 per month, you can become a member of the Total Wellness Center located at 125 North Main, on 2B. The center is equipped with weights, power rowers, elliptical machines, treadmills, stair climber, and much more. The center is open Monday-Friday, 6:00 am – 8:30 pm. To become a member of the Wellness Center, you must complete an enrollment application that includes health history, waiver forms and the payroll deduction authorization form. The application is included in the forms section of this guide or you can download a copy from our website. You may contact Health Wellness and Benefits should you have questions or need additional information.

Cigna Wellness and Disease Management Programs

Why is Cigna calling me and should I answer? Through the medical benefits plans, various programs are included to help you get healthy and live well. Programs like Stress Management Weight Management, Tobacco Cessation, Case Management and Disease Management (Diabetes, Asthma, COPD, Low Back Pain, Hypertension, Heart, etc.) are designed to help you better manage your health. Cigna receives information about you from multiple sources such as claims, your health risk assessment, as well as alerts if you have missed your preventive care visit. At this point, Health Advocates are deployed to reach out to you. It is okay to answer the call as the conversations you have with your Health Advocates are completely private and confidential and is not shared with anyone at the City of Memphis. The Health Advocate will talk to you about the program(s) that will best benefit you in managing your health. *Who are Health Advocates?* These are professionals trained as registered nurses, behavioral specialists, health educators, exercise specialists or nutritionists and they are all supported by doctors and pharmacists. *What if I don't receive a call, can I still join a program?* Yes. You can call Cigna or go to their website. See contact information listed in the Vendor Contact section of this guide.

YMCA Information

Employees can join the YMCA at either of the 9 facilities located throughout the City and have the *membership fee payroll deducted. The City of Memphis will provide \$6 per month toward your YMCA membership, if you work out at least 8 times per month.

**Based on your household income, you may qualify for a membership discount. Eligibility determined by the YMCA.*

YOUR OTHER BENEFITS

The City provides a variety of other valuable benefits at no cost to you. These benefits include:

Annual Vacation Leave/Sick Leave/Holidays

(Refer to Policy # 46-01,02 and 03 for details or contact Compensation Data Management)

***Tuition Reimbursement**

*The City of Memphis established a Tuition Reimbursement Program to assist City employees with the cost of college tuition. An employee may be reimbursed only for courses of study which the City of Memphis determines are directly related to the employee's present job or which will enhance the employee's potential for advancement to other jobs within city government. For details related to tuition reimbursement please refer to policy PM-58-03 in the City of Memphis policy manual. You can also contact Alicia E. Jones via email at alicia.jones@memphistn.gov or via phone at 901-636-6443.

DEFERRED COMPENSATION

Our deferred compensation plan is administered by Nationwide Retirement Solutions. A deferred compensation plan is a method that employees can use to defer (delay) taxes and save money. An employee defers part of his or her salary (pre-tax) into a deferred compensation plan. The money grows tax-free until it is withdrawn at which time taxes are owed. Deferred compensation plans are a form of retirement savings plans. Employees also have the option to defer compensation on a post-tax basis.

For more information, contact Sherrie Thomas (901) 488-1566/(901) 605-7893 or Jerry Williams (901) 482-0430.



**Voluntary Benefits offered by Aflac and Colonial Life
(Not Sponsored by the City of Memphis)**

The voluntary products offered by Aflac and Colonial are available on an individual basis and can be set up through payroll deduction. If you are interested in enrolling in any of the plans offered, you must contact Aflac and Colonial directly at the phone numbers listed in the vendor contact section of this guide. You can contact either vendor at any time to enroll; not limited to the City of Memphis open enrollment period.

Products offered by one or both companies:

Short-term Disability Policies

Hospital Policies

Critical Illness Policies

Cancer Policies

Life Insurance Policies

Accident Policies

Vendor Contact Information

Benefit/Vendor	Phone	Website
<i>General/Wellness</i>		
Health Wellness and Benefits	901-636-6800 or Toll Free 1-866-543-4367	http://www.memphistn.gov (Click on Government Click on Human Resources Click on Health, Wellness, and Benefits) or http://openenrollment.memphistn.gov
<i>Medical</i>		
Cigna Medical	1-800-Cigna24	www.mycigna.com
<i>Pharmacy</i>		
Caremark	1-866-722-2001	www.caremark.com
<i>Dental</i>		
United Healthcare Dental	1-866-540-5933	www.myuhcdental.com
<i>Vision</i>		
United Healthcare Vision	1-800-638-3120	www.myuhcvision.com
<i>EAP</i>		
Concern (Employee Assistance Program)	901-458-4000 or toll free 1-800-445-5011	www.concern-eap.com
<i>Voluntary Plans</i>		
AFLAC	Diane Bradley @ office: 901-761-8002/cell: 901-292-1568 or Bud Webb @ 901-866-2190	www.aflac.com
Colonial Life	901-507-8880	www.coloniallife.com
<i>Deferred Compensation</i>		
Nationwide Retirement Solutions	901-323-4154 901-323-4270	www.nrsretire.com

Legislative Notices

COBRA Rights for Employees and Dependents

What is COBRA?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring Group Health Plans offer employees and their families the opportunity for a temporary extension of health coverage called “**Continuation Coverage**” at group rates in certain instances where coverage under the plan would otherwise end.

If you are an employee of the City of Memphis covered by the Medical, Dental and/or Vision plan, you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, the termination of your employment (for reason other than gross misconduct) or layoff.

A spouse and/or dependent covered by the City of Memphis Medical, Dental and/or Vision plan is eligible to continue coverage should any of the following occur:

1. Death of the Employee
2. Layoff or termination of Employee or reduction in Employee’s work hours
3. ***Divorce or legal separation from Employee**
4. Dependent reaches the limiting age

***It is the employee or family member’s responsibility to notify City of Memphis Health Wellness and Benefits Office of a divorce or legal separation within 60 days of the event.**

Refer to the Medical Summary Plan Description for further details of the COBRA Law.

SPECIAL NOTICE: Under the Patient Protection Affordable Care Act (PPACA), in addition to the COBRA option, there may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

How much does COBRA cost for City-Sponsored plans?

	2014 MONTHLY COBRA MEDICAL RATES		
	Basic Plan	Premier Plan	Value Plan
Single	\$468.49	\$527.71	\$416.12
Family	\$949.80	\$1,213.72	\$957.07

	2014 MONTHLY COBRA DENTAL RATES		
	Primary Plan	Basic Plan	Premier Plan
Employee	\$16.56	\$18.88	\$28.42
Employee + 1	\$32.93	\$38.84	\$58.47
Employee + Family	\$60.93	\$56.52	\$85.07

	2014 MONTHLY COBRA VISION RATES	
	Exam and Materials	Materials Only
Employee	\$4.70	\$3.47
Employee + 1	\$8.59	\$6.39
Employee + Family	\$14.68	\$10.84

PATIENT PROTECTION AFFORDABLE CARE ACT

Under the Healthcare Reform Patient Protection Affordable Care Act, The City of Memphis has maintained 'Grandfathered' status but because of a change/correction in the premium contribution strategy and the addition of a third plan option, **effective January 1, 2014, the City's plans will change to "Non-Grandfathered" status.** Although, grandfathered status allowed the City exemption from some of the provisions of PPACA, the City's medical plans already included many of the mandates as required by PPACA. From PPACA's inception, the City has implemented all mandates set forth to date. To comply with additional mandates of PPACA, the City as "non-grandfathered," will make the following changes that become effective for the plan year 2014:

Pre-existing condition limitations

- No longer applies to anyone, regardless of age.

Dependent Coverage to Age 26

- All children are now covered to age 26, even if the child has access to his/her own employer coverage.

Cost Sharing

- In-network out-of-pocket (OOP) maximums cannot exceed \$6,350 individual and \$12,700 family.
- All copayments, deductibles and coinsurance (including mental health/substance abuse) must count toward the (OOP) maximum.

Coverage for Clinical Trials

A qualified clinical trial is defined as a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition. An individual may qualify to participate in a clinical trial based on a referral from a healthcare professional participating in the trial or by providing medical and scientific information establishing that participation would be appropriate. Routine patient care services generally include items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial such as radiological services, laboratory services, intravenous therapy, anesthesia services, hospital services, physician services, office visits, room and board, and medical supplies. Plans do not have to pay for:

- The actual clinical trial or the investigational item, service or device itself
- Items and services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Affordable Plan Option

- The City is offering a new plan option “value plan” that meets the affordable criteria as set forth by PPACA; offering a lower premium cost option for employees.

Women’s Preventive Services/Contraceptive Coverage – No Cost Share –

“Further Guidance issued”

- Contraceptive methods that are generally available over the counter (OTC) should be covered without member cost share if it is both FDA-approved and prescribed for a woman by her health care provider.
- Medical review process to evaluate brand penalties exception requests “if a generic version is not available or would not be medically appropriate for the patient as prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient).”

Vitamin D

- Coverage of Vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.

Health Insurance Market Place (Exchange) Notice

- As required by PPACA, the following is the City of Memphis’ notification to you regarding the New Health Insurance Marketplace Coverage Options.
- Open enrollment for health insurance coverage through the marketplace begins in October 2013 for coverage starting as early as January 1, 2014.
- Because the City of Memphis is offering a plan that meets the criteria for an ‘affordable’ option with the ‘minimum value’ standard, you may lose the City of Memphis’ contribution if you purchase a health plan through the marketplace instead of enrolling in one of the plan options offered by the City.
- Read the below notification carefully and visit HealthCare.gov for more information.
- Should you become eligible to continue coverage through COBRA, you may be eligible for other coverage options through the Marketplace. See additional notification information in the COBRA section of this guide.

NOTICE: New Health Insurance Marketplace Coverage Options and Your Health Care

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by the City of Memphis.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact City of Memphis, Health Wellness and Benefits at 901-636-6800.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by the City of Memphis. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Memphis		4. Employer Identification Number (EIN) 62-6000361	
5. Employer address 2714 Union Avenue Ext., 5th Floor, Room 100		6. Employer phone number (901) 636-6800	
7. City Memphis		8. State TN	9. ZIP code 38112
10. Who can we contact about employee health coverage at this job? Health Wellness and Benefits			
11. Phone number (if different from above)		12. Email address – N/A	

Here is some basic information about health coverage offered by City of Memphis:

- As your employer, we offer a health plan to:

All Regular Full-time Employees

- With respect to dependents: We do offer coverage. Eligible dependents are:

Lawful spouse of the opposite sex, dependents to age 26 (child who is married or unmarried and is your biological, legally adopted, or stepchild of you and/or your spouse).

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the City of Memphis information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

13. Is the employee currently eligible for coverage offered by the City of Memphis, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? **1st of month following 30 days** (Continue)

No (Stop and return this form to employee)

14. Does City of Memphis offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee

The cost is \$84.00 monthly

Women's Health and Cancer Rights Act (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, the City of Memphis benefits plans provides for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Benefits are payable the same as any other medical or surgical benefit covered by your plan.

Newborns and Mother's Health Protection Act of 1996

Under federal law, group health plans and health insurance issuers offering health insurance coverage generally may not restrict benefits for hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after conclusion with the mother, discharges the mother or newborn earlier.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

Important Notice About Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your City of Memphis medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay (This is known as “creditable coverage.”). The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period; you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

You should keep this notice with your important records.

Notice of Creditable Coverage

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
 2. City of Memphis has determined that the prescription drug coverage offered by the health plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
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When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, you and your dependents will no longer be eligible for the City of Memphis drug plan. Be aware eligibility for the City of Memphis drug plan is lost forever; you will not be able to get the coverage back.

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

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

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

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

City of Memphis Health, Wellness & Benefits Office
2714 Union Avenue Ext. 5th Floor Room 100
Memphis, TN 38112
(901) 636-6800 or (866)-543-4367

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Memphis changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. **For more information about Medicare prescription drug coverage: Visit www.medicare.gov; Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; or Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Privacy Practices

Changes to this Notice

The Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Plan receives in the future. If the Plan changes its policies and practices, the Plan will revise this Notice and will provide a copy of the revised Notice to you within 60 days of the change. The Plan will post a copy of the current Notice on the City of Memphis Human Resources webpage.

Filing a Complaint

If you believe your privacy rights have been violated, you may file a written complaint with our Compliance Official at the address below.

**HIPAA Compliance Officer
Human Resources Division
2714 Union Avenue Extended 5th Floor Suite 100
Memphis, TN 38112
901-636-6574**

Complaint forms are available on the COM intranet. You may also file a complaint with the Secretary of Health and Human Services within 180 days of when the act or omission complained occurred. There will be no retaliation for filing a complaint with the COM or the Secretary of Health and Human Services.

Contact Information

To obtain access, amend, or receive an accounting of disclosures of your PHI or receive a paper copy of this Notice you may contact the Plan's Benefit Manager at the address below:

**Benefit Manager
COM Employee Group Health Plan
2714 Union Avenue Extended 5th Floor Suite 100
Memphis, TN 38112
901-636-6479**

**THIS NOTICE DESCRIBES HOW
MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS
TO YOUR HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the City of Memphis (COM) Employee Benefit Health Plan (medical/surgical and mental health/substance abuse programs and prescription programs, collectively referred to as the Plans') to notify plan participants about its practices to protect the confidentiality of their protected health information (PHI). PHI is any information that may identify you and that relates to your past, present, or future physical or mental health condition and any related health care services and payment for those health care services. This Notice describes how the Plans may use and disclose PHI to carry out treatment, payment, or health care operations or other specified purposes permitted or required by law. The Notice also provides you information about your rights to access, to amend, and control the disclosure of your PHI.

The City of Memphis Health Plan is required to abide by the terms of this Notice, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that the Health Plan maintains at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Health Plan at that time.

Effective Date: April 14, 2003

Revised: January 26, 2013

USES AND DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Treatment. The Plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plans may advise an emergency room physician about the types of prescription drugs you currently take.

Uses and Disclosure for Payment. The Plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plans may receive and maintain information about a surgery you received to enable the Plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf, or the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

Uses and Disclosure for Health Care Operations. The Plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plans may use and disclose your PHI for the Plans' administration activities such as quality assessments, case management, disease management programs, care coordination and other Plan-related activities including audits of claims.

Use and Disclosure to the Plan Sponsor. The Plans may disclose health information to City of Memphis, but City of Memphis has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes.

Individual Involved in Your Care or Payment. In limited circumstances, the plans may disclose your PHI to a close friend or family involved in or who helps pay for your health care. The Plans may also, upon request, advise a family member or close friend about your condition, your location (for example, inform an individual that you are in the hospital), or death. If you do not want such information to be shared with these individuals, you may request that these disclosures be restricted as provided in the section of this notice dealing with your rights.

Business Associate. Certain services are provided to the Plans by third party administrators or other vendors who are known as "business associates." The Plans may disclose your PHI to these business associates in connection with their services for the Plan. For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment functions. However, the Plans will require its business associates, through contract, to appropriately safeguard the privacy of your health information. As well, HIPAA requires business associates to comply directly with many of the HIPAA provisions for safeguarding PHI.

USES AND DISCLOSURES PERMITTED AND REQUIRED BY THE PLANS

The Plans may use or disclose your PHI for any purpose required by law. The Plans are required or permitted to use or disclose your PHI without your authorization under the following circumstances:

Public Health Risk. The Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify participants of recalls of products they have been using.

Health Oversight Activities. The Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.

Judicial and Administrative Proceedings. If you become involved in a lawsuit or other legal action, the Plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement Purposes. The Plans may release your PHI if asked to do so by a law enforcement official. For example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime's location or victims, or the identify, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. The Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Organ/Eye/Tissue Donation. If you are an organ donor, the Plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Certain Limited Research Activities. The Plans may disclose information to researchers when an Institutional Review Board has reviewed and approved the research proposal, established protocols to ensure the privacy of your health information and granted a waiver of the authorization requirement.

Health and Safety. The Plans may consistent with applicable law and standards of ethical conduct disclose your PHI if the Plans, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Government Functions. The Plans may use and disclose your PHI for specialized government functions. For example, if you are in the Armed Forces or a veteran for purposes of certain national security; Presidential protection and intelligence activities.

Work-Related Illness and Injuries. The Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with City's On-the-Job Injury Program or others for the purposes related to employer occupational health and safety laws.

Communication related to your health. The Plans may use and disclose your PHI to provide information to you about disease management programs, treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising and Marketing. The Plan will NOT use or disclose your PHI for fundraising or marketing purposes, as defined by HIPAA and its implementing regulations.

All other uses and disclosures of your protected health information will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. Certain uses and disclosures of psychotherapist notes will also require your written authorization.

YOUR INDIVIDUAL RIGHTS

Your rights regarding the health information the Plans maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI maintained in a “designated record set”, generally with thirty (30) days of your request. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions, but does not include psychotherapy notes. If your PHI is maintained by the Plans in electronic format, you have the right to obtain a copy in electronic format and to direct that the Plan transmit the copy to an entity or person that you designate. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you believe that health information is incorrect or incomplete, you may ask the plans in writing to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plans. You must provide the reason (s) to support your request. Generally, the Plans have sixty (60) days to respond to your request, advising you of whether the amendment has been accepted or denied and informing you of details relevant to the acceptance or denial of your request. The Plans may deny your request if you ask the Plans to amend health information that was: (1) accurate and complete; (2) not created by the Plan; (3) not part of the health information kept by the Plan; or (4) not information that you would be permitted to inspect or copy. If your request is denied, you have the right to submit a statement disagreeing with the denial. The Plans must keep a copy of your request for amendment and any statement disagreeing with the denial of the amendment with your PHI and must disclose such documents when it discloses the PHI that is the subject of the requested amendment.

Right to an Accounting of Disclosures. You have the right to request in writing an “accounting of disclosures.” This is a list of disclosure of your PHI that the Plans has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations in accordance with HIPAA law and regulations. Your request must state a time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Generally, the Plans have sixty (60) days to respond to your request. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable. If the Plans uses or maintains your PHI in an electronic health record (created by health care clinicians or staff and transferred to the Plan), you may have a right to an additional, limited accounting of disclosures of health records, in accordance with the amendments to HIPAA under the HITECH Act of 2009.

Right to Request Restrictions. You have the right to request in writing a restriction on the health information the Plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plans discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plans not use or disclose information about a surgery you had. You must advise the Plan: (1) what information you want to limit; (2) whether you want to limit the Plan’s use, disclosure, or both; and (3) to whom you want the limit(s) to apply. **Note:** The Plans are not required to agree to your request, except in circumstances after February 2010 where you are requesting that PHI not be disclosed to a health plan for payment or health care operations if the PHI relates solely to a service or item for which you have paid for in full out of pocket.

Right to Request Confidential Communication. You have the right to request in writing that the Plans communicate with you regarding your health matters by alternative means or at alternative locations. For example, you can ask that messages not be left on voice mail or sent to a particular address. Your request must specify that disclosure of all or part of the information could endanger you, how or where you wish to be contacted and, where applicable, how payment for this service will be handled. The Plan will accommodate all reasonable requests.

Breach Notification. You have a right to receive notification in the event the Plans discovers a breach of your unsecured Protected Health Information and determine notification is required by HIPAA.

Right to a copy of this Notice. You have the right to request a paper copy of this Notice at any time by sending a written request to the Benefit Manager at the address on the last page of this Notice. You may also read and download a copy from our website: www.cityofmemphis.gov

FORMS

ALL-IN-ONE ENROLLMENT/CHANGE FORM

(Medical, Dental, Vision, FSA, Life, Short-Term Disability,
Spouse & Tobacco Affidavit)

&

All-IN-ONE BENEFICIARY FORM

(Death Benefit, Contributory Life, Voluntary Life and Final Pay)

&

TOTAL WELLNESS CENTER ENROLLMENT APPLICATION



City of Memphis

ACTIVE EMPLOYEE BENEFITS ENROLLMENT CHANGE FORM AND INSURANCE AFFIDAVIT

NOTE: Complete **ONLY** if you elect to enroll in or change existing coverage. You must elect FSA each year during open enrollment in order to continue enrollment. All other benefits will continue unless you make a change. When completing the form, if you fail to make a selection, we will assume you are waiving the coverage and will not enroll you nor your dependents for that benefit.

EMPLOYEE ACTION (please select one):

Enroll in Benefits Cancel All Benefits Make Changes Add/Delete Dependents

A. EMPLOYEE INFORMATION

Social Security Number - -	City Oracle ID Number	Last Name M.I.	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Street Address Apt.#		Effective Date of Enrollment/Change:	Division Name	
City, State, Zip		Date of Birth:	Hire Date:	
Email Address:		Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -		

B. REASON FOR ENROLLMENT/CHANGE

Check one Reason:

I am a new hire I am enrolling during Annual Enrollment

There has been a change in my family status (qualifying life event-QLE)*

*You must submit this form along with required documentation within 60 days of the event date.

Please provide QLE and date of event _____ (Qualifying Life Events: Birth/Adoption, Marriage, Divorce or Legal Separation, Change in spouses employment, death, etc.

C. BENEFIT ELECTION (CHECK ONE PER BENEFIT)

Medical Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> VALUE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/> WAIVE COVERAGE If waived, are you are covered by another plan. Yes or No If yes, please list name of insurance carrier _____	<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + FAMILY
Dental Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> PRIMARY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> EMPLOYEE + FAMILY
Vision Plan	ENROLL: <input type="checkbox"/> EXAM & MATERIALS <input type="checkbox"/> MATERIALS ONLY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> EMPLOYEE + FAMILY
Flexible Spending Accounts (FSA)	HEALTH CARE FSA (\$100-\$2500) <input type="checkbox"/> ANNUAL ELECTION AMOUNT:\$ _____ <input type="checkbox"/> WAIVE/CANCEL COVERAGE	DEPENDENT CARE FSA (\$100-5000) <input type="checkbox"/> ANNUAL ELECTION AMOUNT:\$ _____ <input type="checkbox"/> WAIVE/CANCEL COVERAGE
Short Term Disability Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE	

BENEFIT ELECTION CONTINUED...

<p>Contributory Life Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required</p>	<p>You may purchase coverage at 1.5 times your annual base salary up to a maximum of \$200,000. <input type="checkbox"/> 1.5 times salary <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Contributory Dependent Life -\$10,000 ea. (must enroll in contributory life in order to select dependent life)</p>	<p>\$10,000 ea. (must enroll in contributory life in order to select dependent life) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN (6 months to 19 years) if student to age 25 <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Voluntary Note: if you are enrolling after the first 31 days of your employment, evidence of insurability (EOI) is required</p>	<p>(You may purchase in \$10,000 increments with a guaranteed issue amount of \$200,000 or 3 times your annual salary whichever is less. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed \$500,000 or 5 times your annual salary.) <input type="checkbox"/> Amount Requested:\$ _____ <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE</p>
<p>Voluntary Spouse and Dependent Life (must enroll in voluntary life in order to select dependent life)</p>	<p>You may purchase life insurance for your spouse in increments of \$5000 not to exceed 50% of your elected amount with a guaranteed amount of \$30,000 if you are under age 60. You will need to complete an evidence of insurability form for any amount above the guaranteed issue amount. We will mail the EOI form to you upon receipt of the enrollment form. Total coverage (guaranteed plus additional) cannot exceed \$250,000. <input type="checkbox"/> Amount Requested for Spouse:\$ _____ <input type="checkbox"/> CHILDREN (6 MONTHS TO AGE 19) TO AGE 25 IF FULL TIME STUDENT) <input type="checkbox"/> WAIVE COVERAGE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/></p>

D. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered

LAST NAME	FIRST	M.I.	Social Security Number (Required)	Date Of Birth	Check desired Action			Employer Use Only:
					Medical	Dental	Vision	
Spouse:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:

E. OTHER INSURANCE COVERAGE INFORMATION (PLEASE COMPLETE THE SECTION BELOW)

<p>Do you or any of your covered dependents have other Medical/Medicare coverage that is primary to the City's Medical Plan? Yes or No If Yes, Name of Insured: _____ Place of Employment: _____ Insurance Company: _____ Policy #: _____ Insurance Company Phone #: _____ Insurance Company Address: _____</p>	<p>If covered by Medicare, please check what type(s): <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both A&B Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Medicare HIC #: _____ Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____</p>
---	--

ACKNOWLEDGEMENT AND AUTHORIZATION:

I, _____, hereby certify under penalty of perjury that the information provided in this application for employee benefits, including social security numbers, addresses, spouse and or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of employee benefits, disciplinary action including termination of employment from City of Memphis. I authorize the release of this information to my employer, the City of Memphis, and insurance carriers. In addition:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert Health Wellness and Benefits immediately of any errors. Further, I understand that the City of Memphis may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to Health Wellness and Benefits within 60 days of a qualified life event.
- I understand it is my responsibility to contact Health Wellness and Benefits within 60 days to remove my ex-spouse from all benefits plans if I divorce or become legally separated.
- I understand that while on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare, etc.

My signature below indicates I have read and understand the above:

Print Name:	Signature:	Date:	Oracle Employee ID #(Required):

EMPLOYER USE ONLY:

Employee Enrollment Date:	Termination Date:	Employment Status: _Active _COBRA _ NEMP
		Received By/Date:
Received By/Date:	Entered By/Date:	



CITY OF MEMPHIS INSURANCE AFFIDAVIT

If you or a member of your family age 16 or older uses tobacco or nicotine products, you will have to pay the tobacco surcharge.

If your spouse has access to medical insurance through his/her employer but has declined coverage, you will pay the spouse surcharge if you choose to enroll him/her in the City of Memphis medical plan.

To determine if you will be subject to either or both surcharges per pay period, you must answer all of the following questions. Any questions left blank could result in the assessment of the surcharge(s):

- yes or no 1) Do you or your family members age 16 or over who are enrolled/enrolling in the medical plan use nicotine products including, but not limited to cigarettes, snuff, chewing tobacco, etc.?

If so, please list all family members who use tobacco/nicotine: _____, _____
_____, _____

- yes or no 2) Are you enrolling your spouse in medical? (If no, skip to signature section)

- yes or no a) Is your spouse employed?

- yes or no b) Does your spouse have medical insurance through his/her employer or is he/she enrolled in Medicare? (If your spouse has other insurance that is primary, the surcharge will not apply).

- yes or no c) Does your spouse have access to other medical insurance but chooses not to enroll? (If so, a spouse surcharge will be added to your medical premium.)

Please provide your spouse's name, spouse's employer name and telephone number:

Spouse Name: _____ Employer Name: _____

Employer Telephone Number: _____ Insurance Company Name: _____

Group Number: _____ Subscriber ID #: _____

By signing this affidavit, I am certifying that I have answered the questions regarding tobacco/nicotine usage and my spouse's access to medical coverage honestly and completely under the penalties of perjury. If I am found guilty of perjury, I will be held liable to repay all claims and the City of Memphis has the right to terminate my benefits as well as my employment.

Employee Signature:	Employee Oracle ID #:
Employee Printed Name:	Date:

CITY OF MEMPHIS

TOTAL WELLNESS CENTER ENROLLMENT APPLICATION



HUMAN RESOURCES DIVISION

QUINTIN ROBINSON, DIRECTOR

Health History

NAME: _____ AGE: _____ DATE OF BIRTH: _____
 Have you previously been tested for an exercise program? Y N Last test: _____

HOME PHONE # _____ CELL PHONE: _____

PRIMARY PHYSICIAN: _____
 PHYSICIAN PHONE #: _____ FAX #: _____

SPECIALIST (PT, Cardiologist, etc.): _____
 SPECIALIST PHONE #: _____ FAX #: _____

In case of emergency, contact: _____ PHONE#: _____

PLEASE CHECK YES or NO

PAST HISTORY			FAMILY HISTORY			PRESENT SYMPTOMS		
(Have you ever had?)	YES	NO	(Have any of your immediate family or grandparents had?)	YES	NO	(Have you recently had?)	YES	NO
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart attacks.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>
Any heart trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Disease of the arteries.....	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations.....	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beats.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defect.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart operations.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Other family illness.....			Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>				Orthopedic problems.....	<input type="checkbox"/>	<input type="checkbox"/>

Please list any recent hospitalizations/surgeries

Any other medical problems/concerns not already identified? YES NO (Please list below)

(FOR STAFF)

Have you ever had your cholesterol measured? YES ___ NO ___ (value) ___ (Date) ___

Are you taking any Prescription or Non-Prescription medications? YES ___ NO ___ (including birth control)

Medication	Reason for taking medication	For how long?

Do you currently smoke? YES ___ NO ___
How much per day: < .5 pack ___ 0.5 to 1 pack ___ 1.5-2 packs ___ > 2 packs ___

Have you ever quit smoking? YES ___ NO ___ When? ___ How many years did you smoke? ___

Do you drink any alcoholic beverages? YES ___ NO ___ If yes, how much in 1 week?
Beer ___ (cans) Wine ___ (glasses) Hard liquor ___ (drinks)

Do you drink any caffeinated beverages? YES ___ NO ___ If yes, how much in 1 week?
Coffee ___ (cups) Tea ___ (glasses) Soft drinks ___ (cans)

ACTIVITY LEVEL EVALUATION

What is your activity level at work? sedentary/retired ___ light ___ moderate ___ heavy ___

Do you currently engage in vigorous physical activity on a regular basis? YES ___ NO ___
If so, what type? ___ How many times per week? ___

How much time per day? (check one) < 15 min ___ 15-30 min ___ 30-45 min ___ > 60 min ___

Do you ever have an uncomfortable shortness of breath during exercise? YES ___ NO ___

Do you ever have chest discomfort during exercise? YES ___ NO ___ If so does it go away with rest? ___

Do you engage in any recreational or leisure-time activities on a regular basis? YES ___ NO ___

If so, what activities? ___

On average: How often? ___ times/week For how long? ___ time/session

Are you currently following a weight reduction diet plan? YES ___ NO ___
If so, how long have you been dieting? ___ months Is the plan prescribed by your doctor? YES ___ NO ___

Have you used weight reduction diets in the past? YES ___ NO ___ If yes, how often and what type? ___

Please indicate the reason you want to start an exercise program.

To lose weight ___ Doctor's recommendation ___ For good health ___ Enjoyment ___
Release of tension ___ Improve physical appearance ___ Other ___

I have filled out this form to the best of my knowledge:

Signature: _____ Date: _____



CITY OF MEMPHIS
TOTAL WELLNESS CENTER
PAYROLL DEDUCTION FORM

Your membership dues will be collected through the payroll deduction program. The payroll office will deduct \$5.00 from each pay period for twenty-four (24) pay periods. The total amount deducted equals \$10.00 per month.

Your first deduction will be made the pay period after you have enrolled. If you are interested in terminating your fitness center membership, you must complete a membership withdrawal form and submit to Health, Wellness & Benefits at 2714 Union Extended, 5th floor, Suite 100.

NAME: _____ EMPLOYEE#: _____
DIVISION: _____ DIVISION #: _____
DEPT NAME: _____ OFFICE PHONE #: _____

Until further written notice is given to the payroll department, I hereby authorize the deduction of \$5.00 per pay period for my membership in the employee Total Wellness Center sponsored by the City of Memphis.

Signature

Date

**CITY OF MEMPHIS
TOTAL WELLNESS CENTER
Agreement and Release of Liability**

In consideration of gaining membership or being allowed to participate in the activities and programs of the City of Memphis Total Wellness Center and to use its facilities, equipment and machinery, I do hereby waive, release and forever discharge the City of Memphis and their respective officers, agents, employees, representatives, and executors (collectively, the "Ownership Entities") from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities at, or my use of equipment or machinery in, the City of Memphis Total Wellness Center or arising out of my participation in any activities at said facility. I hereby release the Ownership Entities and all others employed by them or acting upon their behalf (collectively, the "Released Parties") from any responsibility or liability for any injury or damage to myself arising out of my activities at the City of Memphis Total Wellness Center, including any injury or death which is caused by the negligence of any of the Released Parties, including negligence relating to the operation, maintenance or repair (or lack thereof) of the exercise or training equipment at the City of Memphis Total Wellness Center. (Please initial _____).

I understand and am aware that strength and flexibility training, as well as vigorous exercise, including the use of exercise equipment, are potentially hazardous activities. I also understand that fitness activities involve risk of injury and even death and that I am voluntarily participating in these activities and using exercise equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept all risks of injury or death. (Please initial _____).

I do hereby further declare myself physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in any of the activities and programs at the City of Memphis Total Wellness Center or use of equipment or machinery except as hereinafter stated. (Please initial _____).

I acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activities, exercise and the use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. (Please initial _____).

I acknowledge that I have either had a physical examination and have been given permission by my physician to participate, or that I have decided to participate in activity and/or use of equipment and machinery without approval of my physician and do hereby assume all responsibility for my participation, activities and utilization of equipment and machinery in my activities. (Please initial _____).

I do hereby expressly assume responsibility for any injury or death which I may sustain as a result of my participation in activities within the City of Memphis Total Wellness Center and/or my utilization of exercise equipment and training equipment and machinery in such facility. (Please initial _____).

Signature: _____ Date: _____

Witness: _____ Date: _____

CITY OF MEMPHIS TOTAL WELLNESS CENTER

Informed Consent Agreement

Thank you for choosing to use the facilities, services, or programs of the City of Memphis Total Wellness Center. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, _____, declare that I intend to use some or all of the activities, facilities, programs and services offered by the City of Memphis Total Wellness Center and I understand that each person, (myself included), has a different capacity for participating in such services. I am aware that all services offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental, or emotional) and to the awareness, care, and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, service or program of the City of Memphis Total Wellness Center brings with it my assumption of those risks or results stemming from this choice and the health, awareness, care, and skill that I possess and use.

I hereby release the City of Memphis Total Wellness Center, my employer, and any other organizations associated with this program, their affiliates, directors, officers, employees, successors, assigns, and contractors from all liability arising from and in any way connected with this program.

I further understand that full time personnel who have earned a Bachelor's degree in Nutrition, Wellness, Health Education, or other health-related field conduct the activities, programs and services offered by the City of Memphis Total Wellness Center. Some personnel have successfully completed or are currently pursuing a Master's degree. Each staff member maintains current CPR/AED and various other health & fitness certifications. I accept the fact that the skills and competencies of some personnel will vary according to their area of expertise, training, and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition and that the above mentioned are not herein employed to provide such professional services.

I recognize that by participating in the activities, programs and services offered by the City of Memphis Total Wellness Center, I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, nausea, etc. and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising staff member of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop or delay my participation by a supervising staff member who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs and services offered by the City of Memphis Total Wellness Center at any time before, during, or after my participation.

I know and understand that during the hours of operation the City of Memphis Total Wellness Center may not be "supervised", meaning that there is no one on hand to observe, regulate or aide the members or their activities. I recognize that my use of the equipment and participating in any activities, which occur in the City of Memphis Total Wellness Center, are voluntary on my part. I assume all risk for my behavior, or any injuries occurring as a result of my participation in any activities occurring in the City of Memphis Total Wellness Center.

I declare that I have read, understood and agree to the contents of this informed consent. Any questions I had were answered to my satisfaction.

Signature: _____ Date: _____

Witness: _____ Date: _____



DIVISION OF HUMAN RESOURCES
Health, Wellness and Benefits
2714 Union Ave Ext., 5th Floor - Suite 100
Memphis, Tennessee 38112

City of Memphis Active Employees
2014 Benefits & Enrollment Guide
October 7, 2013 - October 18, 2013

Time Sensitive:

**Please read this information booklet to learn about
upcoming changes and what is new for 2014**