TRI-COUNTY
MENTAL HEALTH SERVICES

Tri County Mental Health Services

January 1, 2020 - December 31, 2020
Employee Benefit Guide

AN OVERVIEW OF THE WIDE ARRAY OF BENEFITS PROVIDED BY Tri County Mental Health Services TO HELP YOU ENJOY INCREASED WELL-BEING AND FINANCIAL SECURITY

Table of Contents & Vendor Contacts

Refer to this list when you need to contact one of your benefit vendors. For general information contact Your HR Team.

Eligibility

All eligible employees may elect to enroll in the benefit program during our annual open enrollment period, or when they first become eligible. The minimum required hours employees must work in order to be eligible are listed below as well as the waiting periods.

Type of Coverage	Minimum Number of Hours Required	Waiting Period
Medical	24 hours/week	1st of the month following date of hire or increase in hours per week resulting in meeting Minimum Number of Hours Required for Eligibility.
Dental	20 hours/week	
Life & AD&D	20 hours/week	
Voluntary Life & AD&D	20 hours/week	
Short Term Disability	20 hours/week	
Long Term Disability	24 hours/week	

Which Family Members Can Be Covered?
The following family members are eligible for medical and dental benefits through Tri County Mental Heath Services:

- Spouse
- Domestic Partner
- Children to age 26, regardless of student or marital status (Medical and Dental), to age 19/26 if f/t student (Voluntary Life)
- Mentally or physically disabled children of any age if they were disabled prior to the plan's limiting age

How do I Enroll?
Enrollment is a simple process that is facilitated by your Human Resources team. Depending on which coverage you choose to participate in, each carrier has an enrollment form to be completed and signed by you. Certain ancillary benefits (Group Accident, Critical Illness, Voluntary Life and Individual Short or Long Term Disability) can be enrolled via telephone or by meeting with a UNUM benefits enroller.

*Times when you **will** need to complete a new enrollment form would be:*

- If you are a newly eligible employee and you are enrolling for the first time
- If the group is changing plans and/or carriers
- If you are adding or dropping a dependent or have a change in your own status (ex: marriage, divorce, *etc.)*

When do I Enroll?
Every group has what is called "open enrollment". This is typically the month prior to your renewal date, but you will be given notice of the open enrolment dates by Human Resources. If you are a newly eligible employee who either did not work during open enrollment or were not eligible, then you may enroll after you satisfy the eligibility waiting period. You may also enroll or change your decision to some extent during the year if you should experience a qualifying event.

What Constitutes as a Qualifying Event?
Unless you have a qualified change in status, you cannot change your benefit elections until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in a child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or a change in spouse's benefits or enrollment status. ***You have 30 days from the date of the event to notify your employer of the qualifying event.***

What Happens If I Don't Enroll?
If you decline coverage, you will not have another opportunity to enroll yourself or your eligible dependents until the next annual Open Enrollment period unless you have a qualifying event throughout the year.

Contact Us

For questions regarding any of the benefits mentioned in this booklet, please reach out to your Human Resources team, or your dedicated BGA/Cross Employee Benefits team at the contact information below.

Your first contact for enrollment, claims and benefit questions:

Earl Fournier
Human Resources Coordinator
Tel: 207-344-1836
Fax: 207-783-4679
Email: efournie@tcmhs.org

Your contact for escalated claims and benefit questions:

CROSS BENEFIT SOLUTIONS

Deb Turcotte, Benefits Specialist
Tel: 207-330-3037
Fax: 207-333-3007
Email: dturcotte@crossagency.com

Buckley Group - Anthoine Financial
bga Financial

Mark Anthoine, Account Executive
Tel: 207-689-3400
Fax: 207-389-3422
Email: mathoine@bgabenefits.com

In Deb's absence, please contact:
Kate, Account Manager
Tel: 207-330-3036
Email: kcornelio@crossagency.com

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide, contact Human Resources.

Our Employees Are Our Most Valuable Asset

That's why at Tri-County Mental Health Services we are committed to offering a comprehensive employee benefit program that helps our employees and families stay healthy, feel secure and maintain a work/life balance.

The purpose of this booklet is to provide you with the information that you need to review your benefit options for the January 1, 2020 to December 31, 2020 plan year. The IRS allows employees to select certain benefit options through pre-tax salary reductions, which lowers taxes and saves money. Because of these tax savings, other than your initial benefits selection at time of hire, the IRS allows you to make changes only during an open enrollment period, unless you experience a qualified status change. Since this is your one opportunity to enroll in or make changes to your benefits this year, please carefully consider your anticipated needs for the upcoming plan year.

We encourage you to take the time to educate yourself about Tri-County Mental Health Services' benefit options and choose the best coverage for you and your family. Included in this booklet is summary information for each line of coverage we offer, contact information for each of the carriers, as well as some important annual notices you should be aware of. If you have questions or need further information please do not hesitate to contact us or our broker representatives at Cross Employee Benefits whose information is also listed.

Medical Insurance

- EMPLOYEE COST SHEET
- SUMMARY OF BENEFITS
- PRESCRIPTION DRUG INFORMATION
- WELLNESS BENEFITS

HEALTH INSURANCE RATES EFFECTIVE JANUARY 1, 2020

CORE PLAN

24+ hrs/week	NO DISCOUNTS	DISCOUNTED Tobacco Free discount only	DISCOUNTED Completed Checklist discount only	DISCOUNTED Completed Checklist/Wellness	DISCOUNTED Tobacco Free/Completed Checklist/Wellness
COVERAGE TYPE	Deductions (24 Pay Periods)				
EE Only	$113.64	$66.86	$93.64	$63.64	$37.92
EE/SP or EE/DMP	$300.15	$270.15	$280.15	$250.15	$220.15
EE/Child(ren)	$269.48	$239.48	$249.48	$219.48	$189.48
EE/Family	$310.69	$280.69	$290.69	$260.69	$230.69

BUY-UP PLAN

24+ hrs/week	NO DISCOUNTS	DISCOUNTED Tobacco Free discount only	DISCOUNTED Completed Checklist discount only	DISCOUNTED Completed Checklist/Wellness	DISCOUNTED Tobacco Free/Completed Checklist/Wellness
COVERAGE TYPE	Deductions (24 Pay Periods)				
EE Only	$160.45	$130.45	$140.45	$110.45	$80.45
EE/SP or EE/DMP	$380.33	$350.33	$360.33	$330.33	$300.33
EE/Child(ren)	$338.48	$308.48	$318.48	$288.48	$258.48
EE/Family	$419.04	$389.04	$399.04	$369.04	$339.04

Starting January 1, 2020 Medical Rates will be based on 24 Pay Periods

HealthPlans, Inc.

Summary of Benefits

Tri-County Mental Health Services

*Medical Benefits for Group **AB8*** *Effective 1/1/2020*

TYPE OF SERVICE	CORE PLAN NETWORK	CORE PLAN NON-NETWORK
Calendar Year Out-of-Pocket Expenses		
CALENDAR YEAR DEDUCTIBLE		
Single:	$5,000	$5,000
Family:	$10,000	$10,000
MAXIMUM OUT OF POCKET (including the deductible)		
Single:	$6,850	$10,000
Family:	$13,700	$20,000
Hospital Services		
Inpatient Care	70% after deductible	50% allowed amount after deductible
Outpatient Care	70% after deductible	50% allowed amount after deductible
Assistant Surgeon	70% after deductible	50% allowed amount after deductible
Emergency Room Visit (if admitted, all expenses paid at Inpatient benefits levels)	70% after deductible	70% allowed amount after deductible
Urgent Care	70% after deductible	50% allowed amount after deductible
Physician Services (in-hospital)	70% after deductible	50% allowed amount after deductible
Pre-Admission Testing	70% after deductible	50% allowed amount after deductible
Diagnostic Lab & X-Ray (in and out-patient)	70% after deductible	50% allowed amount after deductible
MRI, PET CT Scans	70% after deductible	50% allowed amount after deductible
Doctor's Services		
Office Visits (includes doctor office visits at outpatient hospital facilities)		
Non Specialists	70% after deductible	50% allowed amount after deductible
Specialists	70% after deductible	50% allowed amount after deductible
Routine Physical Exam	100%	50% allowed amount deductible waived
Routine Immunizations (includes Flu shots)	100%	100% allowed amount deductible waived
Well Child Care	100%	50% allowed amount deductible waived
Annual Routine Screening (including: cholesterol screening, pap smear, rectal colon exam, mammography, PSA test and sonogram)	100%	100% allowed amount deductible waived
Chiropractic Care (including massage therapy) (Up to $1000 per calendar year)	70% after deductible	50% allowed amount after deductible
Surgery (includes surgery in a hospital, outpatient surgical facility, ambulatory surgical center or physician's office)	70% after deductible	50% allowed amount after deductible
Anesthesia	70% after deductible	50% allowed amount after deductible
Second Surgical Opinion	70% after deductible	50% allowed amount after deductible
Mental Health Care/Alcohol and Substance Abuse		
Outpatient Alcohol & Substance Abuse	70% after deductible	50% allowed amount after deductible
Inpatient Alcohol & Substance Abuse*	70% after deductible	50% allowed amount after deductible
Outpatient Mental Health Care	70% after deductible	50% allowed amount after deductible
Inpatient Mental Health Care*	70% after deductible	50% allowed amount after deductible
Other Services		
Home Health Care (100 visit limit)	70% after deductible	50% allowed amount after deductible
Hospice	70% after deductible	50% allowed amount after deductible
Private Duty Nursing	70% after deductible	50% allowed amount after deductible
Skilled Nursing Facility (100 days per calendar year)	70% after deductible	50% allowed amount after deductible
Ambulance	70% after deductible	50% allowed amount after deductible
Physical, Speech and Occupational Therapy	70% after deductible	50% allowed amount after deductible
Durable Medical Equipment	70% after deductible	50% allowed amount after deductible
Chemotherapy and Radiation Therapy	70% after deductible	50% allowed amount after deductible
Allergy Injections	70% after deductible	50% allowed amount after deductible
Smoking Cessation Counseling	100%	50% allowed amount after deductible
Smoking Cessation Clinics	100%	50% allowed amount after deductible
Gym Reimbursement (reimbursed by Human Resources)	100% up to $20 per month	100% up to $20 per month
Nutritional Counseling	100%	50% allowed amount after deductible
Weight Watchers ($750 per calendar year)	100%	50% allowed amount after deductible
Vision Exam (1 per calendar year)	$25 copay then 100%	$25 copay then 100% allowed amount
Vision Lens Reimbursement (includes contacts, frames and lenses)	$100 per person per cal yr	$100 per person per calendar yr
Hearing Exam (1 exam every 2 years)	70% after deductible	50% allowed amount after deductible
Prescription Drug Benefit – After Deductible	www.southernscripts.net/members	
Southern Scripts Retail Pharmacy (30 day supply)	$15 Generic/$40 preferred Brand/$75 non preferred brand	
Mail Order Pharmacy (90 day supply)	$45 Generic/$120 preferred Brand/$225 non preferred brand	
Specialty Drug Copay	30% to $250 per prescription	
Cana RX Copay (90 day supply)	$0 after deductible	
Preventive Drug List is not subject to the deductible		

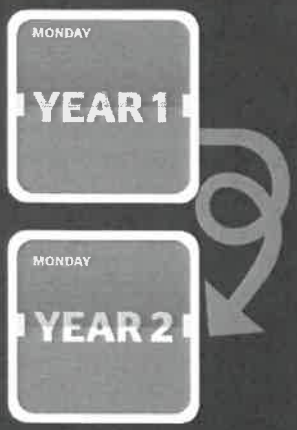
* *UTILIZATION REVIEW / HOSPITAL PRE-CERTIFICATION* is provided by Care Management Services (CMS). CMS can be contacted at 1-866-325-1550. Precertification must be obtained for all hospital admissions including emergency admissions. Failure to precertify will result in a reduction in benefits.

This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Plan Document and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.

TAKE ADVANTAGE OF YOUR HSA

DID YOU KNOW?

Every **unused dollar** contributed to your health savings account **(HSA) is rolled over.** That means if you have **$900 at the end of the year,** you will have **$900 rolled over to use the following year.** There is **NO LIMIT to the amount of unused funds that can be rolled over.**



DIFFERENT FROM AN FSA

Flexible savings accounts (FSAs) employ a **"USE-IT-OR-LOSE-IT" STRATEGY,** meaning **unused dollars are lost at the end of the plan year.** There are some exceptions to this, but, in most cases, **FSA funds must be used or they will be lost.**

BUILT FOR THE FUTURE

HSAs enable you to build an incredible financial resource for **health care stability.** The huge **TAX ADVANTAGES** and **ROLLOVER POLICIES** of an HSA make it ideal for anyone looking to **take control of their health care finances.**

CROSS
BENEFIT SOLUTIONS

The tax advantage of a HSA is based on enrollment in a High Deductible Health Plan (HDHP). The Tri-County Mental Health Services' CORE Plan qualifies as a HDHP.

HealthPlans, Inc.

Summary of Benefits

Tri-County Mental Health Services

*Medical Benefits for Group **AB8** Effective 1/1/2020*

BUY UP PLAN

TYPE OF SERVICE	NETWORK		NON-NETWORK	
Calendar Year Out-of-Pocket Expenses	**Standard**	**HRA**	**Standard**	**HRA**
CALENDAR YEAR DEDUCTIBLE		**Member Pays**		**Member Pays**
Single:	$6,000	$2,500	$6,000	$2,500
Family:	$12,000	$5,000	$12,000	$5,000
MAXIMUM OUT OF POCKET (including the deductible)				
Single:	$6,850	$3,500	$12,000	$9,500
Family:	$13,700	$7,000	$24,000	$19,000
Hospital Services				
Inpatient Care	70% after deductible		50% allowed amount after deductible	
Outpatient Care	70% after deductible		50% allowed amount after deductible	
Assistant Surgeon	70% after deductible		50% allowed amount after deductible	
Emergency Room Visit (if admitted, all expenses paid at Inpatient benefits levels)	70% after deductible		70% allowed amount after deductible	
Urgent Care	$50 copay then 100%		50% allowed amount after deductible	
Physician Services (in-hospital)	70% after deductible		50% allowed amount after deductible	
Pre-Admission Testing	$50 copay then 100%		50% allowed amount after deductible	
Diagnostic Lab & X-Ray (in and out-patient)	100%		100% allowed amount deductible waived	
MRI, PET CT Scans	70% after deductible		50% allowed amount after deductible	
Doctor's Services				
Office Visits (includes doctor office visits at outpatient hospital facilities)				
Non Specialists	$20 copay then 100%		50% allowed amount after deductible	
Specialists	$25 copay then 100%		50% allowed amount after deductible	
Routine Physical Exam	100%		50% allowed amount deductible waived	
Routine Immunizations (includes Flu shots)	100%		100% allowed amount deductible waived	
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Second Surgical Opinion	$25 copay then 100%		50% allowed amount after deductible	
Mental Health Care/Alcohol and Substance Abuse				
Outpatient Alcohol & Substance Abuse	$20 copay then 100%		$20 copay then 100% allowed amount deductible waived	
Inpatient Alcohol & Substance Abuse*	70% after deductible		50% allowed amount after deductible	
Outpatient Mental Health Care	$20 copay then 100%		$20 copay then 100% allowed amount deductible waived	
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Private Duty Nursing	70% after deductible		50% allowed amount after deductible	
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Ambulance	70% after deductible		50% allowed amount after deductible	
Physical, Speech and Occupational Therapy	$25 copay then 100%		50% allowed amount after deductible	
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Smoking Cessation Clinics	100%		100% allowed amount deductible waived	
Gym Reimbursement (reimbursed by Human Resources)	100% up to $20 per month		100% up to $20 per month	
Nutritional Counseling	100%		100% allowed amount deductible waived	
Weight Watchers ($750 per calendar year)	100%		100% allowed amount deductible waived	
Vision Exam (1 per calendar year)	$25 copay then 100%		$25 copay then 100% allowed amount	
Vision Lens Reimbursement (includes contacts, frames and lenses)	$100 per person per cal yr		$100 per person per calendar year	
Hearing Exam (1 exam every 2 years)	$25 copay then 100%		$25 copay then 100% allowed amount deductible waived	
Prescription Drug Benefit	www.southernscripts.net/members			
Southern Scripts Retail Pharmacy (30 day supply)	$15 Generic/$40 preferred Brand/$75 non preferred brand			
Postal Prescription Service Mail Order Pharmacy (90 day supply)	$45 Generic/$120 preferred Brand/$225 non preferred brand			
Specialty Drug Copay	30% to $250 per prescription			
Cana RX Copay (90 day supply)	$0			

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See Notice about Nondiscrimination and Accessibility next page

Language Assistance Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-532-7575 (TTY: 711).

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-800-532-7575 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-532-7575 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-800-532-7575 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-532-7575（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-800-532-7575 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-532-7575 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغةِ **العربية** ، خَدَمات اَلمُساعَدة اَللُّغَوية مُتَوفرة لك مَجانا ً **إتصل على 1 800-532-7575**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, បើដមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ ឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-800-532-7575 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-532-7575 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-532-7575 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-532-7575 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-800-532-7575 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-532-7575 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-800-532-7575 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-800-532-7575 (TTY: 711)

(Continued)

Notice about Nondiscrimination and Accessibility

Your employer complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your employer does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Your employer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact your employer's Civil Rights Compliance Officer or call 800-532-7575.

If you believe that your employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance. For contact information for your employer's Grievance Coordinator, please go to https://www.**healthplansinc.com/**, click on *Log in to My Plan*, then click on the link to Important Non-Discrimination Information. If you have no internet access, you may call 800-532-7575 for help. You can file a grievance with your employer in person or by mail, fax or email. If you need help filing a grievance, the Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Medical and Dependent Care Flexible Spending Account (FSA)

Tri County Mental Health Services provides you the opportunity to pay for out-of-pocket medical, dental and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You can save approximately 27% on these expenses when you participate in an FSA. Any enrollments or changes will be effective January 1st and run through December 31st.

A medical FSA is used to reimburse eligible out-of-pocket expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you or your spouse works.

Contributions to your FSA come out of your paycheck before taxes are withheld. This means that you don't pay federal income tax, Social Security taxes and state and local income taxes on the portion of your pay that you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses during the plan period. Generally expenses must be incurred by the end of the plan year in order to be reimbursed from your FSA. This is the "use it or lose it" IRS rule.

The amounts you may contribute to the Medical and Dependent Care Flexible Spending Accounts are below.

Flexible Spending Accounts	Minimum Annual Contribution	Maximum Annual Contribution
Medical	$260	$2,600
Dependent Care	$260	$5,000 if single or married filing jointly $2,500 if married filing separately

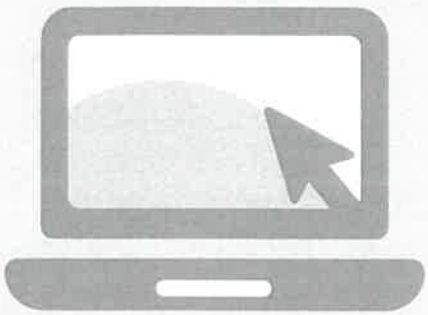
In order to participate, a new enrollment form must be completed EACH YEAR.
You do not have to enroll in the agency's medical plan to enroll.

****Please Note: You cannot elect to participate in the Medical FSA if you are enrolled in the Core Plan. Please refer to the HSA information provided.**

my plan

MANAGE YOUR PLAN ONLINE WITH MY PLAN

24/7 access to your plan and account details



Register in Minutes!

1. Go to the website listed on the back of your member ID card (it will be at the top)
2. Click on the **Members** section and the link to **Get Registered**
3. Enter your information to create your username and password

If you are a dependent, be sure to have the five-digit home ZIP Code and the last four digits of the employee's (plan subscriber's) social security number.

Access all of your account details* in one secure location anytime, anywhere!

- Review your claims
- Check your benefits
- Access your prescription drug plan
- Search your provider network
- Download a report of your claims
- Request claim reimbursements
- View, print or order your member ID card
- View or print applicable tax forms
- Find a Primary Care Provider (PCP)
- View your health spending account details

On your mobile device!

** You will have access to details applicable to your plan. Please note, not all of the items listed above apply for all plans.*

Have questions? Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.

HealthPlans, Inc.

HPI is a Harvard Pilgrim company

16-3217-103017

A new kind of PBM

southernscripts

PHARMACY BENEFIT MANAGEMENT

www.southernscripts.net

Getting the Most out of Your Pharmacy Benefits

Southern Scripts is your pharmacy benefit manager offering you multiple ways to save on your prescription drugs. Check your plan for pharmacy cost-share information.

SAVE 60-75%

when you request generic medication over brand name drugs. Look for a **first**choice Pharmacy for cost savings: www.southernscripts.net/members.php

firstchoice and Retail:

Present your member ID card when filling a prescription at any major retail chain or independent pharmacy across the country. If your pharmacy is not yet in Southern Scripts' network, have your pharmacist call the number on your ID card to enroll. Visit our pharmacy locator tool to find a pharmacy: www.southernscripts.net/members.php. Our preferred network, **first**choice will help you reduce your prescription costs by providing the best discounts.

Mail-Order:

To find a mail order pharmacy, call 800.710.9341 or visit our website:

southernscripts.net/members.php

Specialty Pharmacy:

Certain medications used to treat serious or complex health conditions are provided by top quality specialty pharmacies. Use the pharmacy locator tool at www.southernscripts.net/members.php to find specialty pharmacies in your area, or call Southern Scripts to find the right option for you.

Variable Copay™ Program:

The Variable Copay™ Program is designed to combat the rising cost on high cost medications. The Variable Copay™ Program uses coupons provided by the manufacturer to greatly reduce costs for eligible medications. Certain medications including Humira, Enbrel, and Prolia are eligible for savings. Your copay may be drastically reduced at CRx preferred pharmacy & our Variable copay network for variable copay medications.

Your medication(s) may be eligible for variable copay savings. Please contact a CRx Customer Care Associate at 1.800.710.9341 or visit: www.southernscripts.net/members.php

After your plan effective date, register at www.southernscripts.net/members.php to manage your pharmacy plan online – you'll have instant access to your benefits, price-check tools, and more.

Live Customer Service: 1.800.710.9341
Weekdays: 6:30 am - 8 pm (CST),
Sat. 8 am-5 pm (CST)& Sun. 8 am-4 pm (CST)
Plus 24/7 Emergency Service
southernscripts.net/members

TCMHSCanaRx

Introduction:

TCMHSCanaRx is an international mail order option for eligible employees and dependents of Tri-County Mental Health Services. Your list of qualified maintenance medications is on the reverse.

Copayments:

All member copayments have been waived for this prescription drug program **only.**

TCMHSCanaRx	Vs.	Current Local Purchase Plan				
Annual Cost *No Copays!*		Monthly Copays		Refills		Annual Savings
$0	**Vs.**	**$40**	**x**	**12**	**=**	**$480 / Script**
	Vs.	**$75**	**x**	**12**	**=**	**$900 / Script**

Ordering Instructions:

To place your first order please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification*.

**Similar to a number of states in the US, some CanaRx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site www.CanaRxDocs.com. If not included, a CanaRx representative will contact you when required by the pharmacy dispensing your medications.*

Ask your doctor for a prescription for a **3 month supply** with **3 refills.** We will call you prior to each renewal to ensure that you have a continuous supply. Please allow 4 weeks for delivery.

Medications must be tried for 30 days before ordering through **TCMHSCanaRx.**

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:

BY FAXING TO: 1-866-715-MEDS (6337) TOLL FREE

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR

BY MAILING TO: TCMHSCanaRx

235 Eugenie St. West
Suite 105D
Windsor, ON, Canada
N8X 2X7

OR

P.O. Box 44650
Detroit, MI 48244-0650
(This P.O. Box is used for expediting all communications crossing the border.)

More forms are available:

Additional forms may be obtained at the Human Resources Office, by printing them from the website at www.TCMHSCanaRx.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

Welcome to TCMHSCanaRx

October 2019

TCMHSCanaRx

For More Information: Call 1-866-893-MEDS (6337)

ABILIFY (G) 2MG
ABILIFY (G) 5MG
ABILIFY (G) 10MG
ABILIFY (G) 15MG
ABILIFY (G) 20MG
ABILIFY (G) 30MG
ACIPHEX 20MG
ACTONEL 5MG
ACTONEL 30MG
ACTONEL 35MG
ACTONEL 150MG
ACTOPLUS 15MG-850MG
ACULAR (G) 0.5%
ACULAR LS (G) 0.4%
ACZONE 5%
ADCIRCA 20MG
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AGGRENOX 200/25MG
ALOCRIL 2%
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
ANORO ELLIPTA 62.5/25MCG
APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARCAPTA NEOHALER 75MCG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN 25MG
ARTHROTEC 50MG
ARTHROTEC 75MG
ASACOL HD 800MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ASTAGRAF XL 5MG
ASTELIN 137MCG
ATACAND 4MG
ATACAND 8MG
ATACAND 16MG
ATACAND 32MG
ATACAND HCT 16MG/12.5MG
ATACAND HCT 32MG/12.5MG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AUBAGIO 14MG
AVANDIA 2MG
AVODART (G) 0.5MG
AXERT 12.5MG
AZELEX 20%
AZILECT 0.5MG
AZILECT 1MG
AZOPT 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BANZEL 200MG
BANZEL 400MG
BECONASE AQ 42MCG
BENICAR (G) 20MG
BENICAR (G) 40MG
BENICAR HCT (G) 20MG/12.5MG
BENICAR HCT (G) 40MG/12.5MG
BENICAR HCT (G) 40MG/25MG
BENZACLIN PUMP
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S 0.25%
BINOSTO 70MG
BONIVA (G) 150MG
BREO ELLIPTA 100/25MCG
BREO ELLIPTA 200/25MCG
BRILINTA 60MG
BRILINTA 90MG
BYSTOLIC 2.5MG
BYSTOLIC 5MG
BYSTOLIC 10MG
BYSTOLIC 20MG
CADUET 5/10MG
CADUET 5/20MG
CADUET 5/40MG
CADUET 5/80MG
CADUET 10/10MG
CADUET 10/20MG
CADUET 10/40MG
CADUET 10/80MG
CAMBIA 50MG
CARDURA XL 4MG
CARDURA XL 8MG
CELEBREX 100MG
CELEBREX 200MG
CLARINEX 5MG
CLIMARA PATCH 25MCG
CLIMARA PATCH 50MCG
CLIMARA PATCH 75MCG
CLIMARA PATCH 100MCG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT 20MCG/100MCG
COMTAN 200MG
CRESTOR (G) 5MG
CRESTOR (G) 10MG
CRESTOR (G) 20MG
CRESTOR (G) 40MG
CRINONE GEL 8%
CYMBALTA (G) 20MG
CYMBALTA (G) 30MG
CYMBALTA (G) 60MG
DALIRESP 500MCG
DETROL 1MG
DETROL 2MG
DETROL LA 2MG
DETROL LA 4MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM 0.1%
DIFFERIN GEL 0.1%
DIFFERIN GEL 0.3%
DIPENTUM 250MG
DIPROLENE OINT 0.05%
DIVIGEL 0.5MG
DIVIGEL 1MG
DUAVEE 0.45-20MG
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
DYMISTA 137/50MCG
EDARBI 40MG
EDARBI 80MG
EDARBYCLOR 40MG/12.5MG
EDARBYCLOR 40MG/25MG
EDECRIN 25MG
EFFIENT (G) 5MG
EFFIENT (G) 10MG
ELIDEL 1%
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTOCORT 3MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIDUO GEL PUMP 0.1%/2.5%
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EPIVIR/HBV 100MG
ESTROGEL 0.06%
EUCRISA 2%
EVISTA 60MG
EXELON 3MG
EXELON 6MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
EXFORGE HCT 160/12.5/5MG
EXFORGE HCT 160/12.5/10MG
EXFORGE HCT 160/25/5MG
EXFORGE HCT 160/25/10MG
EXFORGE HCT 320/25/10MG
FARESTON 60MG
FARXIGA 5MG
FARXIGA 10MG
FELDENE 10MG
FELDENE 20MG
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
FETZIMA 120MG
FINACEA GEL 15%
FLAREX 0.1%
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FOSRENOL CHEW 500MG
FOSRENOL CHEW 750MG
FOSRENOL CHEW 1000MG
FOSRENOL POWDER 750MG
FOSRENOL POWDER 1000MG
FROVA 2.5MG
GELNIQUE 10%
GENVOYA 150-150-200-10MG
GILENYA 0.5MG
GLUCAGEN HYPOKIT 1MG
GLUMETZA ER 1000MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
IMITREX AUTOINJECTOR STATDOSE 6MG/0.5ML
IMITREX NASAL SPRAY 5MG-2DOSE
IMITREX NASAL SPRAY 20MG-2DOSE
INCRUSE ELLIPTA 62.5MCG
INDERAL LA 60MG
INDERAL LA 80MG
INDERAL LA 120MG
INDERAL LA 160MG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
INVOKAMET 50MG-500MG
INVOKAMET 50MG-1000MG
INVOKAMET 150MG-500MG
INVOKAMET 150MG-1000MG
INVOKANA 100MG
INVOKANA 300MG
IRESSA 250MG
JADENU 90MG
JADENU 180MG
JADENU 360MG
JALYN 0.5MG/0.4MG
JANUMET 50/500MG
JANUMET 50/1000MG
JANUMET XR 50MG/500MG
JANUMET XR 50MG/1000MG
JANUMET XR 100MG/1000MG
JANUVIA 25MG
JANUVIA 50MG
JANUVIA 100MG
JARDIANCE 10MG
JARDIANCE 25MG
JENTADUETO 2.5MG-500MG
JENTADUETO 2.5MG-850MG
JENTADUETO 2.5MG-1000MG
JUBLIA 10%
KAZANO 12.5/1000MG
KEPPRA (G) 250MG
KEPPRA (G) 500MG
KEPPRA (G) 750MG
KEPPRA (G) 1000MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LESCOL XL 80MG
LEXIVA 700MG
LIALDA 1.2GM
LINZESS 72MCG
LINZESS 145MCG
LINZESS 290MCG
LOCOID LIPOCREAM 0.1%
LOTEMAX GEL 0.5%
LOTEMAX SUSP 0.5%
LOTRISONE CREAM (G) 1%/0.05%
LOVENOX 40MG
LOVENOX 60MG
LOVENOX 80MG
LOVENOX 100MG
LUMIGAN 0.01%
MESNEX 400MG
MESTINON TS 180MG
METRO CREAM 0.75%
METROGEL (G) 0.75%
METROGEL PUMP 1%
MICARDIS HCT 40/12.5MG
MICARDIS HCT 80/12.5MG
MICARDIS HCT 80/25MG
MIGRANAL 4MG/ML
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MIRVASO 0.33%
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NASONEX 50MCG
NESINA 6.25MG
NESINA 12.5MG
NESINA 25MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEXIUM 20MG
NEXIUM 40MG
NEXIUM DR 10MG
NORITATE CREAM 1%
OMNARIS 50MCG
ONGLYZA 2.5MG
ONGLYZA 5MG
ORTHO-TRI-CYCLEN LO (G)
OTEZLA 30MG
PATADAY 0.2%
PATANOL 0.1%
PAZEO 0.7%
PENTASA 500MG
PRADAXA 75MG
PRADAXA 150MG
PRANDIN (G) 0.5MG
PRANDIN (G) 1MG
PRANDIN (G) 2MG
PRED FORTE 1%
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMARIN CREAM 0.625MG/GM
PREMPRO 0.3MG/1.5MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROMETRIUM 100MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
QTERN 10-5MG
QVAR REDIHALER 40MCG
QVAR REDIHALER 80MCG
RANEXA 500MG
RAPAFLO 4MG
RAPAFLO 8MG
RAPAMUNE 0.5MG
RAPAMUNE 2MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RENVELA 800MG
RESTASIS MULTIDOSE 0.05%
RESTASIS VIALS 0.05%
RETIN A MICRO GEL PUMP 0.04%
RETIN-A MICRO GEL PUMP 0.1%
REXULTI 0.25MG
REXULTI 0.5MG
REXULTI 1MG
REXULTI 2MG
REXULTI 3MG
REXULTI 4MG
RHINOCORT AQ 32MCG
SAPHRIS 5MG
SAPHRIS 10MG
SEASONIQUE 0.15/0.03/0.01MG
SENSIPAR 30MG
SENSIPAR 60MG
SEREVENT DISKUS 50MCG
SEROQUEL XR 50MG
SEROQUEL XR 150MG
SEROQUEL XR 200MG
SEROQUEL XR 300MG
SEROQUEL XR 400MG
SIMBRINZA 1%/0.2%
SINGULAIR GRANULES (G) 4MG
SOLARAZE (G) 3%
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STARLIX 60MG
STARLIX 120MG
STEGLATRO 5MG
STEGLATRO 15MG
STIOLTO RESPIMAT 2.5/2.5MCG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
STRIBILD
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TARKA 2/180MG
TARKA 4/240MG
TASMAR 100MG
TAZORAC CREAM 0.05%
TAZORAC CREAM 0.1%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA 120MG
TECFIDERA 240MG
TEKTURNA 150MG
TEKTURNA 300MG
TEKTURNA HCT 150-25MG
TEKTURNA HCT 300-12.5MG
TEKTURNA HCT 300-25MG
TIVICAY 50MG
TOBREX OINT 0.3%
TOVIAZ 4MG
TOVIAZ 8MG
TRADJENTA 5MG
TRAVATAN Z 0.004%
TRELEGY ELLIPTA 100-62.5-25MCG
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TUDORZA PRESSAIR 400MCG
TWYNSTA 40/5MG
TWYNSTA 40/10MG
TWYNSTA 80/5MG
TWYNSTA 80/10MG
ULORIC 80MG
UROCIT-K 10MEQ
URSO 250MG
VAGIFEM 10MCG
VECTICAL 3MCG/GM
VENTOLIN HFA 90MCG
VESICARE 5MG
VESICARE 10MG
VIIBRYD 10MG
VIIBRYD 20MG
VIIBRYD 40MG
VIMOVO 375/20MG
VIMOVO 500/20MG
VIVELLE-DOT 25MCG
VIVELLE-DOT 37.5MCG
VIVELLE-DOT 50MCG
VIVELLE-DOT 75MCG
VIVELLE-DOT 100MCG
VRAYLAR 1.5MG
VRAYLAR 3MG
VRAYLAR 4.5MG
VRAYLAR 6MG
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELCHOL 625MG
WELCHOL PACKET 3.75G
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XADAGO 50MG
XADAGO 100MG
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELJANZ XR 11MG
XELODA 500MG
XENICAL 120MG
XIGDUO XR 5/1000MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
XIIDRA 5%
YASMIN 28
YAZ 3/0.02MG
ZELAPAR 1.25MG
ZETIA (G) 10MG
ZOMIG (G) 2.5MG
ZOMIG NASAL SPRAY 5MG
ZOMIG ZMT 2.5MG
ZOVIRAX CREAM 5%
ZYCLARA PACKET 3.75%

NOTE: Medication names appearing with **(G)** are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

October 2019

TRI-COUNTY
MENTAL HEALTH SERVICES

In order to promote healthier lifestyles and to help lower the cost of the Tri-County Mental Health Services medical plan in future years, here are some of the Wellness benefits offered to employees and their covered dependents.

WELLNESS BENEFITS OFFERED		HOW THEY ARE PAID
Nutritional Counseling		100% paid
Weight Watchers Membership		100% paid up to $750 per year
Routine Eye Exam		$25 copay, then 100% paid; one exam per person per calendar year
Routine Hearing Exam (Buy Up Plan Only)		$25 copay, then 100% paid; one exam per person every two years
Flu Shots		100% paid through the medical plan
Gym and Exercise Reimbursement*		Employees will be reimbursed up to $20 per month toward gym membership and must provide proof that you work out at least 8 times per month. You may also be reimbursed up to a maximum of $20 per month for attending exercise classes taken with a certified instructor. Must attend all classes to be eligible
Smoking Cessation		100% paid through the medical plan
Routine Screenings (Includes cholesterol pap, rectal colon exam, mammograms, PSA and sonograms)		100% paid through the medical plan
Routine Well Child Care		100% paid through the medical plan
Routine Well Care (adult physical exams, annual OB-GYN exam, includes lab work)		100% paid through the medical plan

***All employees are eligible--not required to have health insurance through TCMHS.**

This is a summary of your Wellness benefits. Please refer to the Plan Documents for details.

Rev. 2018

Dental Insurance

- EMPLOYEE COST SHEET
- SUMMARY OF BASIC/LOW DENTAL PLAN
- SUMMARY OF ENHANCED/HIGH PLAN

DENTAL INSURANCE RATES EFFECTIVE JANUARY 1, 2020

BASIC/LOW DENTAL PLAN

COVERAGE TYPE	Deductions (24 pay periods)
EE Only	$21.17
EE/SP or EE/DMP	$40.41
EE/Child(ren)	$44.87
EE/Family	$65.90

ENHANCED/HIGH DENTAL PLAN

COVERAGE TYPE	Deductions (24 pay periods)
EE Only	$24.77
EE/SP or EE/DMP	$47.29
EE/Child(ren)	$51.93
EE/Family	$77.12

Tri-County Mental Health Services - High

Effective Date: January 01, 2020

Cigna.

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum	Progressive Plan	
(Class I, II, III, IX Expenses)	Class I applies Year 1: $2000, Year 2: $2150 Year 3: $2300, Year 4: $2450	Class I applies Year 1: $2000, Year 2: $2150 Year 3: $2300, Year 4: $2450
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	100%, After Deductible	100%, After Deductible
Class III Expenses - Major Restorative Care		
Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children Only Lifetime Maximum	50%, No Ortho Deductible $1000	50%, No Ortho Deductible $1000
Class IX Expenses - Implants		
Plan Calendar Year Max	50%, After Deductible $2000	50%, After Deductible $2000
Dental Plan Reimbursement Levels	Based on Contracted Fees	90th Percentile
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	
Progression	Members progress to the next level by utilizing Class I services in the prior year.	

P0010 Network.

Tri-County Mental Health Services - High

Effective Date: January 01, 2020

Cigna.

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	For dependent children, up to age 19
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for 12 months; thereafter, considered a Class III expense
Late Entrant Limit	50% coverage on Class III, IV and IX (if applicable), for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Tri-County Mental Health Services - Low

Effective Date: January 01, 2020

Cigna.

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum	Progressive Plan	
(Class I, II, III, IX Expenses)	Class I applies Year 1: $1250, Year 2: $1400 Year 3: $1550, Year 4: $1700	Class I applies Year 1: $1250, Year 2: $1400 Year 3: $1550, Year 4: $1700
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	100%, After Deductible	100%, After Deductible
Class III Expenses - Major Restorative Care		
Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
	Not Covered	Not Covered
Class IX Expenses - Implants		
	50%, After Deductible	50%, After Deductible
Plan Calendar Year Max	$1250	$1250
Dental Plan Reimbursement Levels	Based on Contracted Fees	90th Percentile
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	
Progression	Members progress to the next level by utilizing Class I services in the prior year.	

P0010 Network.

Tri-County Mental Health Services - Low

Effective Date: January 01, 2020

Cigna.

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for 12 months; thereafter, considered a Class III expense
Late Entrant Limit	50% coverage on Class III, IV and IX (if applicable), for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

DISCRIMINATION IS AGAINST THE LAW

Dental coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

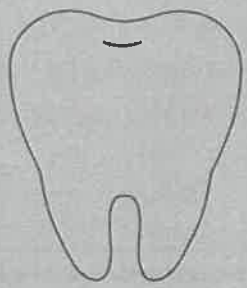
Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمارهگیری کنید).

MAKE THE MOST OF YOUR CIGNA DENTAL PLAN



Programs and services that can help

Nothing is more important than your health. That's why there's myCigna.com – your online home for assessment tools, plan management, dental health information and much more. Once you've enrolled in a Cigna dental plan, you can use myCigna.com to:

- **Choose** dentists and create, download and print a personal directory.
- **Verify** plan details such as coverage, coinsurance/copays and deductibles (the amount you pay before your plan starts to pay).
- **Print** a dental ID card.
- **Get** the forms you need.
- **Access** dental health information through WebMD® Dental Health Resource Center.
- **Estimate** your dental costs before your next visit.

Get to know your oral health

Are you at risk for gum disease? Knowing the answer to this question could help your overall health. That's because research shows an association between gum disease and other health conditions like diabetes, heart disease and stroke. Pregnant women with untreated gum disease may be at an increased risk for delivering preterm and/or low birth weight babies. Think cavities are just for kids? Think again. Many adults have untreated cavities (25% of those 20–44 years, 21% of those 45–64 years and 20% of those 65 years and older).[1] And tooth decay (cavities) is the single most common chronic childhood disease – four times more common than asthma.[2]

Assess your risks

The Periodontal (gum) Disease and Cavity Risk Assessment Tools are designed to help you and your dentist identify factors that might increase your risks for gum disease and cavities. The quizzes are quick and easy. The Periodontal Disease Risk Assessment is just 20 questions. The Cavity Risk Assessment is just 12 questions for adults and 16 questions for children under age 12. And when you complete the quizzes, you'll get detailed score sheets that tell you whether you are low risk, low to moderate, moderate risk or high risk for gum disease or tooth decay, depending on which quiz you've taken. Take the quizzes today and share the results with your dentist at your next dental checkup.

Please note that these tools serve as a guideline to assess your risks for cavities and gum disease. It's important to visit your dentist on a regular basis to discuss your oral health.

Together, all the way.℠

Cigna®

Prevention is key

Regular dental visits may do more than brighten your smile. Research shows receiving regular dental care often catches minor problems before they become major and expensive to treat. Practice prevention and take advantage of your plan's preventive care services – certain services may be covered at low cost or no cost to you when you visit a network dentist. Covered services* may include, but are not limited to:

- Oral exams
- Cleanings
- Fluoride treatments
- X-rays
- Oral cancer screenings

*The following is not an exhaustive list of exclusions and limitations. See your plan documents for additional details. Exams, cleanings and fluoride treatments are limited to two per calendar year. Routine X-rays are limited to: Bitewings: Two per calendar year, non-routine X-rays are limited to: Full mouth: One every three calendar years; Panorex: One every three calendar years. The frequency limitations of certain other covered services are set forth on your plan benefit schedule.

We're here when you need us

We know that sometimes you need us at odd hours – late at night, on the weekend or during a national holiday. Sometimes your questions just can't wait for "normal business hours."

- "My son is away at college. Can you help me find a network dentist close to his school?"
- "My dentist told me I need a root canal. Does my dental plan cover this?"
- "My husband has a painful toothache, but he's in Phoenix on a business trip. Can you help me find a dentist?" That's why our customer service hours include weekdays, Saturdays, Sundays and holidays. Call us at **800.Cigna24** any time you need us – we'll be there. We're on the clock for you 24 hours a day, 7 days a week, 365 days a year.

Health and wellness discounts

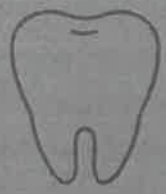
Save money when you purchase health and wellness products and services through the Cigna Healthy Rewards® program.[3] Programs include:

- Weight and nutrition management
- Fitness
- Tobacco cessation
- Vision and hearing care
- Vitamins, health and wellness products
- Alternative medicine
- Anticavity products
- Healthy lifestyle products

Cigna®

1. www.cdc.gov/oralhealth/factsheets/dental_caries American Dental Association; May 31, 2012, CDC report: Selected Oral Health Indicators in the United States, 2005-2008.
2. Surgeon General's Report on Oral Health in America, Centers for Disease Control and Prevention, July, 10 2013, Preventing Dental Caries With Community Programs.
3. Healthy Rewards is a discount program. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge**. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time.

SMILE!



It's easy to find a dentist or specialist in the Total Cigna DPPO network.

Finding a Total Cigna Dental PPO (DPPO) network dentist or specialist is quick and easy – whether you opt to search online or speak to a customer service representative. Let us show you how.

Make the most of your dental plan by registering and using myCigna.com.

By registering for myCigna.com, you can get individualized information, set to your dental plan. And, in a recent study, we found that people who use the myCigna® website and have a claim save on average 36.2% more than those who do not use myCigna.* So register today and access helpful information to find a dentist for your individual needs and budget. When searching for a dentist, your home zip code will be entered automatically, but you can change the zip if you are looking for a dentist in a different area. Once you've registered and logged on, you can search for a Cigna DPPO network dentist or specialist by choosing "Find Care and Costs" at the top of the screen, and following the prompts to search based on provider name, location, procedure type or specialty.

You'll see a list of results that has facts that can help you make a good choice about what dentist you want to use.

The search results will include information that can help you make an informed decision about who to see for the care you need. Provider profiles may include the following:**

- **Brighter Score® feature.** Use this scoring method to help you compare dentists. The score is derived from factors such as affordability, patient experience and professional history.
- **Dental office reviews and comparisons.** Find detailed information to compare dental offices. View dentist profiles with pictures and video content. Read verified patient reviews.
- **Enhanced search and transparent pricing.** Search for a dentist by a procedure or group of procedures. Information is personalized for your specific plan. Shows estimated out-of-pocket costs including coinsurance and deductibles.
- **Easy access.** These features are available anytime. 24/7 access on the go – on mobile phones or tablets.

Savings you can see.

Dentists listed "Total Cigna DPPO" have all agreed to offer care at discounted rates.

Out of Network – You may still choose to see a dentist who is not in the Total Cigna DPPO network, but your benefits may be lower and you may have to file your own claims. See your plan documents for the details of your specific dental plan.

If you are not registered on myCigna.com, you can still search for a dentist from the online directory on Cigna.com.

Because this is a public site, you don't need to register or log in to view search results. Just keep in mind that you'll only be able to view limited information about dentists such as office address, network type and contact information.

- To search for a dentist on **Cigna.com**, visit the site and click **"Find a Doctor, Dentist or Facility."**
- Follow the prompts on screen and when asked to choose your plan, select "DPPO/EPO > Total Cigna DPPO."

For help locating a Cigna network dentist or specialist, call Cigna to use the automated Dental Office Locator or speak to a customer service advocate. You can also ask for a customized directory based on the type of dentist you are looking for in your area.

(continued on next page)

Cigna®

Offered by: Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

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Call your current dentist to see if he or she is in the Total Cigna DPPO network.

When you call, be sure to ask if your dentist is in the Total Cigna DPPO network for your plan.

Call or click to find a dentist in-network that's right for you.

At Cigna, we work to deliver better savings, better health and a better customer experience. Our goal is to support you and your dental health. From full-help to self-help, Cigna has your dentist search covered.

Call us at 800.Cigna24
(800.244.6224)

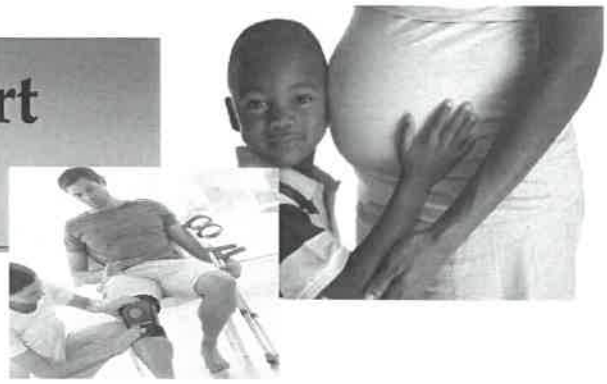
Cigna®

* Cigna Internal Data and Reporting, July 2018. Study Design: retrospective matched case control analysis, using one to one coarsened exact matching method. Population: new national DPPO standalone members who joined between February 1, 2017 and January 31, 2018 and were not enrolled in a family plan. Study group: members who visited mycigna.com and had at least one dental visit after the search. Control group: members who didn't visit myCigna and had at least one dental visit during the measurement period. Measurement Period: dental claims occurred from 2/1/2017 through 4/30/2018. Matching Factors: Age, Gender, ZIP Code (first 3 digits), Enrollment History. Results may vary.

** Actual features may vary by dentist and Cigna Dental plan type. These and other dentist directory features are for educational purposes only and should not be the sole basis for decision-making. They are not a guarantee of the quality of care that will be delivered to individual customers. Customers are encouraged to consider all relevant factors and to speak with their treating dentist when choosing where to receive dental care.

The dentists who participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients. Dentists are not agents of Cigna. Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.

Basic Life & AD&D / Short Term Disability - CIGNA



Who is Eligible and When:
Employees working 20 or more hours per week will be eligible beginning the 1st of the month following date of hire. The Basic Life/AD&D and Short Term Disability is paid by Tri-County Mental Health Services.

Basic Life/AD&D Benefits You Receive:

- 1 times your annual salary to a maximum of $150,000
- Benefits will be reduced at age 70 to 65% and at age 75 to 50%
- Basic AD&D – Your beneficiary will receive 2 times your Life Benefit if your death is a result of an accident

Short Term Disability Benefits You Receive:

- Class 1: Employees with less than 2 years of service:
  - 50% of your weekly covered earnings to a maximum of $1,000 per week
- Class 2: Employees with 2 or more years of service:
  - 60% of your weekly covered earnings to a maximum of $1,000 per week

- Before collecting Short Term Disability benefits, you must satisfy the benefit waiting period following your date of disability which is 0 days for an accident or 14 days for sickness

- The maximum benefit duration under this plan is 13 weeks

Voluntary Life/AD&D -CIGNA

You, as the employee, are eligible to purchase Voluntary Life, Spousal Life, and Dependent Life through Unum at your expense. Employees must participate in order for the dependents to be eligible and elect coverage.

Voluntary Life/AD&D Benefits You Can Elect:

Employee:

- Up to 5 times salary in increments of $10,000 –*Not to exceed $500,000*
- Guaranteed Issue Amount of $200,000 –*During initial eligibility*
- **During Open Enrollment** –if you currently have coverage you can elect up to the guarantee issue without Evidence of Insurability. If you do not have the benefit, any elections will require completion of an Evidence of Insurability form.
- Benefits will be reduced at age 70 to 65% and at age 75 to 50%

Spouse:

- Up to 100% of employee coverage amount in increments of $5,000 –*Not to exceed $500,000*
- Guaranteed Issue Amount of $30,000-*During initial eligibility*
- **During Open Enrollment** –if you currently have coverage you can elect up to the guarantee issue without Evidence of Insurability. If you do not have the benefit, any elections will require completion of an Evidence of Insurability Form.
- Benefits will be reduced at age 70 to 65% and at age 75 to 50%

Dependent Child:

- Up to 100% of employee coverage amount in increments of $2,500 –*Not to exceed $10,000*
  Under 14 days old - $500; 15 days old to 6 months - $1,000

Voluntary Long Term Disability
CIGNA

Who is Eligible and When:

Employees working 24 hours per week will be eligible to purchase this beginning the first day of the 1st of the month following date of hire. The benefit is paid by the Employee. **Health Statements required after initial eligibility.**

Benefits You Receive:

- 60% of your monthly earnings to a maximum of $7,500 per month
- Before collecting Long Term Disability benefits, you must satisfy the benefit elimination period which is 90 days
- The maximum benefit duration under this plan is as follows:

Age at Disability	Maximum Benefit Period
Less than Age 62	**To age 65 or to Social Security Normal Retirement Age (SSNRA)**
Age 62	**60 Months**
Age 63	**36 Months**
Age 64	**30 Months**
Age 65	**24 Months**
	After benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Pre-Existing Condition Exclusion:

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage

HELPING YOU REDUCE ABSENCES AND IMPROVE PRODUCTIVITY

Cigna Life Assistance Program[SM]

From health and wellness support to help with life's everyday needs and challenges, Cigna Life Assistance can help with life challenges from personal, work and family, caregiving, bereavement, legal, financial to pet care issues, just to name a few. This program also helps you avoid the impact of unscheduled absences and lost productivity to your business.

Cigna Life Assistance Program includes:

- Confidential clinical and work-life consultation by phone 24 hours a day, seven days a week, from licensed Cigna clinicians to address many of life's challenges and to help individuals restore peace of mind.
- Up to three free in-person counseling sessions[1] from Masters' and PhD-level licensed behavioral health clinicians in the large Cigna network of independent, contracted providers.
- 30-minute legal consultation[2] with a licensed practicing attorney and a 25% discount off standard fixed or hourly attorney's fees.
- 30-minute financial consultation with a certified financial expert and a 25% discount on tax planning and preparation.
- Online articles, resources and videos for work/life challenges including physical and mental health, family, aging, grief, working, balancing, living, thriving and more.
- Monthly webcast seminars on a variety of relevant topics.

The Value of Cigna Life Assistance

- Employers can recognize the value of Cigna Life Assistance immediately since services are available as soon as coverage begins.
- The Life Assistance Program supports employees, their household members and death claim beneficiaries at time of need and from Day One, even if they never submit a claim.
- Cigna also reminds your employees of these services when they submit a disability claim, and as part of Cignassurance® for death claim beneficiaries and offers warm transfers as appropriate.

Together, all the way.®

Cigna®

Offered by: Life Insurance Company of North America or Connecticut General Life Insurance Company.

1. Face to face counseling sessions are per person, per issue, per year
2. Legal consultations and discounts are excluded for employment-related issues.

These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions apply Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description, and are subject to change. Program availability may vary by plan type and location, and are not available where prohibited by law. These programs are not available under policies insured by Cigna Life Insurance Company of New York (New York, NY).

Employer Notices

PTO/Holiday Accrual Chart

Schedule Hrs/Wk	Level One Yrs 1 thru 3	Level Two Yrs 4 thru 6	Level Three Yrs 7+	Maximum Accrual	Holiday Hours
20.0	3.54	4.00	4.46	120.00	4.00
20.5	3.63	4.10	4.57	123.00	4.10
21.0	3.72	4.20	4.68	126.00	4.20
21.5	3.81	4.30	4.79	129.00	4.30
22.0	3.89	4.40	4.91	132.00	4.40
22.5	3.98	4.50	5.02	135.00	4.50
23.0	4.07	4.60	5.13	138.00	4.60
23.5	4.16	4.70	5.24	141.00	4.70
24.0	4.25	4.80	5.35	144.00	4.80
24.5	4.34	4.90	5.46	147.00	4.90
25.0	4.43	5.00	5.58	150.00	5.00
25.5	4.51	5.10	5.69	153.00	5.10
26.0	4.60	5.20	5.80	156.00	5.20
26.5	4.69	5.30	5.91	159.00	5.30
27.0	4.78	5.40	6.02	162.00	5.40
27.5	4.87	5.50	6.13	165.00	5.50
28.0	4.96	5.60	6.24	168.00	5.60
28.5	5.04	5.70	6.36	171.00	5.70
29.0	5.13	5.80	6.47	174.00	5.80
29.5	5.22	5.90	6.58	177.00	5.90
30.0	5.31	6.00	6.69	180.00	6.00
30.5	5.40	6.10	6.80	183.00	6.10
31.0	5.49	6.20	6.91	186.00	6.20
31.5	5.58	6.30	7.02	189.00	6.30
32.0	5.66	6.40	7.14	192.00	6.40
32.5	5.75	6.50	7.25	195.00	6.50
33.0	5.84	6.60	7.36	198.00	6.60
33.5	5.93	6.70	7.47	201.00	6.70
34.0	6.02	6.80	7.58	204.00	6.80
34.5	6.11	6.90	7.69	207.00	6.90
35.0	6.20	7.00	7.81	210.00	7.00
35.5	6.28	7.10	7.92	213.00	7.10
36.0	6.37	7.20	8.03	216.00	7.20
36.5	6.46	7.30	8.14	219.00	7.30
37.0	6.55	7.40	8.25	222.00	7.40
37.5	6.64	7.50	8.36	225.00	7.50
38.0	6.73	7.60	8.47	228.00	7.60
38.5	6.81	7.70	8.59	231.00	7.70
39.0	6.90	7.80	8.70	234.00	7.80
39.5	6.99	7.90	8.81	237.00	7.90
40.0	7.08	8.00	8.92	240.00	8.00

(10/25/2019) 23 Days 26 Days 29 Days 9 Holidays

TRI-COUNTY
MENTAL HEALTH SERVICES
We offer hope

Referral Line: 1-888-304-HOPE (4673)
Statewide Crisis Services: 1-888-568-1112
TTY: 1-888-568-1112
www.tcmhs.org

ADMINISTRATION/ OUTPATIENT/ EMERGENCY & COMMUNITY BASED SERVICES
Mailing:
P.O. Box 2008
Lewiston, ME 04241-2008

Location:
1155 Lisbon Street
Lewiston, ME 04240
Main Number: 783.9141
Toll Free: 1.800.787.1155

SOCIAL LEARNING CENTER
80 Strawberry Ave
Lewiston, ME 04240
Main Number: 783.4672
Toll Free: 1.877.208.6134

BRIDGTON
32 No. High Street
Bridgton, ME 04009
Main Number: 647.5629
Toll Free: 1.800.286.5629

FARMINGTON
144 High Street, Ste 1
Farmington, ME 04938
Main Number: 778.3556
Toll Free: 1.800.559.3556

OXFORD HILLS
143 Pottle Road
Oxford, ME 04270
Main Number: 743.7911
Toll Free: 1.800.750.7911

RUMFORD
49 Congress Street
Rumford, ME 04276
Main Number: 364.7981
Toll Free: 1.800.371.7981

MEMO

Date: October 10, 2019

To: All Staff

From: Donald D. Dufour, Chief Human Resources Officer

RE: **2020 HOLIDAY SCHEDULE**

HOLIDAYS	DAY/DATE TO BE OBSERVED
New Year's Day	Wednesday, January 1, 2020
Martin Luther King's Birthday	Monday, January 20, 2020
Memorial Day	Monday, May 25, 2020
Independence Day	Observed on Friday, July 3, 2020
Labor Day	Monday, September 7, 2020
Veteran's Day	Wednesday, November 11, 2020
Thanksgiving Day	Thursday, November 26, 2020
Thanksgiving Friday	Friday, November 27, 2020
Christmas Day	Friday, December 25, 2020

Legal Notices

Summary of Benefits and Coverage
To help you make informed plan decisions, Tri-County Mental Health Services will make available a Summary of Benefits and Coverage (SBC) for 2020. The SBCs are standardized nationwide by the government and summarize information you need to best compare your benefits across your options. Contact your HR representative for a paper copy.

Women's Health and Cancer Rights Act
The Women's Health and Cancer Rights Act of 1998 was signed into law on Oct. 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and co-insurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.

Statement of Rights under the Newborns' and Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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 consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours).

Women's Preventive Health
There are several benefits that are in place as a result of the Affordable Care Act (health care reform). These benefits are covered at 100% and may include:

- Contraceptive (birth control) counseling and FDA- approved birth control methods that need a prescription.
- Breastfeeding support, supplies and counseling for females
- HPV (female) testing
- Screenings during pregnancy

Details can be found in the separate Summary of Benefits and Coverage (SBCs) or by calling Health Plans Inc. member services.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment, claims and case management.

If you feel that protected health information about you is incorrect or incomplete, you may ask Tri-County Mental Health Services to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources.

COBRA Rights

If you are an Employee of Tri-County Mental Health Services and are covered by the Tri-County Mental Health Services' Employee Benefits Plan, you have the right to choose continuation coverage at group rates if you lose your group health coverage because of reduction in hours or termination of employment (for reasons other than gross misconduct on your part). If you are a spouse of an Employee of Tri-County Mental Health Services and are covered by the Tri-County Mental Services' Group Health Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Tri-County Mental Health Services' Group Health Plan for any of the following reasons:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an Employee covered by Tri-County Mental Health Services' Health Plan, he or she has the right to continuation coverage if group health coverage under the Tri-County Mental Health Group Health Plan is lost for any of the following reasons:

- The death of a parent;
- A termination of parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with Tri-County Mental Health;
- Parent's divorce or legal separation;
- A parent becomes entitled to Medicare; or
- The dependent child ceases to be a "dependent child" under the Tri-County Mental Health Services' Group Health Plan.

Your Responsibilities: Under the law, you and your family member(s) have the responsibility to inform Human Resources of a divorce, legal separation, or child losing dependent status under the Tri-County Mental Health Services' Health Plan within 30 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. You are responsible for notifying the Human Resources Department of reduction in work, or Medicare entitlement. Similar rights may apply to certain retirees, your spouse, and dependent children if Tri-County Mental Health Services commences a bankruptcy proceeding and these individuals lose coverage. Once notified that one of these events has happened, Human Resources will notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date the election notice is sent to you, whichever is later, to inform Human Resources that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end. If you choose continuation coverage, Tri-County Mental Health Services' is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to non- COBRA participants or family members. For more information on your rights under COBRA, please refer to the Initial COBRA Notice you received at the time you were hired, or contact the Human Resources team.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health 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 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). You should contact your State for further information on eligibility.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

When key parts of the health care law took effect in 2014, there were new ways 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 Marketplace.

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 (subsidy) that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 2019 for coverage starting as early as Jan. 1, 2020.

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 (subsidy) through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit (subsidy) 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 9.78 percent 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 (subsidy). (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.)

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 your Human Resources team

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

DISCLOSURE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Important Notice From Tri-County Mental Health Services About Your Prescription Drug Coverage and Medicare

If you or your dependents are not currently entitled to Medicare, then you may disregard this notice until you or they become entitled to Medicare.

If you or your dependents are currently entitled to Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tri-County Mental Health Services 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 and their 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. **Tri-County Mental Health Services has determined that the prescription drug coverage offered by its employer sponsored health plan ("Employer Health Plan") is on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage. Therefore, your coverage is considered Creditable Coverage.** Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

There are three times when you may join a Medicare drug plan:

1. When you first become eligible for Medicare
2. Each year from October 15th to December 7th
3. During the two-month Special Enrollment Period (SEP) which begins when, through no fault of your own, you lose creditable prescription drug coverage under an employer or union sponsored health plan

What happens to your current coverage if you join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current prescription drug coverage under your Employer Health Plan will not be affected unless you decide to drop your prescription drug coverage under your Employer Health Plan. Your current Employer Health Plan provides coverage for many other medical expenses in combination with coverage for prescription drugs.

- If you keep the prescription drug coverage offered under your Employer Health Plan, you will continue to receive all the medical and prescription drug benefits available under the Plan.
- If you drop the prescription drug coverage provided through the Plan, coverage of your other medical benefits under the Plan will also be terminated since all benefits are provided on a combined basis.

If you do decide to join a Medicare drug plan and drop your current coverage under your Employer Health Plan, you and your dependents may not be able to get this coverage back at a later date.

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 under your Employer Health Plan 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 permanently 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

Please contact the person listed at the end of this notice for further information about your prescription drug coverage.

NOTE: Your employer will distribute this notice at least once a year. You will also get a notice if your Employer Health Plan changes and no longer provides creditable prescription drug coverage. 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. After you become eligible for Medicare, Medicare will send you a copy of the handbook in the mail every year. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	10/10/2019
Name of Entity/Sender:	Tri-County Mental Health Services
Contact--Position/Office:	Earl Fournier, Human Resources Coordinator
Address:	1155 Lisbon Street, Lewiston, ME 04241-2008
Phone Number:	(207) 783-9141

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA.

If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.
FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures. For additional information: 1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627 WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013