Guide to Your Retiree Benefits

CITY OF KNOXVILLE

It's My Health

"One of the most important benefits we have at the City is The Center. If it weren't for the annual physical with the PSA test, I wouldn't be here today. Through the annual exam, The Center identified an issue early on and got me in with a specialist. It's the best resource we have!"

John Tillett
Fire Officer,
Knoxville Fire Department

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Welcome to Annual Enrollment

We are pleased to provide you with this 2019 Guide to Your Retiree Benefits. This guide includes all of the benefit options offered to retirees so that you and your family can make informed choices about the plans that best fit your needs. To help you understand all of your benefits, please plan to attend the scheduled annual enrollment meeting for Retirees at **10am on November 9th at the Public Works Complex** (located at 3131 Morris Ave.) or view the video posted online at: www.knoxvilletn.gov/benefits.

Annual Enrollment runs from Nov 1 – Nov 30.

What's New for 2019?

Medical:

GREAT NEWS! The medical rates are staying the same. In addition to no premium increase, there's another positive change to the plan—Mental health office visits will be paid at 80%, not subject to the deductible. (See Page 6 for more information.)

My Health Wellness Program:

We will continue tracking all requirements in the wellness portal, www.cokmyhealth.com. However, one requirement is changing. The requirement for physical activity will **increase** to a minimum of **120 minutes per week** to be closer to what the CDC recommends. If you track steps, the new requirement will be **40,000 steps** per week. (See Pages 7 & 8 for more information.)

Annual Enrollment Checklist

- ☐ Review materials
- ☐ Complete the 2018 Medicare Affidavit **(required)**.
- ☐ Complete the 2018 Retiree Annual Enrollment form (if changing current elections)
- ☐ Mail forms to Employee Benefits at: 400 Main Street, Room 566 Knoxville, TN 37902

Deadline to return forms is November 30th.
Call us at 865.215.2111 or email CityBenefits@knoxvilletn.gov if you have any questions.

Changing Your Benefits

Generally, you cannot change your benefit elections during the year unless you experience a life event. Examples of Life events include, but are not limited to:

- Change in retiree's legal marital status: marriage, divorce, death of spouse
- Change in number of dependents: birth, adoption, placement for adoption, death of dependent
- Gain or loss of benefit eligibility of dependent
- Dependent eligibility changes: dependent is newly or no longer eligible (i.e., reached age 26)
- Material benefit change of retiree or dependent, including dependent's annual enrollment
- Dependents' gain or loss of eligibility for Medicaid or SCHIP coverage

Who is eligible for coverage?

Retiree:

As a retiree, you are eligible to stay on the City's medical plan if you are not eligible for Medicare due to age or disability. You may continue coverage with the City's plan until you become eligible for Medicare. Every year you'll be asked to verify your and your dependent's Medicare eligibility with the City's Medicare Affidavit.

Spouse and/or Children:

Dependents cannot be enrolled in retiree coverage if they are eligible for Medicare, due to either age or disability. Additionally, all dependents on the City's medical insurance plan must meet the following dependent definition:

- The retiree's current legal spouse or qualified same or opposite gender domestic partner, excluding a common-law spouse.
- A dependent child, up to age 26, who is the retiree or retiree's spouse or qualified domestic partner's natural child, legally adopted child (including children placed for adoption), step-child, or child for whom the retiree or retiree's spouse is the legal guardian or legal custodian, or a child of the retiree, retiree's spouse or qualified domestic partner for whom a Qualified Medical Child Support Order has been issued.
- An incapacitated child of the retiree, retiree's spouse or qualified domestic partner.
- Dependents who permanently reside outside the United States are not eligible for coverage.
- The plan's determination of eligibility under the terms of this provision shall be conclusive. The plan reserves the right to require proof of eligibility, including but not limited to a certified copy of any Qualified Medical Child Support Order, birth certificate, and/or proof of court-granted legal guardianship, legal custody and/or legal adoption.

REMEMBER: When adding a dependent to your plan, make sure you explore all available options, as the City's retiree coverage may not be the most economical for every family. If you have questions on other available options, please contact Employee Benefits at 865.215.2111.

How does Medicare affect eligibility?

Retiree:

Once you are eligible for Medicare, you are no longer eligible for the City's retiree coverage. You will need to meet with a Medicare Specialist to determine if you need an advantage or supplemental plan, or to apply for Part A and B.

Spouse and/or Children:

If you become eligible for Medicare first, then your dependents will need to find other coverage, either by accepting the 36 months of COBRA through the City or researching individual coverage on the Marketplace.

If your dependents reach Medicare eligibility before you do, they will need to seek coverage through Medicare and possibly an Advantage or Supplement Plan. The Employee Benefits Department has contacts that can help you research your options so please call us for more information.

Medical

The City offers medical coverage, administered by BlueCross BlueShield of Tennessee (BCBST), to you and your eligible family members. When you enroll, you have two choices to make:

1. Your network

BCBST offers a choice of two networks:

- Network S— Currently, all hospitals in Knox County participate in Network S. As of 9/1/18, UT Medical Center re-joined the network.
- Network P— The larger of the 2 networks. 98% of Knox County doctors and all area hospitals participate.

To see if your doctor participates in either network, check the provider directory at www.bcbst.com. Remember, you have to use BCBST network providers to get in-network benefits. It's important to make sure you take an active role in ensuring the providers you see are in the network, including providers you are referred to for follow-up visits from providers seen in an emergency situation. The network you select during annual enrollment is the one you'll use throughout 2019. You cannot change networks during the year unless you experience a life event as outlined on page 3.

2. Your deductible

- $500 deductible option
- $1,000 deductible option

Both options cover the same services and have the same coinsurance. The difference will be in:

- Deductible
- Your monthly pension deductions
- Coverage of Emergency Department visits.

Preventive Benefits

All medical plan options cover preventive services at 100%—no deductible or copay required—when you use network providers. This means you pay nothing for services recommended by the US Preventive Services Task Force like:

- Annual well woman exam (including screening and counseling for HIV and domestic violence, counseling for sexually transmitted infections and pregnancy prevention)
- High risk HPV testing beginning at age 30 (every three years)
- Contraceptive methods and sterilization procedures including tubal ligations and vasectomies
- Gestational diabetes screening if high risk for diabetes
- Generic prescription and over-the-counter contraceptives
- Lactation support and counseling
- Age appropriate health screenings (e.g., cholesterol, blood pressure, colorectal cancer, depression, diabetes, obesity, osteoporosis)
- Preventive care and screenings for infants and children
- Preventive care and screenings for women (e.g., breast cancer screening, cervical cancer screening)
- Preventive care and screenings for men (e.g., PSA test)
- Immunizations for adults and children
- Flu and pneumonia shots
- Annual exams (including x-rays and lab)
- Vision and hearing screenings (as part of an annual exam)

Exception: A preventive care service must be billed by the provider as preventive care to assure 100% coverage. If a preventive service is billed separately from an office visit, you may be required to share in the cost of the office visit. For example, if you seek a preventive service such as an annual well-woman exam (Pap) or well-man exam (PSA test) and also receive some other kind of treatment (such as care for a sinus infection), cost sharing may apply to your office visit. In other words, the preventive portion of the visit will be covered at 100%, and the illness portion may be covered with applicable cost sharing.

The City encourages you to have health screenings and immunizations at appropriate times and frequency, based on your age, gender, personal and family health history, and other special needs.

2019 Medical options...at a glance

	$500 deductible option		$1,000 deductible option	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
You pay...				
Calendar year deductible	$500/individual $1,000/family	$1,000/individual $2,000/family	$1,000/individual $2,000/family	$2,000/individual $4,000/family
Then the plan pays...				
Physician office visits	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospital care				
Most other services				
Preventive care	100% (no deductible[2])		100% (no deductible[2])	
Outpatient Mental Health Office visits	80% (no deductible)	60% after deductible	80% (no deductible)	60% after deductible
Emergency care	100% after $150 copay[3]		80% after deductible	
Until you reach...				
Calendar Year out-of-pocket maximum[4]	$2,500/individual $5,000/family	$7,500/individual $15,000/family	$2,500/individual $5,000/family	$7,500/individual $15,000/family

[1]Out-of-network benefits are based on maximum allowable charges (MAC). You're responsible for the charges that exceed the MAC. You're also responsible for obtaining the required prior authorization for services if you use an out-of-network provider.

[2]Limits for certain services may apply. See preventive benefits on Page 5.

[3]Some services and procedures may be subject to the deductible and coinsurance, like MRIs.

[4]Once you reach the annual out-of-pocket maximum, the plan pays 100% of eligible expenses for the rest of the plan year. The medical out-of-pocket maximum includes amounts paid toward the deductible, coinsurance, ER copays where applicable, and prescription drug copays.

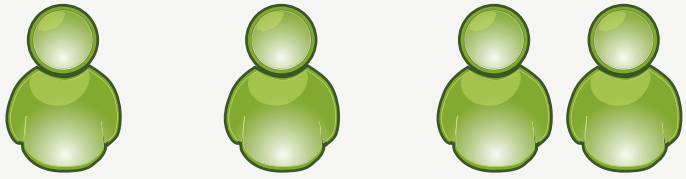
2019 Medical & Rx Rates

As a retiree, you pay 60% of the premium while the City pays the other 40%. Below are the monthly Retiree rates for the medical and prescription drug plans.

	$500 Network S	$500 Network P	$1,000 Network S	$1,000 Network P
Retiree Only	$331.49	$344.12	$324.15	$336.50
Retiree + Spouse	$762.44	$791.49	$745.54	$773.95
Retiree + Child(ren)	$606.64	$629.75	$593.19	$615.79
Retiree + Family	$994.49	$1,032.38	$972.44	$1,009.49

Wellness Credits

If you participate in the My Health Wellness Program, you will receive a wellness credit to help offset the cost of the medical premiums. The credit reduces the amount of your monthly premium deducted from your pension check.



Retiree Only
$40 credit

Spouse Only
$40 credit

Retiree & Spouse
$80 credit

My Health Wellness Program

When you enroll in My Health and maintain all program requirements, you receive the following rewards:

- A wellness credit to offset your medical premiums.
- RHRA dollars from the City. An RHRA is a Healthcare Reimbursement Account set up by the City to help you pay for certain out-of-pocket expenses, like your calendar year deductible, coinsurance, prescription drug copays, and dental and vision care for you and your covered family members. The chart below outlines how much you will receive. See page 9 for information about spending your RHRA dollars for you and your eligible dependents.

If you:	You receive in RHRA dollars:
Participate in the My Health Plan	**$40/month or $480/year** (retiree only) **$80/month or $960/year** (retiree + one or more dependents)
Additionally, if you:	**You receive additional RHRA dollars:**
Or your covered dependent participates in the City's prenatal program (must enroll by the 20th week of pregnancy)	**$200 upon completion of the program**

My Health Wellness Program Requirements

To receive the rewards of the My Health Wellness Program (My Health), enrolled participants (retiree, spouse, and/or qualified domestic partner) must maintain all of the requirements described on the next page. Participants that miss a requirement will be emailed or mailed a postcard reminder. Participants that do not then become current on all requirements, will be emailed or mailed a "2nd strike" postcard reminder, notifying them that they may be removed from My Health if they remain out of compliance. Participants will have 14 days to contact The Center or Employee Benefits to take steps towards compliancy. Participants that do not contact The Center or Employee Benefits within this period, and that remain noncompliant, will no longer receive the wellness credit or the monthly Retiree Health Reimbursement Account (RHRA) contribution.

The good news is that it's easy to get back into My Health and receive the rewards of a health-conscious lifestyle! If you want to continue receiving the wellness credit and the monthly RHRA contribution, please contact Employee Benefits and we will guide you through the process to make sure you meet the requirements listed on the next page. You will need to complete at least two consecutive months of Physical Activity credit and be current on all other requirements before completing a form to re-enroll.

THE CENTER
Served by Premise Health

The City's Health, Education & Wellness Center (The Center) is served by Premise Health. The Center provides free wellness services and health screenings — as well as health coaching for those with chronic conditions — for employees, retirees and spouses and domestic partners who participate in the My Health Wellness Program.

The Center is staffed with a full-time doctor and a full-time Nurse Practitioner and can be used for sick or wellness visits. The Center also provide services to you, your covered spouses and dependent children (ages 2 and up) for a $10 copay. You need to be covered on the City's medical plan to use The Center for acute care, and the $10 copay will apply towards your BCBST out of pocket maximum. You can pay for acute care with cash, check, credit/debit card or use your HRA card.

Consider having labwork done at the Center for a $10 copay, and have the results sent to your provider to save money.

The Center and its staff are subject to confidentiality rules that apply to all medical providers. Care you receive at The Center does not replace treatment provided by your personal physician(s). However, The Center's staff can assist you in researching publicly available information about your condition, treatment options, medications and other self-care information.

To schedule an appointment, call The Center at 865.215.6150 or log onto: www.mypremisehealth.com.

Reminder: When enrolled in the My Health Wellness Program, you and your covered spouse or domestic partner must complete an annual health screening at The Center (which includes a biometric blood draw and completion of a Health Risk Assessment), and meet other requirements as outlined on page 8.

1 Complete an annual health screening

Participants must schedule and complete a health screening at The Center by September 30th every year. The screening includes both a biometric blood draw and completion of a Health Risk Assessment (a link to the Premise Health site to take the health risk assessment is located on the My Health portal's homepage, www.cokmyhealth.com).

2 Stay physically active

Participants must commit to be physically active at least 120 minutes/ week (with a minimum of three sessions per week lasting at least 10 minutes each). **Activity must be submitted in the My Health portal by the 10th of the following month to receive credit.** If you are tracking steps, you must meet 40,000 steps per week.

3 Complete quarterly health education

Participants are required to complete an education requirement each quarter. This can be fulfilled by reviewing CDs, DVDs, approved websites, approved TV shows and written materials available from The Center, Employee Benefits and the Safety Building, as well as attending quarterly education classes taught by health coaches and special guests. There is also an opportunity in the **www.cokmyhealth.com** portal to read an article and take a quiz. As long as you receive a 100% on the quiz, you will receive credit for the quarter.

The Center's health coach/ RN disease management program

Participants diagnosed with a chronic condition(s) listed below, or that are determined to have a moderate or high health risk must participate in The Center's health coach/ RN disease management program. Chronic conditions: obesity, congestive heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, hyperlipidemia and hypertension. The number of visits required are determined by the results of your health risk assessment.

Optional Programs

Actively participate in The Center's health coach program if you use tobacco	Participants who use any form of tobacco (cigarettes, cigars, pipes, chewing tobacco or other tobacco product), are required to have a discussion with a health coach or disease management nurse on readiness to quit. Tobacco cessation drugs are provided at no cost.
Actively participate in The Center's prenatal program, if applicable (optional)	If you or your covered dependent becomes pregnant in 2019, you may enroll in the City's prenatal program by calling BCBST Healthy Maternity program. As long as you enroll by the 20th week of pregnancy, you may qualify for a free breast pump from BCBST and you'll receive an HRA contribution upon completion of the program.

We are committed to helping you achieve your best health. If you think you might be unable to meet a requirement for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by a different means. We will work with you (and if you wish, with your doctor) to find a wellness program requirement that is right for you in light of your health status.

Your RHRA Dollars

Upon retirement, your HRA account was converted into a RHRA, which is simply an HRA you can use during retirement. Please understand that this was a new account and cannot pay for any claims prior to retirement. So make sure you submit any outstanding claims prior to your retirement.

You can use the RHRA dollars you earn from participating in My Health to pay for many medical, pharmacy, dental and vision expenses incurred by you and your eligible dependents. This includes deductibles, copays, coinsurance and other eligible healthcare expenses you pay out of your own pocket. However, not all healthcare expenses are eligible. For a full list of eligible expenses, visit www.wageworks.com.

If you don't spend all your RHRA dollars during the year, they roll over to the next year and are available to you as long as you are covered on the City-sponsored medical plan and for a year afterwards. This allows you to accumulate funds for future expenses.

*Eligible dependents: You may only spend the money in your RHRA on your dependents who are covered by an employer-sponsored plan. It does not have to be the City's plan, just another employer's plan. You cannot use the money on a dependent who is covered by Medicare, Tricare, or TennCare. If you are covering a Domestic Partner, s/he must be your tax dependent in order to use your RHRA dollars for their healthcare expenses.

Spending Your RHRA Dollars

You have three ways to spend your RHRA dollars. You can:

1. **Use your WageWorks debit card.*** It contains your RHRA balance and works like cash at any vendor that accepts healthcare debit cards.
2. **Pay My Provider.** Log onto your RHRA account at **www.wageworks.com** and use the Pay My Provider function to have a check sent directly from your account to the provider's office.
3. **Pay Me Back.** Pay the expense as you normally would. Then submit your receipts, along with a WageWorks claim form via mail (to the address on the form), email, fax or electronically through the mobile app.

* If you're new to the My Health/HRA program, you'll receive a WageWorks debit card in the mail after enrollment. If you already have a WageWorks debit card, check the expiration date. If it is not set to expire, your 2019 RHRA dollars will automatically be loaded on it and you can continue to use the card in 2019.

Your WageWorks Debit Card

1. Your WageWorks card works like a debit card, but when you swipe your card at the checkout, you must choose "credit."
2. Keep your receipts in case you are asked by WageWorks to verify a purchase. This is especially important if you use your debit card at a provider's office. The IRS requires proof that funds have been used toward eligible expenses. Acceptable verification includes a detailed receipt or other proof of service and cost, such as an EOB. The receipt must contain the provider's name and address, name of the person receiving the service, date and cost of the service, and service details. You can print EOBs for your covered services from BCBST's website (**www.bcbst.com**). Credit card receipts do not provide enough information to substantiate a purchase.
3. You can register online at **www.wageworks.com**. Once registered, you can:
   - View your monthly statement
   - Check your account balance(s) and track activity
   - Request WageWorks to pay providers directly or reimburse you from your account
   - View a list of eligible expenses
   - See if you need to substantiate any purchases

NOTE: If you lose your card, call WageWorks immediately to report your missing card and order a new one. Or, you can order a replacement card online at www.wageworks.com.

IMPORTANT: To get reimbursed for a 2018 expense in 2019, you must submit a paper/fax/email claim or use the Pay Me Back or Pay My Provider features at www.wageworks.com.

Prescription Drugs

When you enroll in the City's medical plan, you automatically receive prescription drug coverage, which is administered by OptumRx. Remember, there is a separate ID card for pharmacy. So make sure you use your BCBST card at the doctor's office and the OptumRx card only at the pharmacy.

You have three ways to purchase prescription drugs:

- At a network retail pharmacy
- Through the home delivery program
- At participating 90-day at retail pharmacies (you may purchase up to a 90-day supply at these designated pharmacies if your prescription drug does not have quantity limits)

Prescription drug benefits...at a glance

	Preventive Prescriptions	Non-Preventive Prescriptions
You pay...		
Level 1 (preferred generics)	$0.00	$5.00
Level 2 (non-preferred generics)	$5.00	$10.00
Level 3 (preferred brand)	$10.00	$20.00
Level 4 (non-preferred brand)	$20.00	$40.00
Level 5 (specialty)*	$40.00	$80.00
90 day at retail locations can be filled 2.5 times the copay / 90 at mail will continue to be filled at 2 times the copay		

*All Level 5 Specialty Drugs must be dispensed by the OptumRx Specialty Pharmacy, BriovaRx.

Prescription Drug Rules

The City's prescription drug plan has certain rules that may affect your benefits.

Generics vs. Brand Name

If you request a brand name drug when a generic equivalent is available, you will pay the Level 1 or 2 generic copay plus the cost difference between the brand name and generic drug.

Step Therapy Program (ST)

The step therapy program encourages you to try first-line or generic drugs before "stepping up" to more expensive "step-two" or brand name drugs for certain conditions. For example, if your provider prescribes Lunesta and you haven't taken it before, the pharmacist will not fill the prescription until you have tried a generic alternative.

If the generic alternative doesn't work for you, you can step up to the brand name drug.

Prior Authorizations (PA)

The Prior Authorization program is a cost-savings feature to make sure the medication being used is appropriate. The program is designed to prevent the prescribing of a certain drug that may not be the best choice for the condition. Check the City of Knoxville Drug List to see if your drug is listed with a PA.

If you are a new user of this drug, you will need to allow time for your doctor to submit information to OptumRx for approval.

For more information, please visit:

www.cityofknoxvillerx.com.

Quantity Level Limits (QL)

Some drugs may have a limit on the amount you can receive. Based on FDA guidelines, the purpose is to reduce risk of overdose and unwanted drug reactions. If your doctor prescribes you more than the QL, they will need to contact OptumRx for approval.

Opioid Management Program

Opioid misuse and abuse is a national health crisis. Drug addiction is now the leading cause of accidental death. OptumRx is confronting the opioid epidemic with an end-to-end solution, driving opioid safety and prevention through engagement, smart prescribing and ongoing monitoring. If the generic alternative doesn't work for you, you can step up to the brand name drug.

If your doctor prescribes a short-acting opioid, such as Morphine, Oxycodone, Percocet or Vicodin, your prescription will be limited to a 7-day supply maximum. Two 7-day supplies are allowed in a 60-day period. If more medication is medically necessary, your doctor will be required to submit a prior authorization to OptumRx for approval.

Over-the-Counter (OTC) Program

The OTC program requires that if you take certain prescription drugs when an OTC alternative is available, your coverage will be reduced from the normal copay to 50% of the drug's cost. For example, Prilosec has an OTC alternative called omeprazole that may be as effective. And the full cost of omeprazole may be less than 50% of the cost of Prilosec.

Over-the-Counter Medications

Over-the-counter medications, such as aspirin, antihistamines and heartburn medications can't be reimbursed under the RHRA unless you provide a doctor's prescription and a letter of medical necessity. See page 9 for more information.

> "Remember, there is a separate ID card for pharmacy. So make sure you use your BCBST card at the doctor's office and the OptumRx card only at the pharmacy."

It's My Health

> "My health coach holds me accountable, which motivates me to do the things I need to do to stay healthy. I was surprised what a big difference that small changes made in my overall health. It's awesome to work for an organization that makes an investment in me and I want to be proactive in my screenings to allow me to be the best employee for my employer!"

Tatia Harris
Title VI Administrator,
Community Relations

Important Contacts

Benefit/Vendor	Website	Phone
General Benefits Questions		
Employee Benefits Division	www.knoxvilletn.gov/benefits	215.2111
Medical		
BlueCross BlueShield of TN	www.bcbst.com	1.800.565.9140
My Health Wellness Program		
Propel Wellness Portal	www.cokmyhealth.com	1.888.339.4131
Screening, Coaching, Acute Care		
The Center, by Premise Health	www.mypremisehealth.com	215.6150
Telehealth Services		
Physician Now	www.bcbst.com/member (Talk with a Dr Now)	1.888.283.6691
Prescription Drugs		
OptumRx	www.optumrx.com www.cityofknoxvillerx.com	1.800.797.9791
FSA/HRA		
WageWorks	www.wageworks.com	1.877.924.3967
Deferred Compensation		
Prudential Jessica Coleman	www.prudential.com/online/retirement	1.800.992.4472 865.314.2109
Pension		
Pension Board	http://cokpension.org	215.1444

CITY OF KNOXVILLE

This brochure provides highlights of the City of Knoxville's benefits program. It is not intended to include all of the benefit plan details. Complete details about how the plans work are included in the summary plan descriptions and plan documents, which are available upon request. If there are any inconsistencies between this brochure and the official plan documents, the plan documents will govern. The City reserves the right to change or end any of the plans at any time. This document does not constitute a contract or offer of employment.