2017-2018 - OPEN ENROLLMENT BROCHURE

This brochure represents the 2017–2018 benefits for Millington Municipal Schools

PLEASE JOIN US FOR INFORMATIONAL MEETINGS TO BE HELD IN YOUR DISTRICT

April 19th- 3:15 pm
E.A.Harrold Elem. Library

April 24 - 2:30 pm
MCHS Cafeteria

April 26th - 3:15 pm
Millington Elem. Library

Benefits covered inside this booklet include:

2017-2018 - OPEN ENROLLMENT BROCHURE

IMPORTANT - NEW THIS YEAR - CHANGES

- MEDICAL – The Medical plan is changing from Meritain to HealthSCOPE. See the Medical portion of the brochure to learn about HealthSCOPE.
- HealthSCOPE will take over your current benefits on *07-01-2017*. Changes made during Open Enrollment will become effective *09-01-2017*.
- A new medical plan is being offered. It is called a Transparent Pricing Arrangement (COPAY Plan). Please review the plan summary as this plan has ***NO DEDUCTIBLES***, only COPAYS.
- The HRA Plan will continue in a grandfathered status. This means no new members may enroll.
- Please see the *RATES* sheet for this year's new premiums.

DENTAL – Delta Dental

- No changes to benefits
- Please see *RATES* included in this brochure for this year's new premium

VISION – Davis Vision

- No change to benefits
- Please see *RATES* included in this brochure for this year's new premium

LIFE INSURANCE – Standard

- Voluntary Life
  - No changes to rates
  - Can add to lesser of 5 times annual earnings up to $500,000. (Evidence of Insurability applies)
- Spouse Life
  - No changes to rates
  - Can add up to lesser of 50% of employee's life benefit to maximum of $250,000 (Evidence of Insurability applies)
- Child Life
  - No changes to rates
  - May add $10,000 or $20,000 (Evidence of Insurability applies)

LONG-TERM DISABILITY

- No changes to rates
- Evidence of Insurability applies

AMERICAN FIDELITY PRODUCTS

- Cancer
- Critical Illness
- Short-Term Disability
- Flexible Spending Account Medical/Dependent Childcare

2017-2018 - OPEN ENROLLMENT BROCHURE

WHAT IS TRANSPARENT PRICING?

New this year is a medical plan, which is different from the current model. Current models use contracts with the facility and insurance company to pay a fee based on a discount off billed charges. The problem with that model is that inflation over time means that those discounts become less, which can increase rates substantially over time.

The New Transparent Pricing Arrangement, also known as the "COPAY" plan changes this approach. A transparent pricing plan doesn't use a provider network to reduce costs; rather, the plan pays providers a fair and reasonable fee for services based on price averages in your region. This allows you to receive care from any provider you choose with no financial penalty. Services for hospital procedures are "bundled", meaning your copay pays for all providers, i.e., physicians, testing, lab and hospital.

What you'll notice with this plan is that *all services are paid by a copay.* No more deductibles or coinsurance. If you should receive a bill by a facility for the balance not paid by the plan, you should notify HealthSCOPE.

HealthSCOPE has access to the Baptist and St. Francis hospital network system.

HRA CHANGES

There are no changes to the benefit or deductibles of the HRA plan, but this year there will not be any new enrolled members. Only current members will continue the benefits under the HRA, or they may opt for one of the other three plans offered, EPO, Basic or New Transparent Pricing Arrangement plan (COPAY Plan). If the member chooses to switch plans, accumulated "funds" are forfeited as of 09-01-2017.

TRANSITION TO HealthSCOPE

The change to the new Medical TPA, HealthSCOPE, will occur on 07-01-2017. HealthSCOPE has access to the Baptist/St. Francis hospital network system; therefore, you should not experience any disruption with your care with your doctor. You will receive new ID cards prior to 07-01-2017. This means that for any services after 07-01-2017, you'll need to present your new HealthSCOPE ID card. Any changes you make during Open Enrollment will become effective 09-01-2017. That is also when the "New" Transparent Pricing Arrangement plan (COPAY Plan) will take effect.

2017-2018
20 PAY PERIOD RATES
Arlington Community Schools, Bartlett City Schools, Collierville Schools, Millington Municipal Schools

MEDICAL		
HEALTHSCOPE BENEFIT	**COVERAGE TIER**	**PER PAY PERIOD RATES (20 DEDUCTIONS)**
COPAY (Transparent Pricing Plan)	EMPLOYEE	**$ 70.92**
	EE + ONE	**$ 182.69**
	FAMILY	**$ 254.86**
HRA (Health Reimbursement Arrangement)	EMPLOYEE	**$ 72.74**
	EE + ONE	**$ 187.38**
	FAMILY	**$ 261.40**
BASIC	EMPLOYEE	**$ 106.10**
	EE + ONE	**$ 250.10**
	FAMILY	**$ 348.89**
EPO (Exclusive Provider Organization)	EMPLOYEE	**$ 127.77**
	EE + ONE	**$ 300.62**
	FAMILY	**$ 419.37**
DENTAL		
DELTA DENTAL	**COVERAGE TIER**	**PER PAY PERIOD RATES (20 DEDUCTIONS)**
PLAN 1-DPPO $2000	EMPLOYEE	**$ 22.13**
	EE + ONE	**$ 46.48**
	FAMILY	**$ 66.39**
PLAN 2-DPPO $1500	EMPLOYEE	**$ 15.34**
	EE + ONE	**$ 32.20**
	FAMILY	**$ 46.01**
VISION		
DAVIS VISION	**COVERAGE TIER**	**PER PAY PERIOD RATES (20 DEDUCTIONS)**
VISION	EMPLOYEE	**$ 3.79**
	EE + ONE	**$ 7.25**
	FAMILY	**$ 11.77**

PLAN SUMMARY OF BENEFITS - 2017-2018

	EPO PLAN	BASIC PLAN		HRA FUND		*****COPAY Plan- Transparent Pricing Arrangement
	IN-NETWORK ONLY (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPTIALS)	IN-NETWORK (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)	****OUT-OF-NETWORK	IN-NETWORK (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)	****OUT-OF-NETWORK	(BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)
***WELLNESS (Routine Care)						
Physical Exams (per ACA)	100% (no Ded.)	100% (no Ded.)	Not Covered	100% (no Ded.)	Not Covered	100% (no Ded.)
Well Child Care (Including Immunizations)	100% (no Ded.)	100% (no Ded.)	Not Covered	100% (no Ded.)	Not Covered	100% (no Ded.)
Mammogram (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Pap Smears (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Prostate Blood Test/Colonoscopy (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Fecal Occult Screening (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
**Annual Health Fund Provided to Employees and Dependents	Not Applicable	Not Applicable		$500 Indv. $750 Indv. +1 $1,000 Fam (Please note: the "Fund" is applied to the back end of the Deductible)		Not Applicable
MAJOR MEDICAL						
*Deductible (Ded.)	$500/Indv. $750/Indv.+1 $1,000/Fam.	$500/Indv. $1000/Indv. + 1 $1,500/Fam.	$1,000/ Indv. $2,000/ Indv. + 1 $3,000/ Fam.	$1,500/Indv. $3,000/Indv. + 1 $4,500/Fam.	$3,000/ Indv. $6,000/ Indv. + 1 $9,000/ Fam.	N/A
Plan Paymt (Coinsurance)	100%	80%	50%	80%	50%	100%
Out-of-Pocket Max.* (Including Ded.)	$2,000/Indv. $3,750/Indv. + 1 $5,500/Fam.	$4,000/Indv. $8,000/Indv. + 1 $12,000/Fam.	$9,000/ Indv. $18,000/Indv. + 1 $27,000/ Fam.	$5,000/Indv. $10,000/Indv. + 1 $13,700/Fam.	$12,000/ Indv. $24,000/ Indv. + 1 $34,700/ Fam.	$2,000/Indv. $3,750/Indv. + 1 $5,500/Fam.
Lifetime Max. per Fam Mbr.	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
HOSPITAL BENEFITS						
In-Patient	$500 Copay (then Ded.) per admission	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 per admission
Out-Patient	$250 Copay (then Ded.) per visit	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$250 Copay
Emergency Room	$150 Copay (then Ded.) per visit	$150 Copay, then Ded., then 100%		80% (after Ded.)		$150 Copay
Non-Emergency	Not Covered	$150 Copay, then Ded. , then 100%	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 Copay
	Copay Waived if admitted due to Medical Emergency					
SURGICAL / PHYSICIAN BENEFITS						
In-Patient/Out-Patient	100% (no Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
PHYSICIAN'S OFFICE VISIT						
Primary Care	100%; after $20 Copay	100%; after $25 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay
Specialist	100%; after $35 Copay	100%; after $35 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$35 Copay
DIAGNOSTIC SERVICES						
Routine X-Ray & LAB Services (outpatient)	100% (no Ded.)	80% (no Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
(MRI, MRA, CAT and Pet Scan are subject to Deductible)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	CAT Scans - ($150 Copay) MRI/MRA/PET Scans- ($250 Copay)
PRESCRIPTIONS						
GENERIC	$10	$10	50% (after $100 Ded.)	$10	50% (after $100 Ded.)	$10
PREFERRED	$25	$25	50% (after $100 Ded.)	$25	50% (after $100 Ded.)	$25
NON-PREFERRED	$50	$50	50% (after $100 Ded.)	$50	50% (after $100 Ded.)	$50
MENTAL/NERVOUS & SUBSTANCE ABUSE						
In-Patient	$500 Copay (then Ded.) per admission	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 per admission
Physician's Ofc. Visit	100%; after $20 Copay	100%; after $25 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay
ADDITIONAL MEDICAL BENEFITS						
Physical Therapies/ Chiropractic (60 visits max)	100%; after $35 Copay	100%; after $35 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay - (15 visits)
Home Health Care (Precertification) (60 visits max)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
Extended Care Facility (60 visits max)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$100 Copay
Hospice (Precertification)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
Urgent Care	$75 Copay, (then Ded.)	$75 Copay, (then Ded.)	$75 Copay, (then Ded.)	80% (after Ded.)	50% (after Ded.)	$40 Copay
Ambulance Services	100% (after Ded.)	80% (after Ded.)	80% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$50 Copay
Medical Supplies & DME	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$50 Copay

***Deductibles and Out of Pocket Expenses Accumulate on a calendar year basis.**

**The HRA Fund pays at the back end of the deductible and is funded 50% for enrollments beginning September 1. On January 1, the fund will be funded the full amount listed in this summary and any funds remaining at the end of the calendar year will be added to it. Please note that the fund cannot exceed 100% of the in-network Deductible.

***For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits.

The plan document is the governing document; therefore any discrepancies which may be found in this summary are not binding. The Plan Document may be found by going to your district's Employee Portal and looking under "Documents/Links".

**** Out of Network providers may bill for amounts above the Usual and Customary charges, which the Member may also be charged on top of the deductibles and coinsurance amounts.

***** **Transparent Pricing Arrangement (COPAY Plan)** uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated by HealthSCOPE

Revised 03-25-2017

Welcome to HealthSCOPE Benefits!

HealthSCOPE Benefits is pleased to be the administrator for your Medical health plan, beginning on July 1, 2017. This flyer includes important information about your plan. Please read it carefully! If you have any questions, contact HealthSCOPE Benefits at 800-458-1060

New ID card

New ID card(s) will be issued in June for you to use starting on July 1, 2017. Your old ID card(s) should be discarded and no longer used for services received as of July 1, 2017.

HealthSCOPE Benefits at your service!

HealthSCOPE Benefits is the administrator of your medical plan and has access to your claims, eligibility and medical plan information. Beginning June 1st, both you and your doctor should call HealthSCOPE at 800-458-1060 with any questions or concerns you may have.

Customer Care Specialists are available between 8 am and 5 pm Central Standard Time, Monday through Friday. Most questions can also be answered through our Interactive Voice Response (IVR) telephone system, available 24/7/365. The IVR allows you and your doctor to check eligibility, claim and payment status, as well as benefit information.

When you receive your new ID card in June, you will gain access to a dedicated website to quickly and easily search for providers. Make sure to contact HealthSCOPE Benefits for eligibility, claims, and benefit information. The provider networks cannot access your records and cannot answer questions regarding your benefits.

Important Information!

Coordination of Benefits (COB): The Plan requires HealthSCOPE Benefits to update other insurance coverage information at least once per year. This other insurance information is used to coordinate benefits with other medical insurance coverage. This is needed even if your dependents do not have additional coverage through another medical plan. Your claims may be denied or paid incorrectly if the data is not current.

The Explanation of Benefits for your claims will include a specific message when it's time to update your COB information. You can also call 800-458-1060 at any time to easily update your records. For more information on COB updates, please refer to the Coordination of Benefits flyer on the HealthSCOPE Benefits website (www.healthscopebenefits.com). See next page for instructions on how to access the site.

Precertification/Prior Authorization: Beginning June 1, 2017, to obtain approval for services that require precertification/prior authorization for date of service July 1, 2017 and after, please call 800-458-1060. These services include, but are not limited to inpatient admissions, and surgical procedures. For a complete listing of all services that require prior authorization or precertification, please review your Summary Plan Documents or call HealthSCOPE Benefits at 800-458-1060.

Pharmacy/Rx: MedBen will be your prescription drug vendor beginning July 1, 2017. For questions and more information about your prescription drug plan, please call MedBen at 800-549-0097.

Network Provider Information: Beginning June 1, 2017, if you have any questions about your provider's participation in the network, please call HealthSCOPE Benefits Customer Care at 800-458-1060. You can also access the network provider directories through our website at www.healthscopebenefits.com. Login instructions are shown below.

Website: The website (www.healthscopebenefits.com) provides valuable information and enables you to access our online claims and Customer Care portal whenever you need it. Here, you can review your benefits, check the status of a claim, sign up to receive electronic Explanation of Benefits or request a replacement ID card, among other things. All you have to do is register to set up a personalized web account.

Each primary insured and adult dependent must set up their own account and can view only their own information. The primary insured can also view data for dependents under the age of 18. Adult dependents can call 800-458-1060 after June 1, 2017 to grant viewing access to the primary insured member.

To access the HealthSCOPE Benefits website the first time:

- Go to www.healthscopebenefits.com and click "Member" at the top of the page.
- Under Company Name, type **MSSC.**
- Select the New Member Registration link.
- Enter the Primary Member's ID Number listed on your ID Card.
- Fill in your own First Name, Last Name, Date of Birth and Zip Code.
- Simply follow the system prompts to set up a web account.

To access the HealthSCOPE Benefits website after your account has been set up:

- Go to www.healthscopebenefits.com and click "Member" at the top of the page.
- Under Company Name, type **MSSC**
- Enter the Username and Password you created when registering.

We are here to help, so if you have any problems or need assistance of any kind, please call the HealthSCOPE Benefits Customer Care department starting June 1, 2017 at 800-458-1060. We look forward to providing outstanding service to you!

Member Web Portal

You have 24/7 access to your personal benefits, claims, and eligibility information. Here's how it works.

1 Connect to www.healthscopebenefits.com and click on **Member**.

2 Enter your **Company Name** (**MSSC**) and click **Enter**.

3 Enter your user name and password and click **Sign In**. If you haven't registered an account yet, follow the on-screen prompts to do so.

4 On the next screen, click **Claims and Eligibility**.

5 The **Member Dashboard** displays several options, including:

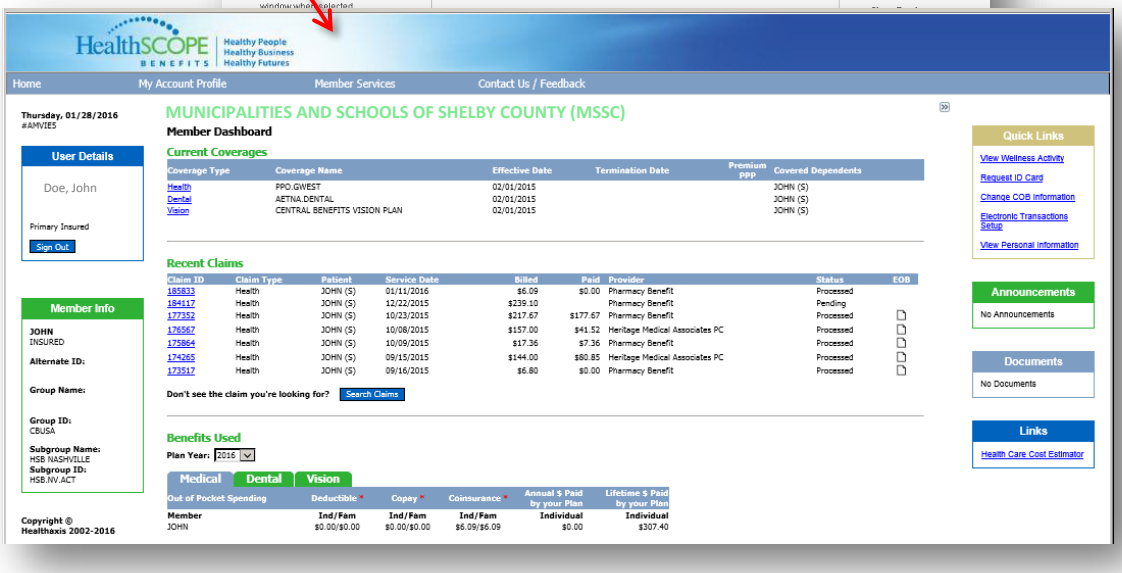
Current coverages – displays current plans and any changes in history.

Recent Claims – displays claims history.

Benefits Used – displays dollar amounts paid per category per benefit year and overall lifetime maximum.

Quick Links – users can request duplicate ID cards, or review demographic information.

Wellness Activities - displays current wellness activity completion.



Delta Dental of Tennessee

Municipal Schools of Shelby County – Option 1

Your Delta Dental Benefit Highlights

Group #6733

Network	*Delta Dental PPO*	*Delta Dental Premier*	***Out of Network*
Services	**Delta Dental Pays***		
Diagnostic & Preventive			
Oral examinations, cleanings, x-rays, fluoride treatments, space maintainers, sealants, emergency palliative treatment	100%	100%	100%
Basic Services			
Restorative (fillings), general anesthesia, simple extractions, injectable antibiotics, perio maintenance	80%	80%	80%
Periodontic Therapy *treatment of gums and bones supporting teeth*	80%	80%	80%
Endodontic Therapy *root canal therapy*	80%	80%	80%
Complex Oral Surgery	80%	80%	80%
Major Services			
Complex Restorations & Related Services *crowns, bridges, dentures, full mouth debridement*	60%	60%	60%
Orthodontic Services			
Straightening of teeth for all members	50%	50%	50%
Maximums			
Calendar Year – Per Person *Excludes Orthodontics*	$2000		
Lifetime Orthodontics	$2000		
Annual Deductible			
Per Person	$25	$50	$50
Family	$75	$150	$150
Deductible excludes Diagnostic & Preventive & Orthodontic Services			

You're now a member of Tennessee's largest dental benefits family!

As a member of Delta Dental of Tennessee, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. With 3 out of 4 dentists participating, these two networks provide great access to care as well as the privilege of reduced rates through our agreed upon fees with dentists. When seeing a dentist in either the Premier or PPO networks you cannot be balance billed – giving you added savings. You are also free to visit non-network dentists, but you may be balance billed.

Finding a Delta Dental provider

Finding a dentist in one of our networks is easy. Simply visit our Web site, www.DeltaDentalTN.com, or call our Customer Service hotline at 800-223-3104.

When do benefits start?

Your benefits begin on the effective date indicated on the highlight form. You may visit a dentist at any time following that date. If you do not enroll when first eligible, you must wait until the first open enrollment period to enroll in the plan. Please refer to your Certificate of Coverage for re-enrollment requirements.

View your benefit details online

You can get information on your Delta Dental benefits at your convenience using our Consumer Toolkit. Review claims, amounts used toward annual maximum, print ID cards, and more. Visit www.DeltaDentalTN.com and select the login for Subscribers.

Questions?

If you have questions about your Delta Dental benefits, visit our Web site, www.DeltaDentalTN.com, call our Customer Service hotline at 800-223-3104, or consult your Benefits Administrator.

*** Non par providers are paid at the 90th percentile.*

Age and frequency limitations apply. For a detailed description of your benefit plan, please refer to your Certificate of Coverage. This form is not a contract of insurance. Terms and conditions are set forth in the Master Group Policy issued directly to your group

**You are not responsible for charges exceeding the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You* are *responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.*

Delta Dental of Tennessee

Municipal Schools of Shelby County – Option 2

Your Delta Dental Benefit Highlights

Group #6733 coverage

Network	*Delta Dental PPO*	*Delta Dental Premier*	***Out of Network*
Services	**Delta Dental Pays***		
Diagnostic & Preventive			
Oral examinations, cleanings, x-rays, fluoride treatments, space maintainers, sealants, emergency palliative treatment	100%	100%	100%
Basic Services			
Restorative (fillings), general anesthesia, simple extractions, injectable antibiotics, perio maintenance	80%	80%	80%
Major Services			
Periodontic Therapy *treatment of gums and bones supporting teeth*	50%	50%	50%
Endodontic Therapy *root canal therapy*	50%	50%	50%
Complex Oral Surgery	50%	50%	50%
Complex Restorations & Related Services *crowns, bridges, dentures, full mouth debridement*	50%	50%	50%
Orthodontic Services			
Straightening of teeth for all members	50%	50%	50%
Maximums			
Calendar Year – Per Person *Excludes Orthodontics*	$1500		
Lifetime Orthodontics	$1500		
Annual Deductible			
Per Person	$50	$100	$100
Family	$150	$300	$300
Deductible excludes Diagnostic & Preventive & Orthodontic Services			

You're now a member of Tennessee's largest dental benefits family!

As a member of Delta Dental of Tennessee, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. With 3 out of 4 dentists participating, these two networks provide great access to care as well as the privilege of reduced rates through our agreed upon fees with dentists. When seeing a dentist in either the Premier or PPO networks you cannot be balance billed – giving you added savings. You are also free to visit non-network dentists, but you may be balance billed.

Finding a Delta Dental provider

Finding a dentist in one of our networks is easy. Simply visit our Web site, www.DeltaDentalTN.com, or call our Customer Service hotline at 800-223-3104.

When do benefits start?

Your benefits begin on the effective date indicated on the highlight form. You may visit a dentist at any time following that date. If you do not enroll when first eligible, you must wait until the first open enrollment period to enroll in the plan. Please refer to your Certificate of Coverage for re-enrollment requirements.

View your benefit details online

You can get information on your Delta Dental benefits at your convenience using our Consumer Toolkit. Review claims, amounts used toward annual maximum, print ID cards, and more. Visit www.DeltaDentalTN.com and select the login for Subscribers.

Questions?

If you have questions about your Delta Dental benefits, visit our Web site, www.DeltaDentalTN.com, call our Customer Service hotline at 800-223-3104, or consult your Benefits Administrator.

*** Non par providers are paid at the 90th percentile.*

Age and frequency limitations apply. For a detailed description of your benefit plan, please refer to your Certificate of Coverage. This form is not a contract of insurance. Terms and conditions are set forth in the Master Group Policy issued directly to your group

**You are not responsible for charges exceeding the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You* are *responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.*

See better – live better

Delta Dental Vision provided by EyeMed Vision Care

Your eyes say a lot about you – from your emotions to vision and your overall health. And, when you're proactive about protecting your eyes, the impact is clear.

Regular eye exams not only correct vision problems, they also can reveal early warning signs of more serious health conditions such as hypertension, cardiovascular disease and diabetes. So, schedule exams annually and you'll be set on a path to better health.

Keep on saving

You can use your EyeMed discount as often as you like, all year long, on nearly all your vision care purchases at EyeMed's participating providers.

Visit eyemed.com to learn more

Need to locate a provider? Want to learn about vision wellness? Visit eyemedvisioncare.com/deltadental.

Locate a provider

You love choices - and so do we. That's why our network has thousands of independent doctors and retail providers.

Schedule an appointment

Call ahead or stop by one of the many providers that offer walk-ins. Most also have evening and weekend hours to fit any schedule.

Show your ID card

When you arrive, let the provider know you have an EyeMed discount through Delta Dental.

Please note your discount cannot be combined with any other discounts, coupons or promotional offers.

DELTA DENTAL

Member/Patient Services:
1.866.246.9041
ACCESS DISCOUNT PLAN

DELTA DENTAL
Discount Plan#: 9231093

Signature: _____

This is not insurance.
Dependents are eligible.

Please detach carefully at perforation and keep card in your wallet.

Delta Dental

Discount plan - Employees must be enrolled in the Dental plan to be eligible for the discount.
Access network
Discounted exam and a defined materials discount

Vision care services	Member cost
Exam and dilation as necessary	$5 off routine exam $10 off contact lens exam
Complete pair of glasses purchase*: Frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard plastic lenses:	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Frames	35% off retail price
Lens options:	
UV treatment	$15
Tint (solid and gradient)	$15
Standard plastic scratch coating	$15
Standard polycarbonate	$40
Standard progressive lens (Add-on to bifocal)	$65
Standard anti-reflective coating	$45
Other add-ons and services	20% off retail price
Contact lens materials: (Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser vision correction:**	
LASIK or PRK	15% off retail price or 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact lenses	Unlimited

THIS IS NOT INSURANCE

*Items purchased separately will be discounted 20% off of the retail price.

**Since LASIK and PRK vision corrections are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your location. For a location near you and the discount authorization, please call 1.877.5LASER6.

Member will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this discount. The 20% off discount does not apply to EyeMed providers' professional services or contact lenses. Retail prices may vary by location. All discounts cannot be combined with any other discounts or promotional offers.

This discount design is offered with the EyeMed Access panel of providers.

Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under plan
- Services provided as a result of any Worker's Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount

Visit eyemedvisioncare.com/deltadental to learn more or locate a provider near you.

DAVIS VISION
EYECARE REFRAMED℠

Designer Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

Contact your Human Resources department today to enroll.

For more details about the plan, just log on to the Open Enrollment section of our Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code **3148**

IN-NETWORK BENEFITS	
Eye Examination	Every September 1, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every September 1, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses after $20 copayment
Frames	Every other September 1, **Covered in full** Any Fashion or Designer frame from Davis Vision's Collection[1] (value up to $175) OR $130 retail allowance toward any frame from provider, plus 20% off balance[2]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every September 1, Collection Contacts: **Covered in full** after $20 copayment OR Non Collection Contacts: Standard Contacts: 15% discount[2] Specialty Contacts[3]: 15% discount[2]
Contact Lenses (in lieu of eyeglasses)	Every September 1, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$40	$0
Polycarbonate Lenses	$64	$0[4]-$30
Standard Anti-Reflective (AR) Coating	$62	$0
Standard Progressives (no-line bifocal)	**$154**	**$0**
Plastic Photosensitive (Transitions®[5])	$123	$65

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$100	$10
Lenses		
Bifocals	$80	$20
Scratch-Resistant Coating	$40	$0
Transitions®[5]	$123	$65
Frame	$150	$0
Total	$493	$95

Savings up to: ***$398***

Employee Contributions	20-Pay
Employee	$3.79
Employee plus Spouse	$7.25
Employee plus Family	$11.77

new

[1] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
[2] Additional discounts not applicable at Walmart or Sam's Club locations.
[3] Including, but not limited to toric, multifocal and gas permeable contact lenses.
[4] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[5] Transitions® is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

OE00757 6/9/14

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 3148.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$125	$0
Designer Frame (from the Davis Vision Collection)	$175	$0
Premier Frame (from the Davis Vision Collection)	$225	$25
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$33**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$20**	**$0**
Scratch-Resistant Coating	**$40**	**$0**
Polycarbonate Lenses	$64	$0[/1] or $30
Ultraviolet Coating	$28	$12
Standard Anti-Reflective (AR) Coating	**$62**	**$0**
Premium AR Coating	$80	$13
Ultra AR Coating	$113	$25
Intermediate-Vision Lenses	$150	$30
Standard Progressive Addition Lenses	**$154**	**$0**
Premium Progressives (Varilux®[/2], etc.)	$248	$40
High-Index Lenses	$120	$55
Polarized Lenses	$103	$75
Plastic Photosensitive Lenses	$123	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1/] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2/] Varilux® is a registered trademark of Societe Essilor International

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $30 | Frame up to $30 Spectacle Lenses (per pair) up to: Single Vision $25, Bifocal $35, Trifocal $45, Lenticular $60 Elective Contacts up to $75, Medically Necessary Contacts up to $225

LIFE AND LTD INSURANCE

STANDARD—BASIC LIFE BENEFITS	
ACTIVE BENEFITS	• 2 times annual contract salary • AD&D - 2 times annual contract salary (Accidental Death and Dismemberment) • District pays 100%
MAXIMUM BENEFIT	• $300,000
Basic Life benefits reduces 35% at age 65/ 50% at age 70	

STANDARD—SUPPLEMENTAL LIFE BENEFITS	
OPTIONAL LIFE	• ALL CURRENT OPTIONAL LIFE BENEFITS ARE CONTINUED • INCLUDES AD & D • SAME LOW RATES • CAN ADD, IN INCREMENTS OF $10,000, UP TO LESSER OF 5 TIMES ANNUAL EARNINGS OR $500,000. • A Statement of health is required for all new enrollment
OPTIONAL SPOUSE LIFE	• ALL CURRENT SPOUSE LIFE BENEFITS ARE CONTINUED • INCLUDES AD & D • SAME LOW RATES • CAN ADD, IN INCREMENTS OF $5,000, UP TO LESSER OF $250,000 OR ½ OF EMPLOYEE'S OPTIONAL LIFE BENEFIT • A Statement of health is required for all new enrollment
CHILD LIFE	• ALL CURRENT CHILD LIFE BENEFITS ARE CONTINUED • INCLUDES AD & D • SAME LOW RATES • COVERAGE IS $10,000 OR $20,000 AND COVERS ALL CHILDREN IN THE HOUSEHOLD UP TO AGE 25 • A Statement of health is required for all new enrollment

ADDITIONAL FEATURES	• **ACCELERATED BENEFIT (If you become terminally Ill, you may be eligible to receive up to 75% of your combined Basic and Additional Life to a maximum of $500,000)** • **LIFE INSURANCE WAIVER OR PREMIUM – If you became totally disabled while insured under the plan, your life insurance premiums may be waived.** • **LIFE INSURANCE PORTABILITY – If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance.** • **LIFE INSURANCE CONVERSION – If your insurance reduces or ends, you may be eligible to convert your existing policy without submitting proof of good health.**
Medical Underwriting is required for:	• **New Enrollment except for new employees** • **Request for coverage increases** • **Reinstatements**

AGE AS OF SEPT 1	YOUR RATE PER $1000	YOUR SPOUSE'S RATE PER $1000
Under 30	.094	.094
30-34	.0120	.0120
35-39	.1340	.1340
40-44	.1640	.1640
45-49	.2440	.2440
50-54	.3540	.3540
55-59	.6440	.6440
60-64	.9740	.9740
65-69	1.853	1.853
70 and up	2.994	2.994

Calculate your per pay period rate by multiplying the amount of your additional life benefit times the rate associated with your age as of Sept 1, then divide by 2.

Example: The per pay period rate on a $150,000 policy on a 40 year old employee is calculated, 150*.1640/2 = $12.30

STANDARD—LONG-TERM DISABILITY

- **Plan pays 60% of you pre-disability monthly earnings**
- **Maximum Monthly Benefit is $5000**
- **Minimum Monthly Benefit is $100 or 10 percent of LTD benefit**
- **No changes to Rates - AFEnroll, benefit enrollment system will provide an estimate of your per pay period premiums for your review**
- **Medical underwriting applies to "Late Enrollment"**

CONCERN
Your Employee Assistance Program

Your Employee Assistance Program

Life situations can become very stressful, but we can help.

When we begin to experience personal problems, reaching out to family, friends, or others can be very supportive and satisfying. However, if additional help is needed, your employer has made available to you and your immediate family a professional counseling service that can help you resolve these problems. The program is called CONCERN and it is your employee assistance program.

The need for the program.

Your employer knows that employees have many stresses when facing changes in life. The way employees manage these stresses can have a significant impact on their work as well as their personal life. When employees are effectively managing personal issues, they are generally much more productive.

What does CONCERN cost?

The services of CONCERN are a company-paid resource. There is no cost to you or your dependents if services are used. If you and your counselor decide that additional services are required beyond short-term CONCERN counseling, and these referral services are used, you will be responsible for any costs not covered by insurance

CONCERN Counselors.

The professional staff are master's degreed counselors or clinical social workers. They are licensed and were required to have at least three years of clinical experience before joining CONCERN.

When can I use CONCERN?

Services are available when you need them. It is recommended that you use the program in early stages of problem development because it is easier to solve a problem in these early stages.

CONCERN counselors can help you through a crisis or they can help you to manage common problems that anyone can experience. Common problems include family or marital difficulties, relationship problems, grief, emotional or psychological stress, financial and legal worries, alcohol or drug abuse, gambling problems, or a combination of the above. Some problems are big, some are small. You can bring any size problem to CONCERN.

How does CONCERN work?

If you need to talk over a problem with a CONCERN counselor, simply call for an appointment. During your first visit or two, the counselor will listen and try to gain a clear understanding of your problem, help you sort out options, and develop a problem-resolution plan with you. Help can usually be found through continued short-term counseling at CONCERN. If additional or specialized help is needed, your counselor will put you in touch with a qualified professional or a support group best suited to help. Your counselor will remain available to you until you feel the difficulties are under control.

How confidential is the service?

Strict confidentiality is maintained by CONCERN. The employee or dependent calls to make his own appointment. No one will know of your participation unless you tell them or give your counselor permission to speak with someone. CONCERN complies with all state and federal laws regarding confidentiality.

To make an appointment call 901.458.4000 or 1.800.445.5011.

Convenient Tools and Resources

HealthSCOPE BENEFITS | Healthy People Healthy Business Healthy Futures

Visit your personalized member website, www.healthscopebenefits.com, to find the benefits information you need.

Once enrolled as a HealthSCOPE Health member, you will have access to valuable information, which enables you to access our online claims and Customer Care portal whenever you need it. Here, you can review your benefits, check the status of a claim, sign up to receive electronic Explanation of Benefits or request a replacement ID card, among other things. Each primary insured and adult dependent must set up their own account and can view only their own information. The primary insured can also view data for dependents under the age of 18. Adult dependents can call 800-458-1060 to grant viewing access to the primary insured member.

To access the HealthSCOPE Benefits website the first time:

* Go to www.healthscopebenefits.com and click "Member" at the top of the page.
* Under Company Name, type **MSSC**.
* Select the New Member Registration link.
* Enter the Primary Member's ID Number listed on your ID Card.
* Fill in your own First Name, Last Name, Date of Birth and Zip Code.
* Simply follow the system prompts to set up a web account.

To access the HealthSCOPE Benefits website after your account has been set up:

* Go to www.healthscopebenefits.com and click "Member" at the top of the page.
* Under Company Name, type MSSC
* Enter the Username and Password you created when registering.

Important Contact Information

Company	Telephone/ Website	Description
HealthSCOPE BENEFITS | Healthy People Healthy Business Healthy Futures HealthSCOPE www.healthscopebenefits.com	1-800-458-1060 (available June 1) 8 am and 5 pm Central Standard Time, Monday through Friday.	Medical benefits, In-network providers, claims, benefits
	Precertification 1-800-458-1060	To obtain approval for services that require precertification or prior authorization. These services include, but are not limited to inpatient admissions, and surgical procedures. For a complete listing of all services that require prior authorization or precertification, please review your Summary Plan Documents or call HealthSCOPE
US Imaging	1-877-904-0877	Schedule MRI,CAT, and PET Scan
MedBen	1-800-549-0097	For questions and more information about your prescription drug plan.
DELTA DENTAL	1.800.223.3104 http://www.deltadentaltn.com/	To lookup providers and benefits
DAVIS VISION EYECARE REFRAMED	1.800.999.5431 www.davisvision.com	Vision - benefits/providers
CONCERN EP Your Employee Assistance Program	1.800.445.5011 1.901.458.4000 http://www.baptistonline.org/services/employee-assistance/	Employee Assistance Program
AMERICAN FIDELITY a different opinion	1.800.465.2129 (FSA) 1.901.458.9252 www.americanfidelity.com	FSA Administration, Short-term Disability/Accident/Cancer
TheStandard	1.800.348.3226 www.standard.com/	Life & Long-Term disability
Care4Us in partnership with CareHere!	1.877.423.1330 http://carehere.com/	To schedule an appointment
Employee Benefits	1.901.202.0855, ext. 242 or 228 benefits@bartlettschools.org	Benefit Administration for Bartlett City Schools, Collierville Schools and Arlington Community Schools.

If you are an employee of Lakeland School System or Millington Municipal Schools, please contact your HR department if you have questions.

Health & Dependent Care FSA - American Fidelity

Are out-of-pocket medical expenses squeezing your budget?

Flexible Spending Account (Health)

A Health FSA can save you money by allowing you to set aside part of your pay, on a pre-tax basis, to reimburse yourself for eligible medical, dental and vision expenses such as co-payments, medical deductibles, prescriptions, and much more. Expenses incurred for you, your spouse, and other qualifying individuals are eligible for reimbursement. The maximum amount you may set aside is ***$2,600*** per plan year. *(This is an increase from last year's maximum.)*

Flex Debit Card

A flex debit card allows you to use Flexible Spending Account funds to pay for eligible medical, dental and vision expenses instead of paying out-of-pocket. It gives you direct access to your FSA funds and helps you avoid waiting on reimbursement checks!

What Else Should I Know?

- The card cannot be used until your plan year begins.
- The card is only for eligible medical, dental and vision expenses.
  Dependent daycare expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription; you will need to file a manual claim.
- Save your receipts!
- There is a fee for replacement cards.

Are you saving money with Dependent Day Care?

Dependent Day Care FSA

A Dependent Day Care FSA allows you to set aside pre-tax dollars to reimburse yourself for incurred eligible dependent care expenses. You may allocate up to $5,000 per plan year for reimbursement of dependent day care services ($2,500 if you are married and file a separate tax return).

For a complete list of eligible expenses for the Health FSA and Dependent Day Care FSA, talk to your American Fidelity representative when enrolling.

Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

Whether a weekend warrior with an active lifestyle or the stay at-home type, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.[1]

[1]*Premium and amount of Benefits may vary dependent upon Plan selected.*

Optional Accident Disability Income Rider

This rider covers you 24-hours a day and pays a Monthly Benefit Amount when a Covered Person becomes Totally Disabled due to Injuries received in a Covered Accident after the Elimination Period. The monthly benefit will be paid directly to you to use as you see fit.

Coverage Feature	What It Means For You
Plan Options: Enhanced and Enhanced Plus	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Wellness Benefit	After the policy has been in force for 30 days, you receive a benefit for an annual routine exam, including immunizations and preventive testing once per policy per
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to	Use the benefit however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
24-Hour Coverage	You are covered on or off the job.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your Premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class(AO-03Series).

Cancer Insurance

Limited Benefit Cancer Indemnity Insurance Policy

American Fidelity Assurance Company

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity's Cancer Insurance can help offer financial protection so you can focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the money directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

Coverage Feature	What It Means For You
Plan Options	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

Critical Illness Insurance

Limited Benefit Hospital Indemnity Insurance Policy

American Fidelity Assurance Company

Surviving a critical illness, such as a heart attack or stroke, can come at a high price. With advances in technology to treat these diseases, the cost of treatment rises more and more every year. Even with medical insurance, the out-of-pocket expenses associated with a critical illness can affect anyone's finances.

American Fidelity Assurance Company's Limited Benefit Critical Illness Insurance can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by standard medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a Recurrent Diagnosis Benefit that can provide an additional 50% of the Critical Illness benefit amount after the second occurrence date of the specified Critical Illness.

Guaranteed Renewable

You are guaranteed the right to renew your base policy until age 75 as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

Optional Benefit Riders

Enhance your base plan with these riders:

- Sudden Death Due to a Cardiac Arrest Benefit Rider
- Hospital Confinement Benefit Rider

Coverage Feature	What It Means For You
Plan Options	Choose from three lump sum benefit amounts: $15,000, $20,000 or $25,000.
Four Choices of Coverage: Individual, Individual & Spouse, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wellness Benefit	Receive a benefit for your annual screening test.
Benefit Paid Directly to You	Use the benefit however best fits your financial needs.
Multiple Critical Illness Benefits	You will be covered for 10 different critical illnesses.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

Short-Term Disability Income Insurance

American Fidelity Assurance Company

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity's Short-Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, Short-Term Disability Income Insurance will pay up to 60% of your monthly income once you have satisfied the elimination period. Disability benefits will be payable up to the benefit period stated in your policy.

Benefits Begin (Elimination Period)

For the Short-Term Disability Income plan, benefits can begin on the eighth day or 15th day, depending on the plan selected at the time of application. Benefits are payable for a covered Injury or Sickness up to 90 days or 180 days, based on the plan your employer has selected. Refer to your employer's plan and your Certificate for details regarding benefit amounts and more.

Eligibility

All full-time employees and employees of members on active service working 25 hours or more per week. Applicant's eligibility for this program may be subject to insurability. It is your responsibility to see the American Fidelity representative once you have satisfied your employer's waiting period.

Coverage Feature	What It Means To You
Maximum Benefit of 60% Of Your Monthly Gross Income	Protect up to 60% of your paycheck.
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Accidental Death Benefit	Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury.
Affordable Premiums	Your monthly premiums could be paid with only one hour of a week's paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.
Physician Benefit	Receive a benefit if you receive treatment by a Physician due to a covered Injury.
Accidental Death Benefit	Receive a benefit if death occurs as a direct result of an Injury within 90 days after the Injury.
Guaranteed Issue	First-time eligible employees may Be able to receive coverage without being subject to insurability.
Age at Entry Premiums	Premiums will be based on the date your policy becomes effective.

VALIC®

Retirement Plan Highlights

SAVING : INVESTING : PLANNING

Municipal School Districts of Shelby County

403(b) and 457(b) Retirement Plan

Portfolio Director® Fixed and Variable Annuity

Issued by The Variable Annuity Life Insurance Company

Your employer offers both a 403(b) retirement plan and a 457(b) deferred compensation plan, providing you with an exceptional opportunity to help accumulate money for a secure retirement. You may contribute pretax dollars to one or both plans automatically by convenient payroll reduction, which might lower current income taxes. You may also make after-tax contributions to a Roth account in the 403(b) plan, the 457(b) plan, or both by convenient payroll deduction. Your accounts benefit from the opportunity for tax-advantaged growth.

This is not your plan document. The administration of each plan is governed by the actual plan document. If discrepancies arise between this summary and the plan document, the plan document will govern.

Eligibility
403(b) and 457(b)
You are immediately eligible to begin contributing to either or both plans.

Personal service
For assistance, please call our Contact Center at 1-800-448-2542 or one of our local advisors .

David Stratton	Michael Seebeck	Lee Lakey
1.800.892.5558, Ext. 87655	1.800.892.5558, Ext. 87655	1.800.892.5558, Ext. 89368
Cell: 662.812.7698	Cell: 901.825.8958	Cell: 843.338.8448
David.stratton@valic.com	Michael.seebeck@valic.com	lee.lakey@valic.com

Fee disclosure information
Obtain specific fee disclosure and fund performance information by visiting VALIC.com and clicking on “Fee Disclosure-Fund Performance” in the blue box at the bottom of the screen.

403(b) plan	457(b) plan
Your contributions (subject to plan terms)	
As much as 100% of your annual includible compensation up to $18,000 in 2017. You may increase or decrease the amount you contribute to the plan as often as your employer allows.	As much as 100% of your annual includible compensation up to $18,000 in 2017. You may increase or decrease the amount you contribute to the plan as often as your employer allows.

403(b) plan	457(b) plan
Catch-up contributions	
You might be eligible to contribute up to an additional ● $3,000 if you have 15 or more years of service with a qualifying employer and have undercontributed in prior years, and/or ● $6,000 in 2017 if you are age 50 or older. ● If eligible for both catch-up contributions above, you must exhaust the 15-year catch-up first.	You might be eligible to contribute up to an additional ● $18,000 in 2017 if you are within the last three tax years ending the year before the year you attain normal retirement age as specified under the plan and have undercontributed in prior years ●$6,000 in 2017 if you are age 50 or older.
Withdrawal restrictions Subject to provisions of your employer's retirement plan. Your plans were established to encourage long-term savings. ● A 403(b) plan has less stringent withdrawal restrictions while you are employed; however, a 10% federal early withdrawal penalty may apply to withdrawals prior to age 59½. The 10% federal early withdrawal penalty may also apply to amounts rolled into the 457(b) plan from non-457(b) plans. ● A 457(b) plan has more stringent withdrawal restrictions while you are employed, but less stringent rules after severance from employment and distributions are not subject to a 10% federal early withdrawal penalty except on amounts rolled over from other non-457(b) eligible retirement plans.	
403(b) distribution events	**457(b) distribution events**
Generally, depending on your employer's plan provisions, you may withdraw your elective deferrals if you meet one of the following requirements: ● Attaining age 59½ ● Retirement or severance from employment* ● Your death or total disability ● Hardship withdrawals Minimum distribution required at attaining age 70½ or upon retirement, whichever is later. Bear in mind that income taxes are payable upon withdrawal. * Distributions where the employee retires or severs from employment on or after age 55 are not subject to the 10% federal early withdrawal penalty. Other exceptions may also apply.	Generally, you can withdraw the value of your vested account balance in the following circumstances: ● Attaining age 70½ (if your plan allows in-service distributions) ● Retirement or severance from employment ● Your death ● Unforeseeable emergencies Minimum distribution required at attaining age 70½ or upon retirement, whichever is later. Bear in mind that income taxes are payable upon withdrawal.

Pretax or Roth contributions

You have a choice regarding your elective contributions to your workplace retirement plan. You can direct all of your contributions to a traditional pretax account, to a Roth account or to a combination of the two.

Contributions to a Roth account are after-tax. Regardless of your election, you are subject to the annual contribution limits detailed previously.

The State of Tennessee 401(k) Deferred Compensation Program is a powerful tool to help you reach your retirement dreams. It complements other retirement benefits or savings that you may have, and allows you to save and invest extra money for retirement.

You may choose to defer taxes immediately or pay the taxes now and watch potential earnings grow tax-free. You may build extra savings consistently and automatically, select from a variety of investment options, and learn more about saving and investing for your financial future.

Read these highlights to learn more about your Program and how simple it is to enroll. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

Getting Started

Why should I participate in the Program?

By participating in your traditional 401(k), you can save and invest additional money for retirement and/or reduce the amount of current state and federal income tax you pay each year. Your State of Tennessee 401(k) Plan can be an excellent tool to help make your future more secure.

You may also qualify for a federal income tax credit by participating in this Plan. For more information about this tax credit, please contact your Retire*Ready*TN representative.[1]

The Program also offers a Roth contribution option, which allows you to contribute on an after-tax basis. This may be an attractive feature if you expect to be in a higher tax bracket during your retirement. The "qualified" distributions of Roth contributions and earnings from the 401(k) account are generally tax-free if they satisfy the five-year minimum deposit restriction. Please refer to the Distributions and Taxes sections for additional information.

What is a 401(k) plan?

- A voluntary retirement savings plan
- Allows eligible employees to complement any existing retirement and pension benefits
- You can save and invest before-tax dollars
- Contributions and any earnings on contributions are tax-deferred until money is withdrawn

What is a Roth 401(k) Contribution?

- Allows eligible employees to complement any existing retirement and pension benefits
- You can save and invest after-tax dollars
- Distributions and any potential earnings are tax-free upon reaching the age of 59½ (if taken after the required five-year holding period)
- You can designate all or a portion of your 401(k) elective deferrals as Roth contributions

Who is eligible to enroll?

All current employees of the following are eligible to participate in the 401(k) plan:

- State of Tennessee
- All Tennessee Public Colleges and Universities
- Local Education Agencies (including K-12 Public Schools)
- Local Government Employees
  Employees are eligible to enroll if the plan is adopted by your governing body.

Check with your HR/Benefits Specialist to determine the availability of plan options and your eligibility to participate.

How do I enroll?

If you are eligible to participate in the Program, you can enroll on a voluntary basis by:

1. Enrolling online at **www.RetireReadyTN.gov**. Click on *Let's Get Started!* You will need your Social Security number and either a personal identification number (PIN) or personal identifying information to enroll.[2]

2. Calling Retire*Ready*TN at **(800) 922-7772**; representatives are available between the hours of 8 a.m. - 7 p.m. Central time.

3. Completing a paper enrollment form. Enrollment forms are available through your Retire*Ready*TN Representative, or you can download the forms online at **www.RetireReadyTN.gov**. Once completed, mail the form to the appropriate address on the form.

If you wish to make changes, you may do so by logging on to the website or by calling Retire*Ready*TN or the TDD line at **(800) 766-4952**.[3]

Important Notice: Local government employees should note that plan availability may vary by employer. Check with your HR/Benefits Specialist to determine the availability of plan options and your eligibility to participate.

Is there an employer match?

State of Tennessee and Employees of Tennessee Public Colleges and Universities

Your employer may match your 401(k) contributions up to an annually appropriated limit.

Check with your HR/Benefits Specialist or campus resource office for current information on employer contributions.

Local Education Agency Employees and Local Government Employees

For K-12 Public School teachers, the employer match does not apply. For local government employees, check with your HR/Benefits Specialist to determine the availability of a plan match.

What are the contribution limits?

In 2017, the maximum contribution amount is 100% of your includible compensation, less any mandatory before-tax contributions to a governmental pension plan, or $18,000, whichever is less. It may be indexed for inflation in $500 increments after 2017.

If you turn age 50 or older in 2017, you may contribute an additional $6,000.

Can I make Roth 401(k) contributions?

The Roth 401(k) option will give you the flexibility to designate all or part of your 401(k) elective deferrals as Roth 401(k) contributions.

In 2017, the maximum limit for 401(k) elective deferrals, for both traditional pre-tax and Roth 401(k) contributions combined, is 100% of your compensation or $18,000, whichever is less.

The maximum contribution amount may then be indexed for inflation in $500 increments in subsequent years.

Roth contributions are made with after-tax dollars, as opposed to the pre-tax dollars you contribute traditionally to a 401(k). In other words, with the Roth option, you've already paid taxes on the money you contribute.

Can employees contribute to multiple plans?

Yes; however, if an employee contributes to another plan, such as a 403(b) plan, the combined total of all contributions cannot exceed the maximum limit of $18,000 in 2017, or $24,000 if age 50 or older. Governmental 457(b) plans have separate deferral limits, so employees who contribute to a 457(b) plan may be able to contribute an additional $18,000 to that plan in 2017 (plus any applicable catch-up contributions). For more information about contribution limits for multiple plans, visit **www.irs.gov**.

Managing your accounts

How do I keep track of my accounts?

You will receive a quarterly account statement from Empower Retirement showing your account balances and activity. Or, you may choose to receive your statements online. Sign up to *Go Paperless* to receive statements electronically and access past online statements for free. You will be notified by email when statements are issued if you have elected electronic statements. Please read the special messages when your statement arrives.

You can also check your account balances and move money among investment options by accessing your account on the website or by calling Retire*Ready*TN.

How do I make investment option changes?

Use your username and PIN to access the Retire*Ready*TN website. You can also use your Social Security number and PIN to contact Retire*Ready*TN. You can move all or a portion of your existing balances among investment options (subject to Program rules) and change how your payroll contributions are invested.[3]

How do I make contribution changes?

Once enrolled in the Program, access your account on the website and click *Change Paycheck Contributions*.

You may also contact Retire*Ready*TN at **(800) 922-7772**.

Rollovers

May I roll over my account from my former employer's plan?

Yes, but only approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the 401(k) plan.

Distributions from these plans may be subject to a 10% early withdrawal federal tax penalty. Please check with your Retire*Ready*TN representative regarding any applicable fees on the rollover account.

You are encouraged to discuss rolling money from one account to another with your financial advisor/planner, considering any potential fees and/or limitation of investment options.

What are my account options if I leave my current employment?

You can leave your entire account balance in your State of Tennessee 401(k) Program account. If you sever employment with your current employer, you may also roll over your account balances to another eligible governmental 457(b), 401(k), 403(b) or 401(a) plan, if your new employer's plan accepts such rollovers, or to an IRA.

Always compare fees, commissions, trading expenses, and other transaction costs before making a decision.

Please contact your Retire*Ready*TN representative or your tax advisor for more information.[1]

You are encouraged to discuss rolling money from one account to another with your financial advisor/planner, considering any potential fees and/or limitation of investment options.

Vesting

When am I vested in the 401(k) plan?

Vesting refers to the percentage of your account you are entitled to receive from the Program upon the occurrence of a distributable event.

For the following agencies:

- State of Tennessee
- All Tennessee Public Colleges and Universities
- Local Education Agency Employees

Your contributions to the Program, the employer match, and any earnings they generate are always 100% vested (including rollovers from previous employers).

For local government employees

The vesting schedule on any matching contributions is determined by your employer. Please contact your HR/Benefits Specialist.

Distributions

When can I receive a distribution from my accounts?

Pre-Tax Contributions

401(k) qualifying distribution events are as follows:

- Retirement
- Disability retirement (allowed but is defined by the Social Security Administration or TCRS)
- Financial hardship (401(k) plan only, as defined by the Internal Revenue Code)
- Attainment of age 59½ (for participant contributions only)
- In-service distribution at retirement age of 60 (all money types allowed)
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Death (upon which your beneficiary receives your benefits)
- Purchase of service credit

Each distribution of pre-tax contributions is subject to ordinary income tax. Distributions taken before age 59½ from the 401(k) plan may also be subject to a 10% early withdrawal federal tax penalty.

Roth 401(k) Contributions

If you withdraw your Roth 401(k) contributions and earnings after you've reached age 59½ or severed employment due to death or disability and have held the account for at least five years, the distribution is income tax-free and penalty-free.

If you take a distribution of your Roth 401(k) contributions before age 59½, death, disability retirement, or the five-year period beginning with your first Roth 401(k) contribution, you will pay income taxes plus a 10% penalty tax on any earnings that are distributed. There is no income or penalty tax due on qualified distributions of Roth 401(k) contributions because contributions are made with after-tax dollars.

What are my distribution options?

1. Leave the value of your accounts in the Program until a future date.
2. Receive:
    - Periodic payments,
    - Partial lump sum with remainder paid as periodic payments,
    - A lump sum.
3. Roll over your account balances to an eligible governmental 457(b), 401(k), 403(b), or 401(a) plan or an IRA.

What happens to my account when I die?

Your designated beneficiary(ies) will receive the remaining value of your accounts, if any. Your beneficiary(ies) must contact a Retire*Ready*TN representative to request a Death Benefit Claim Form.

Expenses

What are the administrative costs for participating in the 401(k) plans?

The annual administration fee is 0.23% (23 bps) with a minimum fee of $12 per year (deducted quarterly).

For example, if you have a $10,000 account balance, your total annual fee would be $23. This would be assessed quarterly at $5.75 per quarter.

Account Balance	Annual Fee	Quarterly Fee
$10,000	$23	$5.75
$20,000	$46	$11.50

Some investment options give voluntary and/or contractual fee reimbursements. These reimbursements are given at the end of each quarter or month, depending on the fund.

Reimbursements may offset the plan administrative fees, depending on the investment options in which you are invested.

Each investment option has an investment management fee that varies by investment option.

These fees are deducted by each investment option's management company before the daily price or performance is calculated. Fees pay for trading individual securities in the underlying investment options and other management expenses.

Funds may impose redemption fees on certain transfers, redemptions or exchanges resulting from presumed market timing. Asset allocation and balanced investment options and models are subject to the risks of the underlying funds, which can be a mix of stocks/stock funds and bonds/bond funds. For more information, see the prospectus and/or disclosure documents. Funds are subject to the risks of the underlying funds.

To participate in the Self-Directed Brokerage Account (SDBA) option, there is a $50 annual administrative fee, charged at $12.50 quarterly, and a 0.23% recordkeeping fee, charged at 0.0575% quarterly. In order to start an SDBA, you must have a balance of $20,000 in core investments, with a minimum initial deposit of $5,000. There must be $15,000 remaining in core investments. Additional SDBA deposits must be a minimum of $1,000.

Loans

May I take a loan from my account?

The 401(k) plan allows you to borrow the lesser of $50,000 or 50% of your total account balance (employee contributions only). Employer dollars are not eligible for loans. The minimum loan amount is $2,000, and you have up to five years to repay your loan—up to 15 years if the money is used to purchase your primary residence. There is also a $50 origination fee for each loan, which is deducted from the loan proceeds, plus a quarterly fee of $6.25.

Loan payments are made through payroll as after-tax deductions.

For more information about loans, please contact your Retire*Ready*TN representative.[1]

Taxes

How does my participation in the Program affect my taxes?

Pre-Tax 401(k) Contributions

Your contributions are taken out of your paycheck before taxes are calculated, so you pay less in current income tax. Distributions from the plans are taxable as ordinary income during the years in which they are distributed. Any withdrawals taken before age 59½ from the plan may also be subject to a 10% early withdrawal federal tax penalty.

Roth 401(k) Contributions

Roth contributions are made with after-tax money. Distributions of earnings and contributions are not taxable if you have reached age 59½ or severed employment due to death or disability retirement and have held the account for at least five years. Income taxes and a 10% early withdrawal federal tax penalty may apply to any earnings distributed before age 59½, death, disability retirement, or the five-year period beginning with your first Roth contribution.

Investment Assistance

Can I get help with my investment decisions?

Employees of Empower Retirement and the State of Tennessee cannot give investment advice. There are financial calculators and tools on the website that can help you determine which investment options might be best for you if you would like to manage your Program accounts yourself.

Your Program offers access to three different levels of investment advisory tools and services called Empower Retirement Advisory Services. With the Managed Account service, you can have Advised Assets Group, LLC (AAG), a registered investment adviser, manage your retirement account for you. Or if you prefer to manage your retirement account on your own, you can use the Online Investment Guidance tool or the Online Investment Advice service. Advisory Services provide a personalized retirement strategy for you based on your investment goals, time horizon and tolerance for risk. There is no guarantee that participation in any of the advisory services will result in a profit or that the account will outperform a self-managed portfolio invested without assistance.

For more detailed information, log in to your Program account by visiting **www.RetireReadyTN.gov** and clicking on the *Advisory Services* tile. Or you may call **(800) 888-4952**, **ext. 41066**, to speak to an AAG investment adviser representative.

What expenses do I pay to participate in Empower Retirement Advisory Services?

Online Investment Guidance and Online Investment Advice are available at no additional cost to you. If you choose to have AAG manage your account for you, the annual Managed Account service fee will be assessed in quarterly installments based on your account balance, as follows:

Participant Account Balance	Managed Account Service Quarterly Fee
Less than $100,000	0.1125%
Next $150,000	0.0875%
Next $150,000	0.0625%
Greater than $400,000	0.0375%

For example, if your account balance is $50,000, the maximum quarterly fee will be 0.1125% of the account balance. If your account balance is $500,000, the first $100,000 will be subject to a maximum quarterly fee of 0.1125%; the next $150,000 will be subject to a maximum quarterly fee of 0.0875%; the next $150,000 will be subject to a maximum quarterly fee of 0.0625%; and any amounts more than $400,000 will be subject to a maximum quarterly fee of 0.0375%.

How do I get more information?

Visit the website at **www.RetireReadyTN.gov** or call Retire*Ready*TN, toll-free, at **(800) 922-7772** or the TDD line at **(800) 766-4952** for more information. The website provides information regarding your Program and financial education, as well as financial calculators and other tools to help you manage your accounts.

Local Retire*Ready*TN representatives are available to meet with you one-on-one or in a group setting.

To schedule an appointment:

- Call your local Retire*Ready*TN representative[1] (visit **www.RetireReadyTN.gov** and click on *Contact Us* to find your representative)
- Contact Retire*Ready*TN at **(800) 922-7772; representatives are available** between the hours of 8 a.m. — 7 p.m. Central time

About Empower Retirement

Empower Retirement specializes in servicing government deferred compensation retirement plans. Headquartered in Greenwood Village, Colorado, Empower helps more than 8 million people work towards replacing — for life — the income they made while working.

After a comprehensive selection process, Empower Retirement was chosen by Retire*Ready*TN to provide administrative, education and communication services. In conjunction with Retire*Ready*TN, Empower is committed to helping you understand and evaluate your financial situation by providing you with the information you need to help you make financial decisions to and through retirement.

Call or visit your local Retire*Ready*TN office at:
545 Mainstream Drive, Suite 407
Nashville, TN 37228
(800) 922-7772
TDD line: (800) 766-4952

1 Representatives of Empower Retirement do not offer or provide investment, fiduciary, financial, legal or tax advice or act in a fiduciary capacity for any clients unless explicitly described in writing. Please consult with your investment advisor, attorney and/or tax advisor as needed.

2 The account owner is responsible for keeping their PIN/passcode confidential. Please contact Client Services immediately if you suspect any unauthorized use.

3 Transfer requests received on business days prior to close of the New York Stock Exchange (4 p.m. Eastern time or earlier on some holidays or in other special circumstances) will be initiated at the close of business the same day the request was received. The actual effective date of your transaction may vary depending on the investment option selected.

Core securities, when offered, are offered through GWFS Equities, Inc. and/or other broker-dealers.

GWFS Equities, Inc., Member FINRA/SIPC, is a wholly owned subsidiary of Great-West Life & Annuity Insurance Company.

Empower Retirement Advisory Services are offered by Advised Assets Group, LLC (AAG), a registered investment adviser and wholly owned subsidiary of Great-West Life & Annuity Insurance Company.

Empower Retirement refers to the products and services offered in the retirement markets by Great-West Life & Annuity Insurance Company (GWL&A), Corporate Headquarters: Greenwood Village, CO; Great-West Life & Annuity Insurance Company of New York, Home Office: NY, NY; and their subsidiaries and affiliates. The trademarks, logos, service marks and design elements used are owned by their respective owners and are used by permission.

Spousal Healthcare Eligibility Affidavit

Employee Name _____ Employee ID _____

Spouse Name _____ Last four of SSN (Spouse) _____

School District _____

Section A: Must complete to enroll your spouse in Group Health Plan Coverage.

Your Spouse is:

#1 ☐ Not employed or is Retired

#2 ☐ An employee of one of the Municipal School Districts or Cities listed below: (Please check one)

Arlington Community Schools ☐ Bartlett City Schools ☐

Collierville Schools ☐ Lakeland School System ☐

Millington Municipal Schools ☐ City of Bartlett ☐

Town of Collierville ☐ City of Lakeland ☐

#3 ☐ *Employed or Self-Employed ***WITHOUT*** access to coverage from his/her employer **(MUST COMPLETE SECTION B)**

#4 ☐ *Employed ***WITH*** access to coverage from his/her employer but employer pays less than 50% of the cost **(MUST COMPLETE SECTION B)**

NOTE: ***If none of the above applies then he or she is not eligible for the Group Health Plan. (He or she is eligible for other benefits such as dental, vision, life.)***

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit my employer to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Group Health Plan coverage.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Section B: Must be completed by spouse's employer or spouse if self-employed

Is the person named above as Spouse *eligible* for coverage with your company?

YES _____ NO _____

If yes, does the employee's share, **exceed 50%** of the total cost of premiums for your cheapest individual coverage?

YES ____ NO ____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

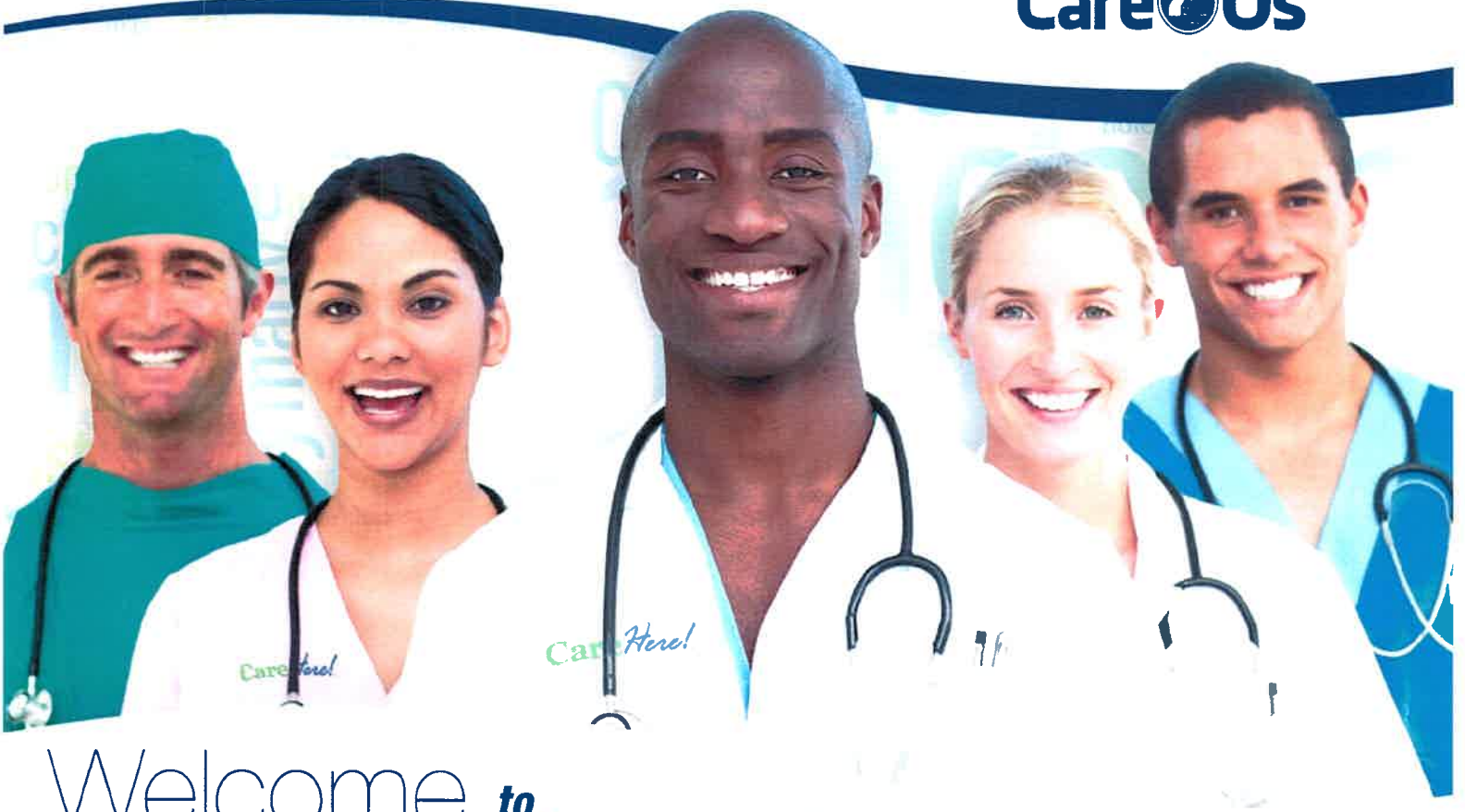
Authorized Employer Name: _____ Title: _____

Authorized Employer Signature _____ Date: _____

Please return completed document to the Employee Benefits office

Email: benefits@bartlettschools.org, Fax: (901)202-0854

CareUs



Welcome to CareHere!

Providing Care. Innovating Services. Changing Lives.

CareHere is a passionate on-site and near-site healthcare organization that is experienced in partnering with employers to provide cost-effective healthcare and online services for their employees.

CareHere has partnered with your employer to provide you and your family with a health center to treat both acute and chronic conditions such as the common cold and the flu, high blood pressure, and diabetes. We also provide annual physicals, health coaching, lab work, and much more.

CareHere is **more than just a clinic.** We are **providing care** and **innovating services** that are helping to **change lives.**

What are the benefits?

- ***No-cost medical care. No deductibles. No copays.***
- ***On-site dispensary with select generic medications. Leave with your medications in hand.*** *(No narcotics will be dispensed, but may be prescribed.)*
- ***National average wait time for an appointment is less than 2 minutes.***
- ***Schedule appointments online, from your smartphone or tablet, or with a representative by calling 24/7.***

Where do I start?

Use the steps on the back of this handout to register and schedule your first appointment. We encourage you to schedule your first appointment to get to know us, even if you aren't sick.

Connect with us, and learn more about CareHere!

www.CareHere.com •

CareHere abides by all federal HIPAA and confidentiality regulations.

Would you like to use one of the Care4Us facilities? Here's how...

Care4Us | CareHere!

1 Register with CareHere.

Each family member enrolled in the HealthSCOPE health plan must be registered separately. There are two ways a patient can complete registration with CareHere. Patients can call 877.423.1330 or follow the steps below at **www.CareHere.com** to register.

1. Click **Member Login**
2. Click **I need to register for the first time with my Access Code**
3. Enter your **Access Code: Listed to the Right**
4. Click **Go**
5. Provide responses to the next 4 web pages: Click **Update** then **Next** after entering responses on each page.

2 Schedule an appointment.

If you are already registered, you can schedule an appointment by calling 877.423.1330 or by following steps below at www.CareHere.com with your computer, smartphone, or tablet.

1. Click **Member Login**
2. Enter your **Username** and **Password** and click **Go**
3. Click **Appointments-SS**
4. Enter **When** you would like to make your appointment
5. Select **What** type of appointment you require
6. Select **Where** you would like to be seen
7. Select **Who** you would like to see
8. Select **Get Appointment**
9. Select an available appointment and then click **Make Appointment**
10. Enter any symptoms
11. Click **Confirm Your Appointment**

Registration Access Codes

City of Bartlett Insured	**MSSC2**
Town of Collierville Insured	**MSSCE3**
Arlington Community Schools Insured	**MSSCA2**
Bartlett City Schools Insured	**BCSM2**
City of Lakeland Insured	**CMCA2**
Collierville Schools Insured	**CSNM2**
Lakeland School System Insured	**AKMC2**
Millington Municipal Schools Insured	**MUNC2**

Hours of Operation

Care4Us in the Town of Collierville

Mondays	7 AM to 5 PM	**Dr. Karima Causey**
Tuesdays	8 AM to 6 PM	**Leigh Ann Presley, NP**
Wednesdays	7 AM to 5 PM	**Dr. Karima Causey**
Thursdays	8 AM to 6 PM	**Leigh Ann Presley, NP**
Fridays	7 AM to 11 AM	**Dr. Karima Causey**

Care4Us in the City of Bartlett

Mondays	8 AM to 6 PM	**Leigh Ann Presley, NP**
Tuesdays	7 AM to 5 PM	**Dr. Karima Causey**
Wednesdays	8 AM to 6 PM	**Leigh Ann Presley, NP**
Thursdays	7 AM to 5 PM	**Dr. Karima Causey**
Fridays	8AM to 12 PM	**Leigh Ann Presley, NP**

Where are the Care4Us facilities located?

Care4Us in the Town of Collierville

777 W. Poplar Avenue, Suite 104
Collierville, TN 38017

Care4Us in the City of Bartlett

7665 U.S. Highway 70, Suite 101
Bartlett, TN 38133

Connect with us, and learn more about CareHere!
www.CareHere.com • 877.423.1330 •

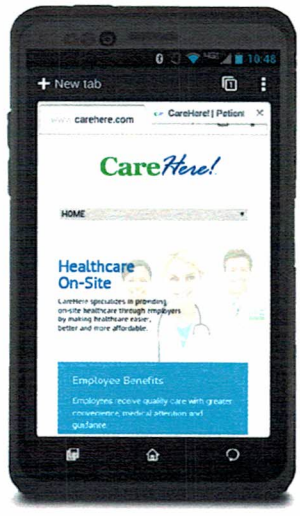
Care4Us | CareHere!

Things to Remember
When Scheduling an Appointment

1. Before scheduling an appointment, each patient will need to register and create an account with CareHere. Dependents will need to be registered separately.
2. Appointments must be scheduled. Walk-in patients are not accepted in the health center.
3. Schedule 2 back-to-back 20 minute appointments for first-time visits, annual physicals, and men and women health exams.
4. Schedule a separate appointment to have your medications refilled. (If you have more than 3 medications to be refilled, it will require 2 back-to-back appointments.)
5. Cancel your appointment, if you can't make it. This helps ensure the minimal wait times with CareHere.
6. Please, don't be late. If you are more than 10 minutes late, you may be rescheduled.

DID YOU KNOW?

You can use our mobile site to schedule appointments with your smartphone and tablet at CareHere.com



CareHere abides by all federal HIPAA and confidentiality regulations. | Call 877.423.1330 or go online at www.CareHere.com

Care4Us | CareHere!

Meet the people proudly serving you.

Care4Us in the Town of Collierville Staff

777 W. Poplar Ave. Suite 104 • Collierville, TN 38017

Karima Causey, MD

Certified by the American Board of Family Medicine, Dr. Karima Causey is a family physician who enjoys serving patients in the Memphis Metropolitan area.

Dr. Karima Causey graduated Magna Cum Laude from Christian Brothers University in Memphis, Tennessee with a Bachelor of Science Degree in Biology.

Dr. Causey completed medical school at the East Tennessee State University Quillen College of Medicine and attended residency at the University of Tennessee, Memphis (UT Saint Francis Family Medicine Program). While in this program, she received awards and honors including the Gregory C. Mitchell, M.D. Award for Outstanding Performance by a First Year Resident and served as Chief Resident her senior year of residency.

Dr. Karima Causey is a member of the Tennessee Medical Association, Tennessee Academy of Family Physicians, and American Academy of Family Physicians.

In her spare time, she enjoys cooking and volunteering with her church where she serves on the medical ministry team.

Leighann Presley, FNP-C

Leighann Presley is a Nurse Practitioner from Tupelo, Mississippi with 13 years of experience as an registered nurse, the last three of which have been as a family Nurse Practitioner.

Leighann has a lifelong passion for medicine. She prides herself in providing high quality care to her patients. She graduated first in her 2003 nursing class from Itawamba Community College with her Associates Degree in Nursing. In 2008, she graduated from Chamberlain College of Nursing with her Bachelors of Science Degree in Nursing. In 2012, she graduated from Mississippi University for Women with her Masters of Science Degree in Nursing as a part of the University's Family Nurse Practitioner Program.

She is a member of Mississippi Nurses Association and Southern Pain Society. Leighann is experienced in managing disease states such as hypertension, COPD, diabetes, along with numerous others. She is skilled in providing care to patients throughout the lifespan including pediatric, adult, and geriatric patients. She is excited to be in the Memphis area and very eager to begin utilizing her skills to provide care for the patients of Care4Us.

CareHere! CONNECT APP

Did you know that you can keep up with your CareHere Connect plan with your Smartphone or Tablet?

The CareHere Connect App is there when you need it. Throughout your day and on-the-go, you can track your health, follow your plans, do your assigned tasks, and earn **Healthies**™ - all within a secured, online connection to your personal health data.

You can download this free app from your smartphone or tablet's app store, such as the App Store or Google Play. Look for the app named **CAREHERE.**

After you have installed the app, click on the app on your smartphone or tablet. Once you are in the app, you will be asked for a **username** and **password**.
The username and password you will use to log into the app is the same username and password you created to log into your personal CareHere account on CareHere.com. This username and password would have been created when you registered with CareHere online.

Please note: You must activate your account on a personal computer before you can utilize the app on your phone or tablet.

Download the CareHere Connect App today!

Available on the Android Market

Available on the App Store

Please NOTE: You **must activate your account** on a personal computer before you can utilize the app on your phone.

Health Coaching at No Cost to You!

Health Coaches are available through your local CareHere Health and Wellness Center!

After completing a health risk assessment at your local Health Center, a Health Coach will automatically be assigned to you.

Your personal health coach will be available as needed to answer questions and/or offer individualized help with your personal health goals!

Our CareHere Wellness Team

Registered Nurse • Need help with regulating your blood pressure, help controlling asthma, need more information on a medication or any health care need?

Registered Dietitian • Need help with diabetes, losing weight, decreasing cholesterol, managing a food allergy or any nutritional concern?

Tobacco Cessation Coach • Need help with quitting smoking? A CareHere health coach will take you through the process of quitting and support you for an entire year!!

Exercise Coach • Need help with exercise, how to exercise with certain diseases or conditions, getting started on an exercise plan or tweaking your current routine to achieve greater results?

Behavioral Health Coach • Need help with stress, balancing your life, emotional eating or need help getting connected with your employee assistance program?

Check out the "My Coaches" tab on the CareHere Connect site to learn more about the health coaches assigned to YOU!

If you would like to talk with one of our health coaches, you may e-mail wellness@carehere.com or call 877-866-6430.

CareHere!

Wellness Health Management Nutrition behavioral health

LEGAL NOTICES

Arlington Community Schools, Bartlett City Schools, Collierville Schools, Lakeland School System and Millington Municipal School System (MSSC) EMPLOYEE BENEFIT PLAN Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice will become effective on _04/05/2017_____.

At*, MSSC* we respect your privacy and will protect your health information responsibly and professionally. This notice describes the privacy practices of the Medical, Dental, Vision and prescription drug programs (the "Health Plan") included in the MSSC Employee Benefit Plan. This notice does not apply to disability benefits, life insurance, or any non-health plans or benefits.

As you read this notice, you'll see the term "Protected Health Information" or PHI. Protected health information is health information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care) that is created or obtained by the Health Plan in connection with your eligibility for or receipt of benefits under the Health Plan.

Federal law requires that the Health Plan maintain the privacy of protected health information, give you this notice of the Health Plan's legal duties and privacy practices, and follow the terms of this notice as currently in effect. These protections will remain in effect with regards to your protected health information held by the Health Plan during your lifetime, and for at least 50 years following your death.

MSSC contracts with claims administrators and other third parties to provide Health Plan services. For purposes of this notice, the "Health Plan" includes third parties when performing services for the Health Plan, including persons or entities creating, receiving, maintaining or transmitting your protected health information in connection with your health coverage (referred to in this notice as "business associates"). Protected health information may be shared among the components of the Health Plan and the third parties providing services for the components of the Health Plan in the course of payment, Health Plan operations, and treatment. The current claims administrators are listed under Contact Information, below. When their services involve the use of protected health information, the third parties and their subcontractors will be required to perform their duties in a manner consistent with this notice.

How the Health Plan Uses and Shares PHI for Payment, Health Plan Operations, and Treatment

Below are some examples of ways that the Health Plan may use or share information about you for treatment, payment, and Health Plan operations. For each category, a number of uses or disclosures will be listed, along with an example. However, not every use or disclosure in a category will be listed. The Health Plan may use or share your protected health information for:

- **Payment:** The Health Plan will use and disclose your protected health information to determine and pay for covered services. Payment activities include determining eligibility; conducting pre- certification, utilization, case management, and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints, and appeals. For example, the Health Plan may use your medical history and other health information to decide whether a particular treatment is medically necessary and what the payment should be. During that process, the Health Plan may disclose information to your provider. Any request for information or use of such information involving psychotherapy notes will only be done with your written authorization. The Health Plan will mail Explanation of Benefits forms and other information to the employee at the address it has on record for the employee.

- **Health Plan Operations:** The Health Plan will use and disclose your protected health information for Health Plan operations. Operational activities include quality assessment and improvement; performance

measurement and outcomes assessment; health services research; and preventive health, disease management, case management, and care coordination. For example, the Health Plan may use protected health information to provide disease management programs for participants with specific conditions, such as diabetes, asthma, or heart failure. Other operational activities requiring use and disclosure of protected health information include administration of stop loss coverage, including underwriting of such coverage; legal, actuarial, and audit services; business planning and cost management; detection and investigation of fraud; administration of pharmaceutical programs and payments; and other general administrative activities, including data and information systems management and customer service. We will not use or disclose any genetic information involving you for underwriting purposes.

- **Treatment:** The Health Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Health Plan may disclose protected health information to doctors, dentists, pharmacies, hospitals, and other health care providers who take care of you. For example, doctors may request medical information from the Health Plan to supplement their own records. The Health Plan may also send certain information to doctors for patient safety or other treatment-related reasons.

The Health Plan may also disclose protected health information to providers or other health plans for the payment, treatment, and certain operational activities of the provider or other health plan.

How the Health Plan Uses and Shares PHI for Communications about Benefits

The Health Plan may use or disclose protected health information to send you treatment reminders for services such as mammograms or prostate cancer screenings. Also, the Health Plan may use or disclose your protected health information to give you information about alternative medical treatments and programs or health-related products and services that may be of interest to you. For example, the Health Plan might send you information about smoking cessation or weight-loss programs. Disclosures involving the sale of your health information to another entity for marketing purposes, or for any purpose not disclosed in this notice, will only be done with your written authorization.

Disclosures that the Health Plan May Make to Others Involved in Your Health Care

The Health Plan may disclose protected health information to a family member, a friend, or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls the Health Plan with prior knowledge of a claim, the Health Plan may confirm whether or not the claim has been received and paid. You may instruct the claims administrator to stop or limit this kind of disclosure. We will continue to permit such disclosure to these individuals following your death, unless doing so is inconsistent with any prior expressed preference made by you that is known to us.

Disclosures You May Authorize the Health Plan to Make

The Health Plan will not use or disclose your protected health information for any reason other than those listed in this notice unless you provide a written authorization. You may give the Health Plan written authorization to use and/or disclose your protected health information to anyone for any purpose. If you give the Health Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure made pursuant to your authorization while it was in effect.

Disclosures that the Health Plan May Make to *MSSC*

To determine if and when you and your family members are covered by the Health Plan, the Health Plan will share enrollment information about you and your family members with ***MSSC***.

The Health Plan will periodically disclose protected health information to ***MSSC*** Human Resources Representatives so that the Human Resources Representatives can assist participants with benefits questions and oversee the administration of the Health Plan. Also, the Health Plan will periodically disclose protected health information to the Finance Department of ***MSSC*** so that the Finance Department can perform financial planning and projections and monitor the performance of third parties. In addition, the Finance Department is responsible for paying the claims covered by the Health Plan.

The Human Resources Representatives and the Finance Department will only use the protected health information for the purposes for which it was disclosed or as required by law.[1] Specifically, ***MSSC*** certifies

that it will:

- Not use or disclose protected health information for employment-related actions and decisions or in connection with any non-health benefits or another employee benefit plan sponsored by ***MSSC***;
- Not use or further disclose protected health information other than as permitted or required by this notice or as required by law;

Ensure that any business associates (including a subcontractor) to whom ***MSSC*** provides protected health information received from the Health Plan agree to the same restrictions and conditions that apply to ***MSSC*** with respect to such information. If any of our business associates fails to take adequate steps to safeguard and protect your health information, including controlling the activities of any of their subcontractors, and to perform the activities necessary to fulfill their responsibilities in regards to such information, including the corrective actions necessary due to a breach, we will terminate our relationship with such entities, if feasible;

- Provide training to our employees, including volunteers, trainees and others who are under are our direct control with access to protected health information maintained by the Health Plan on their responsibilities under the law, including the safeguarding and protection of the information. We will also establish and enforce disciplinary measures against such employees for violations of such responsibilities, and will require our business associates and their subcontractors to do the same;

- Report to the Health Plan's Privacy Officer any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which ***MSSC*** becomes aware;

- Provide notification to you within a reasonable time of our discovery of an impermissible use or disclosures of your protected health information (breach), unless we reasonably determine that there is a low probability that such information has been. Such notification will also be provided to the media or the U.S. Secretary of Health and Human Services if required by law. We will also provide you with notification of any such breaches committed by our business associates, unless we have delegated the responsibility for such notifications to the business associate who is responsible for the breach;
- Confirm that the Health Plan makes your protected health information available to you for access, amendment, and/or accounting, as described below;

- Make internal practices, books, and records relating to the use and disclosure of protected health information received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Health Plan with federal law;

- Return protected health information to the Health Plan (when feasible), destroy protected health information (when return is not feasible and retention is not required by law), or continue to maintain the privacy of all protected health information (when return is not feasible and retention is required by law);

- Use its best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested; and

- Ensure adequate separation between the employees who are Human Resources Representatives or in the Finance Department and all other employees of ***MSSC*** with access to Health Plan information so that protected health information received by these individuals is not disclosed to other employees of ***MSSC*** or other individuals in violation of this notice.

Other Uses and Disclosures of PHI

There are state and federal laws that may require or allow the Health Plan to release your health information to others. The Health Plan may provide information for the following reasons:

- **Health Oversight Activities:** The Health Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections, and licensure activities.

- **Legal Proceedings:** The Health Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

- **Law Enforcement:** The Health Plan may disclose your protected health information to law enforcement officials under limited circumstances. For example, in response to a warrant or subpoena; for the purpose of identifying or locating a suspect, witness, or missing person; or to provide information concerning victims of crimes.

- **For Public Health Activities:** The Health Plan may disclose your protected health information to a government agency that oversees the health care system or government programs for activities such as preventing or controlling disease or activities related to the quality, safety, or effectiveness of an FDA-regulated product or activity.

- **Required by Law:** The Health Plan may disclose your protected health information when required to do so by law.

- **Workers' Compensation:** The Health Plan may disclose your protected health information when authorized by and to the extent necessary to comply with workers' compensation laws and similar programs.

- **Victims of Abuse, Neglect, or Domestic Violence:** The Health Plan may disclose your protected health information to appropriate authorities if the Health Plan reasonably believes that you're a possible victim of abuse, neglect, domestic violence, or other crimes.

- **Coroners, Funeral Directors, and Organ Donation:** In certain instances, the Health Plan may disclose your protected health information to coroners or funeral directors and in connection with organ donation.

- **Research:** The Health Plan may disclose your protected health information to researchers, if certain established steps are taken to protect your privacy.

- **Threat to Health or Safety:** The Health Plan may disclose your protected health information to the extent necessary to prevent or lessen a serious and imminent threat to your health or safety or the health or safety of others.

- **For Specialized Government Functions:** The Health Plan may disclose your protected health information in certain circumstances or situations to a correctional institution if you are an inmate in a correctional facility, to an authorized federal official when it's required for lawful intelligence or other national security activities, or to an authorized authority of the Armed Forces.

- **For Cadaveric Organ, Eye, or Tissue Donation:** The Health Plan may disclose your protected health information for the purpose of facilitating organ, eye, or tissue donation and transplantation.

Your Rights

You have the following rights regarding the protected health information that the Health Plan maintains about you.

- **You have the right to ask the Health Plan to restrict** its use and disclosure of protected health information for the purposes of treatment, payment, or health care operations. Your request must be in writing and sent to the claims administrator. If the information you for which you are requesting the restrictions involves health care services or supplies that were paid in full by you or on your behalf by another person, we will honor such request. Otherwise, the Health Plan will consider your request, but it is not required to agree to restrict the information.

- **You have the right to ask to receive confidential communications.** If you believe that normal communications would put you in danger, you may request that the Health Plan send communications with protected health information (e.g., an Explanation of Benefits) to you by alternative means or to an alternative location. Your request must be in writing and sent to the claims administrator. Your request must include the alternative location (e.g., fax number, address, etc.) to which you would like the Health Plan to send the

information. Such requests, if reasonable, will be accommodated when you state in the request that you believe that normal communications would endanger you.

- **You have the right to inspect and obtain a copy** of the protected health information that the Health Plan maintains about you in a designated record set, including information maintained in paper or electronic formats. A designated record set contains protected health information that the Health Plan collects, maintains, or uses to administer or make decisions regarding your enrollment, payment, claims adjudication, or case management. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Access Request Form and send it to the claims administrator. An Access Request Form can be obtained by contacting the claims administrator or by downloading the form from the claims administrator's website. The Health Plan, or its designee, will respond within 30 days of the receipt of your request. The Health Plan may charge a reasonable, cost-based fee to provide you with the information. If you request such information be provided to you through unencrypted e-mail, you assume the risk on any unauthorized access or such protected health information during its transmission to you, and are responsible for safeguarding such information once it is delivered to you. There are exceptions as to what information can be accessed. For example, information compiled for legal proceedings cannot be accessed. If the Health Plan denies access to your information, in part or in whole, it will notify you in writing. The denial will include the reason for the denial, your review rights (if applicable), and information on how to file a complaint.

- **You have the right to ask the Health Plan to amend** protected health information about you that is contained in a designated record set (as described above) if you think that information is incorrect or incomplete. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Amendment Request Form and send it to the claims administrator. An Amendment Request Form can be obtained by contacting the claims administrator or by downloading the form from the claim administrator's website. Your request must include the reason for the request. The Health Plan, or its designee, may deny your request if you ask the Health Plan to amend information that: is not part of the protected health information kept by or for the Health Plan; was not created by the Health Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy; or is accurate and complete. If the Health Plan denies the request, you may file a written statement of disagreement with the Health Plan.

- **You have the right to request an accounting of certain disclosures** of protected health information. Your request must be in writing and must specify the time period for which you are requesting information. The period cannot start earlier than April 14, 2003, or go back more than six years from the date of your request. Your request must be in writing. If the request pertains to records held by the claims administrator, you must complete an Accounting Request Form and send it to the claims administrator. An Accounting Request Form can be obtained by contacting the claims administrator or by downloading the form from the claim administrator's website. The accounting will not include disclosures made to you or with your written authorization or in the course of treatment, payment, or health care operations. If you request such an accounting more than once in a 12- month period, the Health Plan will charge a reasonable fee.

- **You have the right to a copy of this notice** upon request. Your request must be in writing and sent to the Privacy Officer. A copy of the current notice will be sent to you.

For more information, or to begin the formal process connected with these rights, see Contact Information, below.

Contact Information

If you want to exercise any of the rights described in this notice with respect to the records held, or the disclosures made, by one of the Health Plan's claims administrators, you may contact that claims administrator.

- For matters concerning medical, dental, and vision benefits:
- For matters concerning prescription drug benefits:

Privacy Officer for MSSC

5650 Woodlawn, Bartlett, TN 38134

901-202-0855, Ext. 242

If you call a claims administrator, please tell the customer service representative that your call relates to the privacy of your protected health information.

If you have questions regarding this notice, you may also contact the Health Plan's Privacy Officer, c/o the Benefits Shared Service, 5650 Woodlawn, Bartlett, TN 38134. You may also contact the Health Plan's Privacy Officer if you have any problems in exercising your rights.

Complaints

You have the right to file a written complaint with the Health Plan's Privacy Officer if you think your privacy rights have been violated. Include your name, address, and telephone number. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You won't be retaliated against or denied any Health Plan benefit or service because you file a complaint.

The Health Plan's Privacy Officer will investigate and address any issues of noncompliance with this notice of which any one or more of these entities or persons is notified or becomes aware.

Revisions to the Notice

MSSC reserves the right to change the terms of this notice and to make the new notice effective for all protected health information maintained by the Health Plan. ***MSSC*** will promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, the Health Plan's duties, or other practices stated in this notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new notice in which the material change is reflected.

Important Notice from the Arlington Community Schools, Bartlett City Schools, Collierville Schools, Lakeland School System, Millington Municipal Schools (*MSSC)* About Your Prescription Drug Coverage and 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 the (*MSSC)* and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage with the **(MSSC)** may be affected. If you do decide to join a Medicare drug plan and drop your current **(MSSC)** coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the **(MSSC)** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the **(MSSC)** changes. You also may request a copy of this notice at any time.
For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	04-05-2017
Name of Entity/Sender:	**(MSSC)**
Contact--Position/Office:	Benefits, Shared Services
Address:	5650 Woodlawn, Bartlett, TN 38134
Phone Number:	901-202-0855, Ext. 242

Women's Health and Cancer Rights Act Enrollment Notice

The following is language that group health plans may use as a guide when crafting the WHCRA enrollment notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

EPO –	Deductibles	$500, $750, $1,000
	Coinsurance	100% after copay and deductible met
Basic -	Deductibles	$500, $1000, $1,500
	Coinsurance	80% after copay and deductible met
HRA	Deductibles	$1500, $3000, $4,500
	Coinsurance	80% after deductible met

If you would like more information on WHCRA benefits, call your Plan Administrator 901-202-0855, Ext. 242.

NEWBORNS & MOTHER'S HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (901) 202-0855.

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL COVERAGE

If you have declined enrollment in a ***MSSC*** health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in the medical plan without waiting for the next open enrollment period, provided that you request enrollment within ***30 days after your other coverage ends***. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within ***30 days after the marriage, birth, adoption or placement for adoption. MSSC*** health plan will also allow a special enrollment opportunity if you or your eligible dependents either:

• Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
• Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in a ***MSSC*** health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Model General Notice Of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: The Benefits Department and provide appropriate documents to verify your qualifying event, such as Divorce Decree or Death Certificate.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

The *MSSC* Health Plan (Arlington Community Schools, Bartlett City Schools, Collierville Schools, Lakeland School System, Millington Municipal Schools)

The Benefits Department
5650 Woodlawn
Bartlett, TN 38134

901-202-0855
benefits@bartlettschools.org

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

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

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

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

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

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

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your benefits department at 901-873-5680.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Millington Municipal School System	46-4289512
5. Employer address	**6. Employer phone number**
5020 Second Street	901-873-5680

7. City	8. State	9. ZIP code
Millington	TN	38053

10. Who can we contact about employee health coverage at this job?	
Benefits Department	
11. Phone number (if different from above)	**12. Email address**
901-873-5680	ajones@millingtonschools.org

Here is some basic information about health coverage offered by this employer:

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

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Full-Time employees who are regularly scheduled to work a minimum of 30 hours per week

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Outlined in the 2017-2018 Millington Municipal School System's Open Enrollment Brochure

  ☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $118.20
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☑ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)