For New or Rehire Active
Full Time Permanent Employees

Benefits & You

2019 Benefits Guide

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BENEFITS & YOU

Welcome aboard! As a full time permanent employee you are eligible for benefits including medical, dental, vision, flexible spending accounts (healthcare and dependent care), basic life, supplemental life, employee assistance program, and long term disability.

This booklet contains:

- Benefit plan descriptions
- Premium rates for each benefit plan
- Instructions on how to enroll
- Who to contact with questions

Choose your benefits wisely because your next opportunity to make benefit changes will be the next Annual Enrollment period during the fall of 2019, for 2020 benefits, unless you experience a qualified life event change (i.e., birth of a child, marriage, etc.).

Once you review your benefit options and are ready to do your online enrollment, go to the Online Benefits website www.cgsmarketplace.com and use the convenient benefits enrollment tool.

WHAT YOU NEED TO KNOW

Read this carefully:

- **Effective Date of Coverage:** Benefits begin on the first day of the month after the completion of 30 days. (Example: Hired August 4th, Benefits begin October 1st)
- **Enrollment Deadline:** New Hires have 30 days from their date of hire to enroll. If you are a rehire or have a status change, you have 30 days to enroll. Benefits Insight will include a calendar with details on the days you have remaining to enroll. Please adhere to the online calendar.
- **Cigna Guided Solutions Online Enrollment System:** Step by step enrollment instructions are included in this guide. All employees must enroll online as no paper forms are available. You may elect or waive any of these benefits individually. If you do not log into the system to make choices, all benefits will be waived at the end of your enrollment period.
  - Possible Delayed System Access-Your information is manually loaded to payroll and must then feed to Benefits Insight, which may take up to 2 weeks. If you are trying to enroll in benefits and get a message that you are not recognized, please be sure to try any previous five-digit zip code and check back the Monday after you get your first paycheck. If you are still not recognized, please contact your Benefits Representative.
  - Accurate data entry is imperative when enrolling in benefits. SCS must report to the IRS about coverage offered to you and your eligible dependents. Please be sure to correctly enter the following information for your dependents:
    - Full Legal Name- no surnames, nick-names, etc.
    - Social Security #
    - Date of Birth
- Affordable Care Act Record Accuracy - SCS must report to the IRS information about coverage offered to you and your eligible dependents. **If you are enrolling dependents, please enter or review their information on the About Your Family page to ensure it is correct.** Please be sure that accurate information is listed for your spouse and or child(ren) as follows: full ***legal*** name, social security number (please review the actual card for accuracy), and correct date of birth.

2019 NEW BENEFITS

- **Pet Insurance**
- **Legal / ID Theft Insurance**
- **Student Loan Wellness Tools through Tuition.IO**

More information can be found later in this guide.

ELIGIBILITY

You are eligible for benefit programs if you are a full-time permanent employee. You may enroll your spouse and dependent children who meet the definition of eligibility as defined below for health care benefits.

You may enroll your dependent children including legally adopted children and stepchildren up to age 26. And, based on Board approval, a child who is physically or mentally disabled can be covered over age 26. (Please note: You cannot be covered both as an employee and as a dependent under any Shelby County Schools' health insurance plan.)

Spouse Coverage

- You may NOT cover your spouse for medical coverage if his or her employer provides medical coverage.
- The "spouse opt-out" requirement does NOT apply to spouses who:
  - are also employed or retired from Shelby County Schools and whose employer does NOT provide medical coverage;
  - or are required to pay more than 50% of the cost of coverage for their employer's lowest cost individual plan option.
- If your spouse meets one of the conditions above, a "Spouse Verification Affidavit" is required.
- You may still cover your spouse for dental or vision benefits.

MAKING CHANGES DURING THE YEAR

You can only make changes to your health benefits during Annual Enrollment each year or within 30 days of a qualified life event. Some examples of a qualified life event include the birth of a child, marriage, death and loss of medical coverage due to a reduction in work hours.

Shelby County Schools provides 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 premium assistance program under Medicaid or CHIP. For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in one of Shelby County Schools' health plans.

TOBACCO SURCHARGE

There is a tobacco surcharge for the 2019 plan year. Tobacco is defined as cigarettes, e-cigarettes, cigars, pipes or smokeless tobacco such as chew, dip or snuff. When enrolling for medical benefits, you will be asked to confirm and/or reconfirm whether or not you have used tobacco on a regular basis (five or more times) since January 1, 2018. The surcharge only applies to employees at this time. **Important Note:** *Any employee who intentionally falsifies their tobacco status will lose their non-tobacco discount and may be subject to disciplinary action based on SCS District guidelines.*

2019 MEDICAL BENEFITS – CIGNA

Medical Benefit	OAP IN-NETWORK Plus Network Only Plan	OAP Basic Option		CHOICE FUND HRA Option	
		Network	Out-of-Network	Network	Out-of-Network
	You Pay	You Pay		You Pay	
Annual Deductible					
Employee	$500	$1,000	$2,000	$1,500	$3,000
Employee +1	$1,000	$2,000	$4,000	$3,000	$6,000
Family	$1,000	$2,000	$4,000	$3,000	$6,000
Annual Health Fund provided to employees and dependents to offset your deductible	N/A	N/A		$500/employee, $1,000/employee + 1, $1,000/family	
Out-of-Pocket Maximum					
Coinsurance	20%	20%	50%	30%	50%
Employee	$3,000	$4,000	$8,000	$7,150	$14,300
Employee +1	$9,000	$12,000	$24,000	$14,300	$28,600
Family	$9,000	$12,000	$24,000	$14,300	$28,600
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit					
Primary Care Physician	$25 copay	20%	50%	30%	50%
Specialist	$40 copay	20%	50%	30%	50%
Hospital					
Inpatient	$500 copay	20%	50%	30%	50%
Outpatient	$250 copay	20%	50%	30%	50%
Emergency Room	$250 copay	$400 copay	$400 copay	30%	30%
Urgent Care	$75 copay	20%	50%	30%	30%
TeleHealth (MDLive or American Well)	$25 copay	Copay; 20%	N/A	Copay; 30%	N/A
X-Ray, Labs, Etc.	20%	20%	50%	30%	50%
Preventive Care (mammograms, PAP tests, physicals, immunizations)	0%	0%	Not covered	0%	Not covered
Behavioral Health/Substance Abuse					
Inpatient	$500 copay	20%	50%	30%	50%
Outpatient	$40 copay	20%	50%	30%	50%
Prescription drugs					
Deductible	None	None	$100 per person	None	$100 per person
Retail (30-day supply)					
Generic	$10 copay	$10 copay	50%	$10 copay	50%
Preferred Brand	20% *($25 min/$60 max)*	20% *($25 min/$60 max)*	50%	20% *($25 min/$60 max)*	50%
Non-Preferred Brand	30% *($50 min/$80 max)*	30% *($50 min/$80 max)*	50%	30% *($50 min/$80 max)*	50%
Mail Order (90-day supply)	3 x Retail	3 x Retail	Not covered	3 x Retail	Not covered

The HRA Plan will cover bariatric surgery and fertility treatment (if medically necessary).

For questions about plan details such as specific procedures, covered prescriptions, etc. please contact the Cigna Healthcare Enrollment Information Line at 1-800-401-4041.

Please refer to the Summary of Benefits and Coverage ("SBC") for information regarding the application of copays, deductibles, and coinsurance and how these apply to your out of pocket maximum. SBCs for each plan are available on the Cigna Guided Solutions enrollment site and on the Employee Benefits web page.

WHAT YOU NEED TO KNOW

- Employees enrolling in the Choice Fund HRA option have access to 100% of their Annual Health Fund on January 1, 2019.
- For all plans, any combination of family members can satisfy the family deductible. For example, one (1) member can satisfy the deductible or multiple members' combined expenses can satisfy the deductible.
- For all plans, once one (1) individual with family coverage satisfies the single out-of-pocket maximum, benefits are paid at 100% for that one individual.
- There are several programs sponsored by Cigna that will continue for the 2019 plan year. Program information is included later starting on page 17 in the guide or check on mycigna.com for more information.
  - **"Quit Today"** tobacco cessation program
  - **"MDLive"** allows you to see a physician online using your phone or other portable device
  - **"American Well"** allows you to access a physician by phone – also saving you time and money
  - **"PHS+"** clinical care management program directs you to services that are most appropriate for you
  - **Active & Fit Direct** provides you access to fitness center memberships for $25 a month (plus a $25 enrollment fee)

HEALTH REIMBURSEMENT ACCOUNT (HRA)

If you enroll in the Choice Fund HRA medical plan option, it will include a health reimbursement account (HRA), funded by Shelby County Schools, to help you pay the cost of eligible health care expenses.

At the start of the plan year, Shelby County Schools will deposit a specific dollar amount in an HRA. The medical summary on the previous page shows the Shelby County Schools' 2019 HRA contribution amounts. Cigna manages the claims process for you and applies your HRA funds to pay 100% of your eligible health care expenses until the money is used up. Here's how it works:

- When you go to most in-network providers, the provider does not collect any money from you at the point of service. Instead, the provider sends the claim directly to Cigna.
- Cigna processes the claim, applying any discounts and identifies the amount due to the provider.
- To pay the provider, Cigna deducts monies from your HRA account up to the balance of your account.
- Once your HRA fund balance has been exhausted, you are responsible for future claims up to the Choice Fund HRA plan's maximum out of pocket limit.
- Any funds not used in 2019 will "rollover" to 2020.
- You are not eligible to receive your HRA funds if you leave Shelby County Schools.
- **Reminder:** The HRA Plan will cover bariatric surgery and fertility treatment, if medically necessary.

Cigna will send out quarterly statements to those employees who participate in the Choice Fund HRA plan.

SCS FAMILY CARE CENTERS

Shelby County Schools and Methodist LeBonheur Healthcare have partnered to provide two convenient health care clinics at **no cost** for those that are eligible. The SCS Family Care Centers are available to you for urgent-care type services but are not intended to substitute for visits to your primary care physician. More information can be found on SCS' website.

Eligibility: SCS clinics are open to all active SCS employees with a valid SCS employee ID. Family members covered by the employee's SCS health insurance plan are also eligible. Contract employees are not eligible to access the clinics.

Cost: **FREE** for active SCS employees with a valid SCS ID badge and family members covered under an SCS health insurance plan.

LABs and Prescriptions: In-house labs and any prescribed in-stock generic medications are included in the cost-free services for eligible SCS employees. No billing will occur to the employee at the clinic.

Treatment available: Most minor medical conditions such as colds, flu, sore throat, sinus infection, sprains, cuts, etc. are covered. Work-related injuries, physicals, immunizations, lab work, and drug screens are also covered.

Off-site Referrals: Copays and billing associated with an employee's selected health insurance plan will only apply if you obtain additional services from an off-site primary care physician or specialist. SCS employees not covered by an SCS insurance plan should contact the Employee Benefits office for specific billing questions regarding off-site medical care.

Appointments: Required for **ALL** medical services which reduces wait times. **No Walk-In's are allowed**. To schedule an appointment, call 901-416-6079.

Locations and Hours:

Grays Creek Clinic
(SCS Facility Services Building, Building A)
2800 Grays Creek Drive
Arlington, TN. 38002
7 a.m. - 5 p.m. (school days)
7 a.m. - 4 p.m. (summer and school holidays)

Flicker Clinic
(Behind Central Office)
130 Flicker Street
Memphis, TN 38014
8 a.m. - 6 p.m. (school days)
8 a.m. – 5 p.m. (summer and school holidays)

EMPLOYEE ASSISTANCE PLAN (EAP)

To help you manage in difficult times, the Methodist Employee Assistance Plan (EAP) is available at no cost to benefit eligible employees and their families. The EAP offers counseling by trained professionals through Methodist Healthcare. It is confidential and voluntary to SCS employees.

- ***Who can use the EAP?*** Employees and all members of your household.
- ***Is it confidential?*** Use of the program and issues discussed in all sessions are held in strict confidence.
- ***Who do I call?*** Schedule an appointment by calling (901) 683 5658 or toll free (800) 880 5658 during regular office hours, Monday through Friday, from 8:30 am – 4:30 pm.
- ***What is the cost?*** The EAP is free for you and all members of your household. In most cases, short-term counseling is all the help you will need. When a referral outside the EAP is indicated, the EAP counselor will seek the best resources for your situation.

See additional information on page 26 of this guide.

DENTAL BENEFITS – CIGNA

Benefit	Total Cigna DPPO $2,000 Plan		Total Cigna DPPO $1,500 Plan		DPPO Advantage Plan
	Network	Out-of-Network	Network	Out-of-Network	In-Network
	You Pay		You Pay		You Pay
Annual Deductible					
Individual	$25	$50	$50	$100	None
Family	$75	$150	$150	$300	None
Annual Plan Maximum	$2,000	$2,000	$1,500	$1,500	Unlimited
Diagnostic and Preventive	0%	0%	0%	0%	0%
Basic Services					
Basic	20%*	20%*	20%*	20%*	20%
Periodontic Treatment	20%*	20%*	50%*	50%*	20%
Re-lining/Re-basing of Existing Removable Dentures	20%*	20%*	50%*	50%*	20%
Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	20%*	20%*	50%*	50%*	20%
Major Services					
Major	40%*	40%*	50%*	50%*	50%
Crowns, Jackets and Cast Restoration Benefits	40%*	40%*	50%*	50%*	50%
Prosthodontic Benefits	40%*	40%*	50%*	50%*	50%
TMJ and Implants	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontia Services	50%	50%	50%	50%	100%*
Deductible	None	None	None	None	$2,300
Dependent Children	Up to age 26	Up to age 26	Up to age 26	Up to age 26	Up to age 26
Adults	Not covered	Not covered	Not covered	Not covered	Covered
Lifetime Maximum for Orthodontia	$2,000	$2,000	$1,500	$1,500	N/A

*After deductible

WHAT YOU NEED TO KNOW

- Because the DPPO Advantage plan network is smaller than the Total Cigna DPPO network, please make sure your dentist is a participating provider prior to receiving services.

Did you Know?

Shelby County Schools employees have access to MDLive or American Well. This program allows you to see a physician when your primary doctor is unavailable or when you are traveling on vacation. MDLive or American Well physicians can treat minor issues.

See page 21 or mycigna.com for more information.

VISION BENEFITS – CIGNA

Benefit	Cigna	
	Network	Out-of-Network
Benefit Frequency		
Exam/Lenses/Contacts	12 months	12 months
Frames	24 months	24 months
Exam	$10 copay	Up to $30 allowance
Lenses		
Single Vision	$20 copay	Up to $25 allowance
Bifocal	$20 copay	Up to $35 allowance
Trifocal	$20 copay	Up to $45 allowance
Lenticular	$20 copay	Up to $60 allowance
Lens Options		
UV Coating	Up to $17 copay	Not Covered
Tint/Scratch Resistance	Up to $17 copay	Not Covered
Basic Polycarbonate	Up to $40 copay under age 18	Not Covered
Anti-Reflective		
Standard	Up to $45 copay	Not Covered
Progressive		
Standard	Up to $65 copay	Not Covered
Premium	20% discount	Not Covered
High Index	20% discount	Not Covered
Polarized	20% discount	Not Covered
Plastic Photosensitive	20% discount	Not Covered
Intermediate	20% discount	Not Covered
Frames	$130 credit/allowance + 20% discount (20% savings on amount that exceeds frame allowance)	Up to $30 allowance
Contact Lenses		
Medically Necessary	$20 exam copay, then 100%	Up to $225 allowance
Elective	$20 exam copay, $150 credit/allowance includes fitting and evaluation	Up to $75 allowance
Other Services		
LASIK Vision Services	Up to 15% discount or 5% off promotional	Not Covered

WHAT YOU NEED TO KNOW

- Review the copays and benefits shown above.
- You are eligible for either glasses OR contacts every 12 months, but are not eligible for both in a 12-month period.

EMPLOYEE BASIC & OPTIONAL LIFE INSURANCE - SECURIAN

Benefit	
Eligibility	Permanent full-time employees
Waiting Period	First of the month following 30 days
Benefit Amount	
Employee	Increments of $10,000
Spouse	50% of employee's supplemental benefit
Children	$10,000 or $20,000 up to age 26
Maximum	
Employee	Lesser of 5 x salary or $500,000
Spouse	50% of employee's supplemental benefit up to maximum of $250,000
Child(ren)	$20,000
Additional Features	Waiver of Premium Portability Conversion Accelerated Death Benefit
Benefit Age Reduction	Benefits are reduced on January 1 following an employee's 65th and 70th birthdays as shown below: At Age 65 – 35% benefit reduction At Age 70 – 15% benefit reduction

WHAT YOU NEED TO KNOW

- Employees must enroll in basic life insurance to be eligible to purchase supplemental life insurance for his/her self or spouse.
- The amount of basic life insurance for an employee age 65 or older shall be reduced by a percentage of their benefit amount as shown above.
- As a new employee, employees may elect supplemental life insurance up to 3 times their basic annual earnings without medical evidence of insurability.
- As a new employee, employees may elect spouse and / or dependent child(ren) supplemental life insurance up to $20,000 without medical evidence of insurability.
- If you have questions about supplemental and dependent life insurance, please contact SCS' Benefit Office at 901-416-5344.

VOLUNTARY LONG-TERM DISABILITY (LTD) INSURANCE – THE STANDARD

Your monthly benefit will be 60% of your pre-disability earnings.

Monthly Maximum Benefit:	$5,000
Monthly Minimum Benefit:	$100 or 10% of the LTD benefit before reduction by deductible income, whichever is greater.
Benefits Waiting Period:	If your claim for LTD benefits is approved by The Standard, benefits become payable after you have been continuously disabled for 180 days and remain continuously disabled. Benefits are not payable during the benefit waiting period.
Pre-existing Condition Exclusion:	If you were treated for an illness or injury 90 days prior to your insurance effective date, will be excluded from coverage for a period of 12 months.

Employees who did not enroll for coverage when first hired by SCS must complete an online Medical History Statement before coverage is effective.

The link to the form is: http://www.standard.com/mybenefits/mhs_ho.html.

If you become insured, you will receive a group your insurance coverage.

FLEXIBLE SPENDING ACCOUNTS (FSA)

FOR HEALTHCARE AND DEPENDENT CARE

What is an FSA? Have you ever looked at your paycheck and thought how great it would be if so much of your income didn't go to taxes?

Participating in a Flexible Spending Account is a way to get more out of your pay. An FSA allows you to deduct money from your paycheck on a pre-tax basis and use those funds to pay for eligible health care ("Healthcare FSA") and/or child/dependent care expenses ("Dependent Care FSA") for your children under age 13. Because the expenses are paid with pre-tax dollars, the result is immediate tax savings.

2019 Contribution Limits

	Annual Minimum	Annual Maximum (set by the IRS)
Healthcare FSA	**$300**	**$2,700**
Dependent Care FSA	**$600**	**$5,000**

The FSA plan year begins 1/1/2019 and ends on 12/31/2019 and funds cannot rollover from one plan year to the next. Any money remaining in your **FSA account as of the end of the plan year will be forfeited**. It is important to estimate your expenses carefully.

Qualified expenses that can be reimbursed under the Flexible Spending Accounts include:

- Copays and doctor's fees
- Prescribed and over-the-counter Rxs
- Dental and eye care expenses
- Daycare expenses (for children under age 13)

A complete list of qualified expenses can be found at www.connectyourcare.com. ***You can also use your Healthcare FSA to buy healthcare items through Connect Your Care's online "FSA Store".***

EMPLOYEE CONTRIBUTIONS

Medical Plan	20-Pay Premiums		24-Pay Premiums	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
OAP IN-NETWORK PLUS Option				
Employee	$125.81	$155.81	$104.85	$129.85
Employee + 1	$280.39	$310.39	$233.66	$258.66
Family	$391.13	$421.13	$325.95	$350.95
OAP BASIC Option				
Employee	$88.09	$118.09	$73.41	$98.41
Employee + 1	$215.32	$245.32	$179.43	$204.43
Family	$300.36	$330.36	$250.30	$275.30
CHOICE FUND HRA Option				
Employee	$55.80	$85.80	$46.50	$71.50
Employee + 1	$147.76	$177.76	$123.13	$148.13
Family	$206.12	$236.12	$171.77	$196.77

Dental Plan	20-Pay Premiums	24-Pay Premiums
DPPO ($2,000) Option		
Employee	$25.62	$21.35
Employee + 1	$53.80	$44.84
Family	$76.86	$64.05
DPPO ($1,500) Option		
Employee	$15.48	$12.90
Employee + 1	$32.50	$27.09
Family	$46.43	$38.69
DPPO (ADVANTAGE) Option		
Employee	$11.41	$9.51
Employee + 1	$23.95	$19.96
Family	$34.22	$28.52

Vision Plan	20-Pay Premiums	24-Pay Premiums
Employee	$3.06	$2.55
Employee + 1	$5.86	$4.89
Family	$9.50	$7.92

WHAT YOU NEED TO KNOW

- Employee contributions will be deducted over 24 or 20-pay periods
- Tobacco and non-tobacco rates apply to all medical plans and all coverage tiers
- The tobacco surcharge is $25 for 24-pay periods and $30 for 20-pay periods

LIFE INSURANCE RATES – SECURIAN

The cost for Basic Life & AD&D coverage is $0.0216 per $1,000 of coverage for 20-pay periods, and $0.018 per $1,000 of coverage for 24-pay periods. Optional Life insurance rates per $1,000 of coverage are outlined below.

	Age Bands									
Optional Life	**< 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70 +**
20-pay rate	$0.026	$0.037	$0.045	$0.047	$0.068	$0.105	$0.196	$0.301	$0.580	$0.939
24-pay rate	$0.022	$0.031	$0.038	$0.039	$0.057	$0.088	$0.164	$0.251	$0.483	$0.783

You **must** purchase basic life insurance to be able to purchase optional life. Current employees who have not purchased coverage in the past must provide evidence of good health if they wish to elect coverage.

VOLUNTARY LONG-TERM DISABILITY RATES – THE STANDARD

Age	20-Pay Premium Rate	24-Pay Premium Rate
< 25	$0.048	$0.040
25-34	$0.054	$0.045
35-44	$0.072	$0.060
45-54	$0.162	$0.135
55-64	$0.360	$0.300
65+	$0.426	$0.355

To calculate your per paycheck payroll deduction, use the formula indicated below:

1. Enter your average monthly income, not to exceed $8,333, on Line 1. Line 1:_____

2. Select your rate from the rate table and divide this by 100. Line 2:_____

3. Multiply Line 1 by the amount shown on Line 2. Line 3:_____

The amount shown on Line 3 is your estimated per paycheck payroll deduction.

Did you Know?

Shelby County Schools provides its employees access to an Employee Assistance Program provided by Methodist Healthcare.

See page 26 for more information

ANNUAL ENROLLMENT – INSTRUCTIONS FOR THE ENROLLMENT SITE

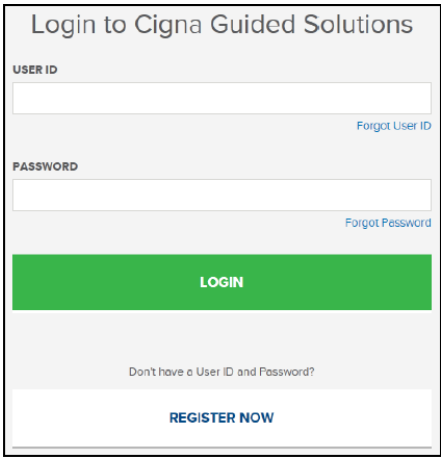
1. Access the Cigna Guided Solutions Enrollment site

Go to www.cgsmarketplace.com

2. Access or Register to use the Enrollment site

Do one of the following:

- If you have been covered by Cigna within the last two years at SCS and have created a myCigna.com user ID and password, please continue with your myCigna.com user ID and password to log in.
- If you are a new to Cigna, or were covered by Cigna at a previous employer, click the **Register Now** button.



Need Help / Forgot Your Password:

- If you have created a myCigna.com user ID and password but have forgotten your user ID or password, click Forgot User ID or Forgot Password respectively to have either one reset.
- You cannot use an existing myCigna.com user ID and password to log in if you created the user ID and password when you were covered under different coverage, for example, if you were a dependent covered under a spouse's or parent's plan.
- Do not use your login credentials from any previous Cigna online benefits enrollment tool because those credentials are no longer valid.

If you have any questions about the CGS Customer Portal or myCigna.com, or continue to have issues **specific to registering** for or logging in to either the CGS Customer Portal or myCigna.com, contact Cigna at 1.800.853.2713.

If you have any questions regarding your **online enrollment**, including questions such as how to navigate the CGS technology, enroll into benefits, or understand plan options, contact 1.855.799.1974.

3. Start Your Enrollment Elections

- Once logged in, you will be brought to the Home Page.
- Notice the Calendar that shows how many days you have left to enroll.
- Click **ENROLL**.

4. *Verify Your Personal Information and Add Dependents*

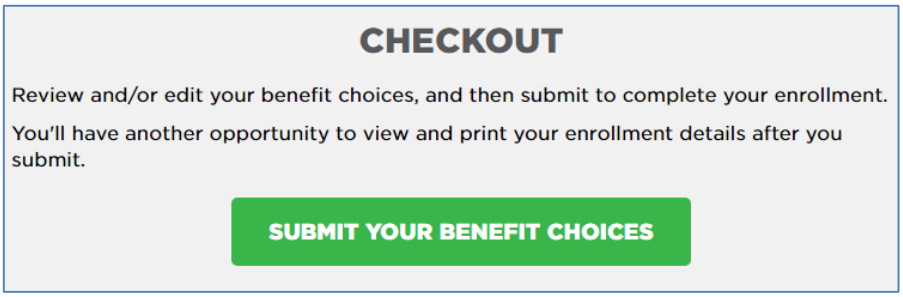
- Review your personal information. If any changes need to be made, contact benefits@scsk12.org.
- After you verify information about yourself, you can add or review information for eligible dependents.
  - Please note: Adding a dependent on Your Family page does NOT enroll the dependent in coverage. You must enroll the dependent in coverage later in the process.
  - ***SCS is required by the Affordable Care Act to report to the IRS information about health coverage offered to you and your dependents.*** If you are enrolling dependents, please enter or review their information on Your Family page to ensure it is correct. Please be sure that accurate information is listed for your spouse and/or child(ren) as follows: full ***legal*** name, social security number (please review the actual card for accuracy), and correct date of birth. Failure to provide accurate information could result in a tax penalty for you, the taxpayer.
  - For dependents under the age of one year, a social security number is not required.

5. *Review and Select Your Benefits*

- You will start the enrollment process with your medical plan options, along with costs.
- See additional plan details by clicking on the **Plan Details** link.
- Once you have made your medical selection, you will be brought to the dental selection page, followed by the vision selection page. You will also have the opportunity to enroll in health and dependent care FSAs, basic and supplemental life insurance and long-term disability coverage.
- After selecting the plan and tier level of coverage you want for each benefit, the next step is to add your dependents.

6. *Review and Confirm Your Summary Information*

- View the confirmation page of your elections and covered dependents carefully.
- Once you review your elections, click **Submit Your Benefit Choices** at the top or bottom of the page to complete the enrollment process. **If you do not click Submit, your changes will not be processed!**



- If you need to make changes, you may do so throughout the enrollment period. However, you must go all the way through and **click submit** for any changes to go into effect.
- After submitting your elections, you can print a confirmation statement. Be sure to keep it with your records.

OFFICE OF HUMAN CAPITAL
DEPARTMENT OF EMPLOYEE SERVICES

160 S. Hollywood St. • Memphis, TN 38112 • (901) 416-5304 • Fax (901) 416-5469 •
www.scsk12.org

SUPPLEMENTAL INSURANCE

Employees may participate in additional payroll deducted benefits including Short-Term Disability, Hospital Indemnity, Accident, Critical & Cancer Care. You may enroll by contacting the carrier directly. See contact information below:

- **AFLAC**
  Mark Turnbow
  Phone Number: (901) 870-4206
  Email: mark_turnbow@us.aflac.com.
- **American Fidelity**
  https://benefits.americanfidelity.com/shelby-county-schools
  Candice Chambers or Kenneth Greene
  Phone number: 901-458-9252
- **Colonial Life**
  support@hro-partners.com or call us at: 1-866-822-0123

Shelby County Schools
403(b) Vendors

American Fidelity Insurance
126 South Flicker
Memphis, TN 38104
(901) 458-9252

Representatives
Kenneth Green
Maurice Henderson
Candice Chalmers
Kristie Greer

Ameriprise Financial
6750 Poplar Ave., Ste 114
Memphis, TN 38138
(901) 312-7806

Representative
Vera Feldman

AXA Equitable
494 Williamsburg Lane
Memphis, TN 38117
(901) 396-3874
(901) 346-8555 Fax

Representatives
Dennis Murphy, Sr. (901)258-1909
Chirag Chauhan (901)365-3477
Stephen Harris (901)682-0903
Doug Jackson (615)386-6360
Timothy McCoy (615)386-6392

College Life Group/Americo
5545 Murray Rd., Suite 205
Memphis, TN 38119
(901) 761-4822

Representative
Lewis Pittman

Great American Life Insurance
301 East Fourth St, 11th Floor
Cincinnati, OH 45202
(800)-438-3398

Representatives
Omar Aquil (800)-977-4091
Robert Stagoski – (901)683-8146
Season Caulkins – (901)489-9486

Horace Mann Insurance
1899 Camberley Circle
Memphis, TN 38119
(901) 461-8689

Representatives
Stephen Boyd
Jim Gammon
Nedia Brassell
Omar Aquil 800-977-4091

ING ReliaStar
5050 Poplar Avenue, Suite 2400
Memphis, TN 38157
(901) 496-2741

Representative
Calvin Reid

Metlife Resources
7715 Highway 70, Suite 103A
Bartlett, TN 38133

Representatives
Ken Hanna (901)734-7099

Midland National
3721 Riverdale Rd, Ste. 102B
Memphis, TN 38115
(901) 552-3042

Representative
Janet Walton
James Huffman
Paul Pollan (901)692-4028
Franklin Hall (901)754-2040

NEA Valuebuilders/Security Benefits
The Legend Group/Legend Equities
P.O. Box 862
Savannah, TN 38372
(731)925-2590

Representatives
Jerry Chaney
Gerald Nelson

Plan Members Services
1278 Salem Rd
Gadsden, TN 38337
(731) 784-6702

Representative
Elaine Cole

Primerica Financial Services
PFS Investment Inc.
5118 Park Ave., Suite 308
Memphis, TN 38117
(901) 398-5239

Representatives
Steve Stokes (901)332-5000
Laloma Harris (901)-828-7137
Dora Richmond (901)794-1504
Alberta Bowdery (901)486-3749

VALIC
278 Franklin Rd., Suite 151
Brentwood, TN 37027
(615)221-2541

Representative
David Stratton (662) 812-7698
Michael Seebeck (901) 825-8958
Lee Lakey– (843) 338-8448

Great West (EMPOWER)
545 Mainstream Dr., Suite 407
Nashville, TN 37228
(800)922.7772

Rosaline Banks
Rosaline.Banks@emplower-retirement.com

403(b) Vendors Contact Information

Shelby County Schools does not discriminate in its programs or employment on the basis of race, color, religion, national origin, handicap/disability, sex, or age.

CIGNA MAKES IT EASIER TO BE HEALTHIER

Cigna makes it easy to be healthier.

Cigna offers so much more than your employer's medical coverage. From helping you answer health questions 24 hours a day to a virtual team of health and wellness coaches, we're here for you.

24/7/365 service

Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year.

- Get answers to health, claims and plan questions.
- Order an ID card, update information and check claim status.
- Find a health advocate for help with improving specific health issues.
- Speak with a Spanish speaking service representative or someone who can translate one of 200 languages.

Health Information Line

Have a health question? You can talk with a clinician 24 hours a day, seven days a week.

- Get help deciding where and when you should get treatment for your immediate care needs.
- Call if you need general health information or have a specific health concern.
- You can also listen to hundreds of podcasts to help you stay informed about your health.

Select a topic and listen via live-stream on your computer via **myCigna.com**.

Network of quality doctors

You can save money when you use a doctor, hospital or facility that's part of your plan's Cigna network. It's easy to find quality, cost-effective care right where you need it. You can find a doctor right on Cigna.com or on the myCigna® website or app once enrolled.

Preventive care covered 100% in-network

Getting and staying healthy is important. That's why certain preventive care services are totally covered when you use an in-network doctor. These services may include:[1]

- Screenings for blood pressure, cholesterol and diabetes.
- Testing for colon cancer.
- Mammograms and Pap tests.

For a complete list of covered preventive care services, see your plan materials or, for more information, go to **Cigna.com/takecontrol**.

Answers by Cigna for Amazon Alexa

Need help with health plan or insurance terms? Just ask Alexa on all Amazon Echo devices. Enable the Answers by Cigna skill and take health care into your own hands – without so much as lifting a finger.[2]

JUST ASK amazon alexa

myCigna

Where you will find everything you need to stay on top of your plan, and your health.

- Find in-network doctors and medical services.
- View ID card information.
- Manage and review your coverage.

Together, all the way.®

Cigna®

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

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- Manage and track claims.
- Take your health assessment.
- Compare cost and quality information for doctors and hospitals.
- Access a variety of health and wellness tools and resources.

You can also access myCigna on the go by downloading the myCigna App.[3]

Telehealth for 24/7 care

Cigna Telehealth Connection helps you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. You can connect with a board-certified provider via video chat or phone, when, where and how it works best for you.[4]

- **Choose when:** 24/7/365. Day or night, weekdays, weekends and holidays.
- **Choose where:** Home, work or on the go.
- **Choose how:** Phone or video chat.

See your enrollment materials for details.

Know before you go

Here's an at-a-glance view of your options when you need medical care.[5] In an emergency, always dial 911 or visit the nearest emergency room.

	Cost	Wait time	Severity
Cigna Telehealth Connection	$		
Convenience care clinic	$$		
Primary care provider	$$		
Urgent care center	$$$		
Emergency room	$$$$		

Cigna Healthy Rewards®[6]

Get discounts on the health products and programs you use every day for weight management, nutrition, vision, hearing care and more.

Just use your ID card when you pay and let the savings begin.

Cigna Veteran Support Line

This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer. Cigna stands ready to connect you with:

- Pain management resources.
- Substance use counseling.
- Financial support.
- Food, clothing, housing.
- Legal assistance.
- Parenting and child care.
- Aging services.
- Weekly Mindfulness for Vets sessions by phone and more.

Call **855.244.6211**.

Pain management resources

Visit **Cigna.com/helpwithpain** or text 25792 to receive tips for healthy pain management[7]

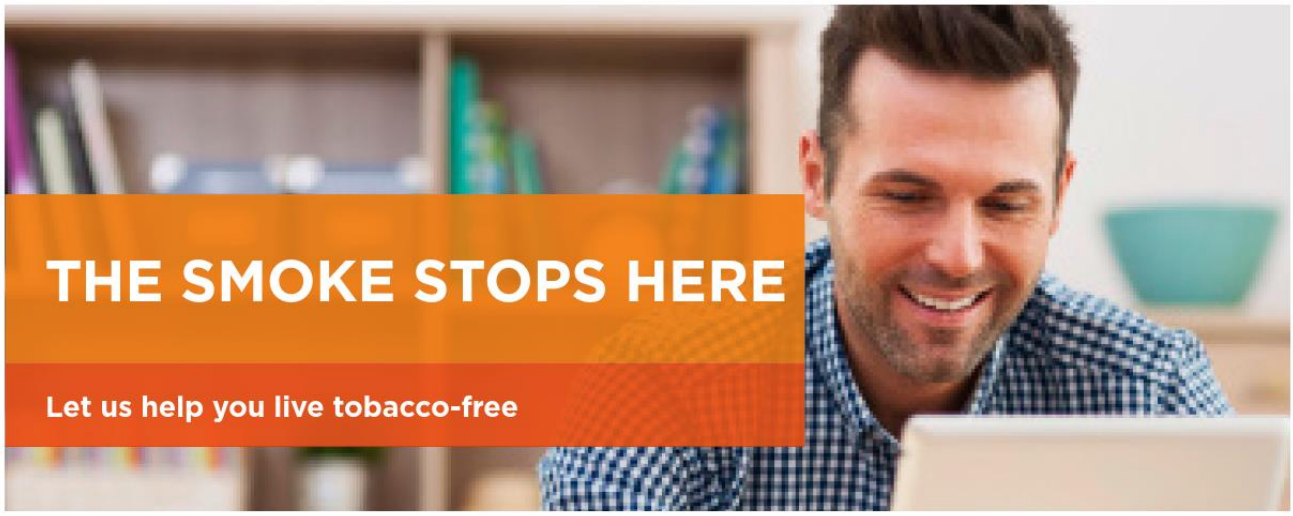
1. Plans may vary and not all preventive services are covered. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). See your plan materials for a complete list of covered preventive care services.
2. The Answers by Cigna skill is for informational and educational purposes only. You are encouraged to consult a licensed insurance agent and review your plan documents for the details of your specific health plan or insurance policy.
3. The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply.
4. Telehealth services are provided by independent third-party providers. These services are provided exclusively by such third-party providers, and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities and video chat is not available in all areas. Telehealth services may not be available to all plan types or in all areas. A primary care provider referral is not required for this service.
5. This chart is for illustrative purposes only and is not medical advice. Actual costs and wait times may vary. Always consult your doctor for appropriate examinations, treatment, testing and care recommendations, including prior to choosing a provider for care. In an emergency, dial 911 or visit the nearest emergency room.
6. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. **A discount program is NOT insurance and you must pay the entire discounted charge.**

7. Message and data rates may apply. To view our Privacy policy, please visit Cigna.com/Privacy. This service is for educational purposes only. Medical advice is not provided.

Health care providers that participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients; they are not agents of Cigna. Product availability may vary by location and plan type and is subject to change.

All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan materials.

CIGNA – TOBACCO CESSATION



If you're ready to let go of your tobacco habit, Cigna has a wide variety of online tools and personal coaching that will not only help you reach your goal, but also help you develop and maintain a healthy lifestyle.

Why quit?

You probably already know that smoking is bad for your health and that quitting will reduce your risk of getting a disease related to smoking, such as heart or lung disease. But did you also know that:

Immediate benefits[1]

Heart rate and blood pressure, which are abnormally high while smoking, begin to return to normal.

- **Within a few hours after quitting**, the carbon monoxide level in your blood drops to normal. (Carbon monoxide reduces the blood's ability to carry oxygen.)
- **Within a few weeks of quitting**, you might notice it's easier to walk up the stairs because you may be less short of breath. Cilia – tiny broom-like hairs that clean your lungs – start to regrow and regain normal function very quickly after you quit smoking.
- **Within several months** of quitting, people can expect substantial improvements in lung function.

Long-term benefits[1]

- **Quitting reduces the risk of cancer**, heart disease and Chronic Obstructive Pulmonary Disease (COPD).
- **Regardless of age, you are less likely to die from a smoking-related illness**, than those who continue to smoke.

Together, all the way.®

Cigna®

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Tobacco Cessation Coaching[2]

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum). There are two options to participate:

Over the phone

› One-on-one wellness coaching to develop a quit plan and relapse prevention strategies
› Convenient evening and weekend hours
› Program workbook and toolkit

Online

› Convenient support
› Self-paced program
› Educational materials, interactive tools and resources

Register today

You can register on the **myCigna℠ website** or **through the app.**

Health Assessment

Taking the health assessment and identifying yourself as a tobacco user puts you in touch with:

- **News and articles** on smoking health and winning strategies for quitting.
- **Ways to set goals** – like trying smoke-free nicotine patches or gums every day for a week to curb nicotine cravings.

To get started go to **myCigna.com** or **the app** to take your health assessment.

Education and support

If you're ready to quit, **myCigna.com** or **the app** can help you get started:

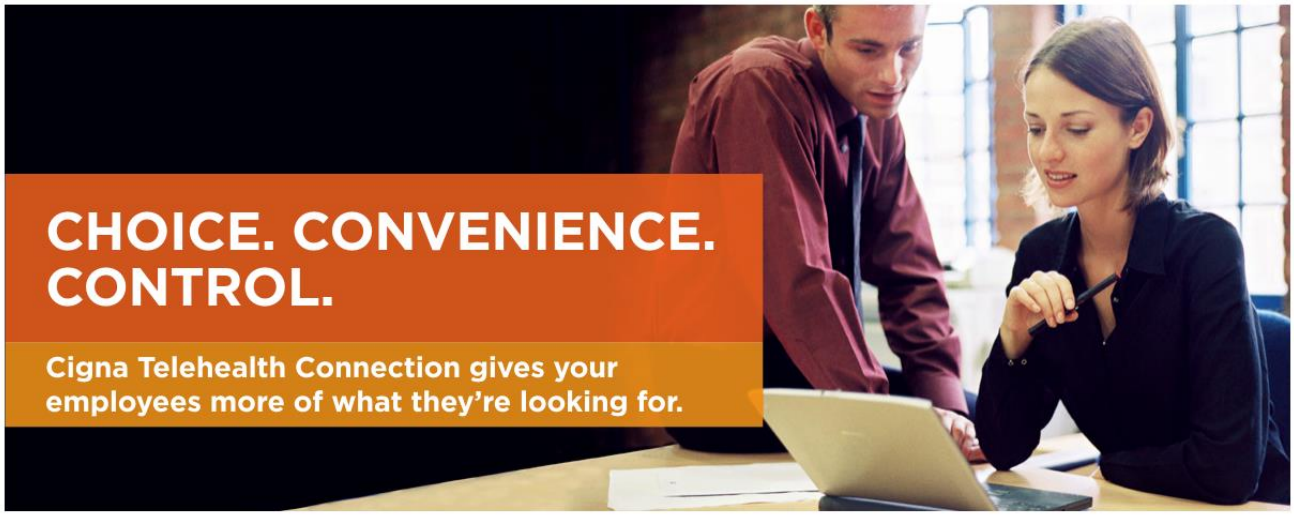
- **Information on quitting tobacco use**, including the benefits of living tobacco-free, and tips for coping with cravings and dealing with side effects like weight gain.
- **Interactive tools** that can help you decide if you're ready to quit, and demonstrate the financial benefits of a smoke-free life.
- **Videos** to help you take the necessary steps and kick your habit once and for all.

To learn more about Cigna's tobacco cessation tools – and other services to help you tackle issues like weight and stress – talk with your employer, **myCigna.com** or **the app** or call the number on the back of your Cigna ID card.

1. https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q7

2. Ask your employer if coaching is included as part of your health plan.

CIGNA TELEHEALTH – MDLIVE & AMWELL



Good news. Now, most Cigna medical plans provide covered employees with access to two telehealth services – American Well (Amwell) and MDLIVE. We call it Cigna Telehealth Connection, telehealth services designed to offer employees greater control when they need to see a doctor.

With Cigna Telehealth Connection, employees can get the care they need – including most prescriptions – for a wide range of minor conditions. They can connect with a board-certified doctor when, where and how it works best for them – via video or phone – without having to leave home or work.

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Amwell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. Giving employees an easy-to-use and cost effective alternative to care can help reduce costs and non-urgent ER visits.

We encourage you to have your employees register for one or both services, so they're ready when and if they need care.

Visit the websites*

- AmwellforCigna.com
- MDLIVEforCigna.com

Or Call*

- Amwell at 855-667-9722
- MDLIVE at 888-726-3171

Tell your employees about Cigna Telehealth Connection, so they'll be ready whenever they need these services.

Amwell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, employees have access to the **Cigna Behavioral Health** network of providers.

- Go to **Cignabehavioral.com** to search for a video telehealth specialist
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit. See your plan materials for costs and coverage details.

Together, all the way.®

Cigna®

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

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CIGNA – CLINICAL CARE PROGRAM

QUALITY RESULTS. REDUCED COSTS.

Personal Health Solutions Plus: Care management for inpatient and outpatient services.

In today's challenging times, medical costs continue to rise. Adopting the right care management approach, like Personal Health Solutions Plus (PHS+), can help improve the health of your employees and their family members and lower overall health care costs.

What is PHS+?

PHS+ helps ensure that your employees and their dependents receive the most appropriate inpatient and outpatient services – helping them find lower-cost services or avoid unnecessary or non-covered medical treatments and procedures through the process of precertification. It also enables earlier integration of case management services, allowing us to quickly identify the need for additional assistance to help them improve their health. It includes:

1 Precertification for inpatient and outpatient services, including:

INPATIENT SERVICES	OUTPATIENT SERVICES
› All inpatient admissions and non-obstetric observation stays such as: – Acute hospitals – Skilled nursing facilities – Rehabilitation facilities – Long-term acute care facilities – Hospice care – Transfers between inpatient facilities › Experimental and investigational procedures › Cosmetic procedures › Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean section)	› Outpatient surgery › High-tech radiology (MRI, CAT scans, PET scans, nuclear cardiology) › Injectible drugs (other than self-injectibles) › Durable medical equipment (DME) › Home health care/home infusion therapy › Dialysis (to direct to participating facilities) › External prosthetic appliances › Speech therapy › Cosmetic or reconstructive procedures › Infertility treatment › Radiation therapy › Sleep management › Musculoskelatal services (major joint surgery and pain management services) › Transplants

Helping you save with PHS+

The combination of inpatient and outpatient care management can result in real savings. Consider this:

69%

of physicians say the average physician prescribes an unnecessary test or procedure at least once a week.*

An inpatient case management program that begins soon after a person enters the hospital and continues throughout their stay can save 1%–2% in total medical costs.**

Including an outpatient precertification program can result in a

19%

reduction in avoidable and unnecessary outpatient procedures.**

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company or its affiliates.

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2 Inpatient case management, including:

- Continued stay review beginning soon after admission and continuing throughout the patient's stay.
- Discharge planning and immediate referrals to case managers (trained nurses) for coordination of services that occur post-discharge, such as home health care and therapies.

Why precertification?

Precertification helps individuals know in advance whether a procedure, treatment or service will be covered under their health care plan. It also helps ensure they'll get the right care in the right setting – possibly saving them from costly or unnecessary services.

Who obtains precertification?

Getting precertification for all in-network services is the responsibility of the doctor – not the individual. The individual is only responsible for getting precertification for out-of-network services.

What are the additional benefits?

For employers:

Savings

- Allows you to keep pace with technology advancements as inpatient services are transitioned to outpatient settings, by reviewing procedures and treatments for medical necessity and cost savings opportunities. Common examples include bariatric surgery, certain lumbar fusions and knee reconstruction including meniscus transplants.

Quality customer service

- Case Managers have received an over 95% overall satisfaction response*** from those enrolled in a case management program.

For employees:

Ease

- There's no extra work for individuals for any in-network services – doctors are responsible for getting precertification for all in-network services. And we've streamlined this process for them with the availability of online tools.
- The individual is only responsible for getting precertification for non-emergency services provided by a non-participating doctor and/or facility. Individuals call the customer service number on the back of their Cigna ID card to begin the precertification process for these services.

Savings

- We look for smart ways to help people save money by reviewing their services and encouraging the use of preferred facilities to lower costs, transitioning inpatient care to outpatient treatment or even helping to identify treatments or procedures which may be avoidable or unnecessary.

Helping you save with PHS+

Outpatient precertification of high-tech radiology treatment may show a

18%

reduction in unnecessary procedures.**

Redirecting requests for outpatient dialysis to participating facilities helps save approximately

$20,000

per case per year.**

Cigna's Well Informed Gaps in Care Program

Consistent with Cigna's mission to improve people's health, the Well Informed Gaps in Care program is included in PHS+.

- Uses data from lab, medical and pharmacy claims to identify possible gaps and omissions in care and communicate them to individuals and health care professionals.
- Is integrated with our case management, chronic and wellness coaching programs, Cigna Pharmacy Management®, as well as collaborative care providers.

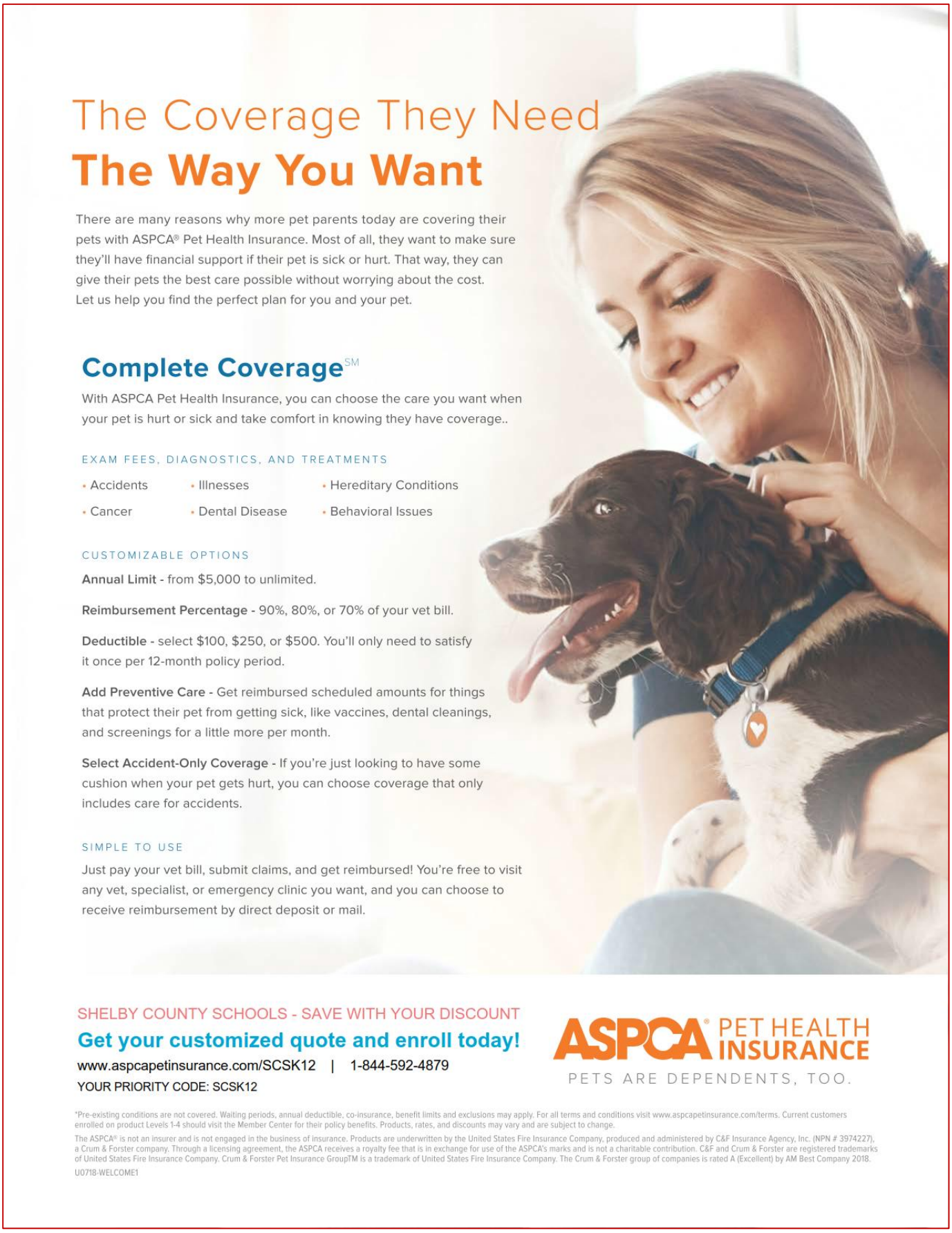
* Research Report."Choosing Wisely – Promoting Conversations between Providers and Patients," ABIM Foundation, Oct. 2017, www.choosingwisely.org/about-us/research-report/.

** Core Care Management, internal analysis of full-year 2016 nationwide book of business. Individual client savings/results may vary.

*** 2016 full-year case management satisfaction results compiled by Cigna's Quality Program and Accreditation unit. Based on responses to the 2016 National Case Management Satisfaction Survey of customers managed in Cigna's case management program.

ACTIVE & FIT FITNESS PROGRAM

PET INSURANCE



EAP SERVICES THROUGH METHODIST HEALTHCARE

What is EAP?

The Methodist Healthcare Employee Assistance Program provides confidential, professional assessment, referral and brief counseling services to you and members of your household. It is paid for by your employer.

What types of problems?

The EAP can help with life's challenges. Here are a few:

- Family issues
- Marital/relationship difficulties
- Alcohol/Drug abuse
- Anxiety or depression
- Major life events such as job loss, relocation, serious illness
- Grieving the loss of a loved one
- Coping with violence
- Improving self-esteem
- Managing the stress of everyday life
- Work/life balance

Who can use the EAP?

- You and your fellow co-workers
- All members of your household

Is it confidential?

Use of the program and issues discussed in all sessions are held in strict confidence. Information can only be released outside the EAP:

- With your written consent
- When required by law
- In life threatening situations

What is the cost?

EAP is free for you and all members of your household. In most cases, short-term counseling is all the help you'll need.

When a referral outside the EAP is indicated, the EAP counselor will seek the best resources for your situation. In most cases, employee insurance can be used to help cover these costs.

How does it work?

You or any members of your household may call the EAP to schedule an appointment with an experienced, licensed counselor. All eligible clinical staff are Certified Employee Assistance Professionals.

Together with your counselor, you will discuss the issue and create a plan of action. Most challenges can be handled at the EAP with short-term counseling.

Who do I call?

You can schedule an appointment by calling (901) 683.5658 or toll free (800) 880.5658. Regular office hours are 8:30 a.m.– 4:30 p.m., Monday through Friday. Evening appointments are also available. In crisis situations, a counselor can be reached 24 hours a day, seven days a week by calling the phone number above.

Methodist℠ Healthcare
Employee Assistance Program

LEGAL & ID THEFT INSURANCE

LegalShield® | IDShield®

Shelby County Schools

www.legalshield.com/info/scsk12

HAVE YOU EVER?

- ☐ Needed your Will prepared or updated
- ☐ Been overcharged for a repair or paid an unfair bill
- ☐ Had trouble with a warranty or defective product
- ☐ Signed a contract
- ☐ Received a moving traffic violation
- ☐ Had concerns regarding child support
- ☐ Worried about being a victim of Identity theft
- ☐ Been concerned about your child's identity
- ☐ Lost your wallet
- ☐ Worried about entering personal information online
- ☐ Feared the security of your medical information
- ☐ Been pursued by a collection agency

THE LEGALSHIELD MEMBERSHIP INCLUDES:

- **Dedicated Law Firm**
- **Legal Advice/Consultation** on unlimited personal issues
- **Letters/Calls** made on your behalf
- **Contracts/Documents Reviewed** up to 15 pages
- **Residential Loan Document Assistance**
- **Lawyers prepare your Will/Living Will/Health Care Power of Attorney/Financial Power of Attorney**
- **Speeding Ticket Assistance**
- **IRS Audit Assistance**
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** for covered situations

Put your law firm in the palm of your hand with the LegalShield mobile app

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children.

This is general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

THE IDSHIELD MEMBERSHIP INCLUDES:

- **Social Media Monitoring**
  Allows you to monitor multiple social media accounts and content feeds for privacy and reputational risks.
- **Privacy and Security Monitoring**
  Internet monitoring of your name, date of birth, SSN, email address, phone numbers, and more. Monthly credit score tracking. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18 for no additional cost.
- **Consultation**
  Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.
- **Full Identity Restoration**
  Complete identity recovery services by Kroll Licensed Private Investigators to its pre-theft status.
- **$5 Million Service Guarantee**
  We'll do whatever it takes for as long as it takes to help recover and restore your identity.

Put Identity Theft Protection in the palm of your hand with the IDShield mobile app

IDShield family coverage includes, the member, member's spouse and up to 8 minor children under the age of 18.

Dependents age 18-26 receive consultation and restoration only.

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

PAYMENT METHOD MONTHLY		
LegalShield	$18.95	
IDShield	$8.95 - Individual	$18.95 - Family
Combined	$27.90	$33.90

FOR MORE INFORMATION, CONTACT YOUR INDEPENDENT ASSOCIATE:

Sharon Larry
404-918-4980
klarrity@gmail.com
Member Services: 800-654-7757

FLIER_LS+IDS_USA_032918

FINANCIAL WELLNESS

tuition.io

Student Loan Wellness Tools

Here's how we can help you with student loan repayment

Learn the Best Way to Manage Your Student Loans

Paying off student loans can be difficult, but our wellness resources can help you avoid making costly mistakes.

Optimizer

We've put together over 150 different strategies to optimize your repayment plan.

Refinancing

Learn all you need to know about refinancing your student loans.

Glossary

Student loan terminology can be confusing, and we can help you master the jargon.

How to Financially Prepare for College

Even if you don't have any loans yourself, it's never to late to start planning for your child's future.

Paying for College

Learn about the different types of student aid available, and how to apply for loans.

College Cost Calculator

Lets you estimate how much you'll need to save for your child's education, based on the year college starts, state, type of school, and number of years in college.

Student Loan Coach

Our student loan coach Jeni Burkhart will answer your most pressing questions about student loan debt and repayment.

Legal Notices

IMPORTANT NOTICE ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage you have under the medical plans sponsored by Shelby County Schools is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2019. (This is known as "creditable coverage.")

Why this is important. If you or a covered dependent are enrolled in any prescription drug coverage in 2019 and are, or become, covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty -- as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read this notice carefully. It has information about prescription drug coverage available under Shelby County Schools' medical plans and prescription drug coverage available through Medicare. It also tells you where you can get help to make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered under any of Shelby County Schools' medical plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2019. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Shelby County Schools' plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Shelby County Schools' coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Shelby County Schools' plans.

You should know that if you waive or leave coverage with Shelby County Schools and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if your Shelby County Schools' coverage changes, or upon your request.

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- **Visit www.medicare.gov for personalized help.**
- **Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).**
- **Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.**

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this creditable coverage notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Shelby County Schools
Employee Benefits
160 S. Hollywood Street
Memphis, TN 38112
(901) 416-5300
http://www.scsk12.org/benefits

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 July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: 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
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're receiving this notice because you are covered under the 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 [*choose and enter appropriate information:* must pay *or* aren't required to 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; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

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. If the notice is not received within the 60-day period, the dependent or spouse will not be entitled to choose continuation coverage. You must provide this notice to Shelby County Schools (please see Plan Contact Information section of this notice).

If you do not choose continuation coverage within the 60-day period, your group health coverage will end at the end of the month in which the qualifying event occurs.

How is COBRA 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.

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

Shelby County Schools
160 S. Hollywood Street
Memphis, TN 38112
(901) 416-5300
www.scsk12.org

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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 the Shelby County Schools' medical plans. Specific deductibles and coinsurance applicable to each of Shelby County Schools' medical plans are included in this enrollment guide and in the medical Summary Plan Descriptions. If you would like more information on WHCRA benefits, call your plan administrator at (901) 416-5300.

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) 416-5300.

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL COVERAGE

If you have declined enrollment in a Shelby County Schools' 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 Shelby County Schools' medical plan without waiting for the next Annual 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.

Shelby County Schools' 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 Shelby County Schools' health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Shelby County Schools Board of Education Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Shelby County Schools Board of Education health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Dental, Vision, Health Reimbursement Account, and Flexible Spending Account. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Shelby County Schools Board of Education as an employer — that's the way the HIPAA rules work. Different policies may apply to other Shelby County Schools Board of Education programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Personal Health Information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Shelby County Schools Board of Education

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Shelby County Schools Board of Education for plan administration purposes. Shelby County Schools Board of Education may need your health information to administer benefits under the Plan. Shelby County Schools Board of Education agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefit department employees are the only Shelby County Schools Board of Education employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Shelby County Schools Board of Education, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Shelby County Schools Board of Education, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or

terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Shelby County Schools Board of Education information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Shelby County Schools Board of Education cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Shelby County Schools Board of Education from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other Federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized Federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse
You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out-of-pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.
If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

The access or copies you requested

- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.
- You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information, but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via email.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, you may file a written complaint with the Benefits Departments.

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact:

Benefits Department
Shelby County Schools Board of Education
160 S. Hollywood Street
Memphis, TN 38112
(901) 416-5300

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 _____.

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)	
Shelby County Schools Board of Education	62-6000834	
5. Employer address	**6. Employer phone number**	
160 S. Hollywood Street	(901) 416-5300	
7. City	**8. State**	**9. ZIP code**
Memphis	TN	38112
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) 416-5344	benefits@scsk12.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:
    All full-time employees
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Outlined in the Annual Enrollment Guide.
  - ☐ 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? $ $93
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

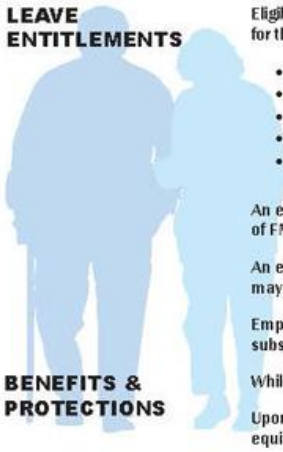
If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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)

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

WHO TO CONTACT WITH QUESTIONS

Plan	Who to Call	Web Address	Phone Number
Medical	Cigna	www.mycigna.com	***Annual Enrollment Questions:*** 1-800-401-4041 ***On-going Customer Service:*** 1-800-736-7568
Dental	Cigna	www.mycigna.com	
Vision	Cigna	www.mycigna.com	
Flexible Spending Accounts	ConnectYourCare	www.ConnectYourCare.com	***Customer Service:*** 1-833-799-1788
Life Insurance	Securian	www.securian.com	***Customer Service:*** *Basic Life Insurance* 1-901-416-5344 *Supplemental Life Insurance* 1-866-492-6983
Voluntary Long-Term Disability	The Standard	www.standard.com/presentations/shelby_county/board_education/	***Customer Service:*** 1-888-937-4783
Employee Assistance Program (EAP)	Methodist Healthcare		***Schedule Appointment:*** 1-901-683-5658 or 1-800-880-5658
Pet Insurance	ASCPA	www.ascpapetinsurance.com/SCSK12 Priority Code: SCSK12	***Customer Service:*** 1-844-592-4879
Legal / ID Theft	LegalShield / IDShield	www.legalshield.com/info/scsk12	***Member Services:*** 1-800-654-7757
Healthcare Clinics – Gray Creek or Flicker	SCS Family Care Clinics	http://www.scsk12.org/?LP=employee&page=family	***Schedule Appointment:*** ***1-901-416-6079***

This annual enrollment guide is intended to be a summary of the benefit programs offered by Shelby County Board of Education. If you would like further details about any of the benefit offerings described herein, refer to each plan's official policy relating to that benefit. Policies are available upon request by contacting the Shelby County Schools' Benefits Department.

Shelby County Board of Education always works to ensure information provided to employees is accurate. However, if for some reason the information in this annual enrollment guide conflicts with any information in the plan or benefits policy, the plan or policy document will govern. Shelby County Board of Education reserves the right to amend, suspend or terminate these plans at any time.

Shelby County Schools
160 S. Hollywood Street
Memphis, TN 38112