Benefits & You
Your 2018 guide to benefits for your health
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Shelby County Schools Employees:

We understand how hard you all work, and it would be impossible to fully express our gratitude. Our people truly are our best asset, and we hope our benefits offering for 2018 reflects that **We are excited to offer increased benefits next year with no change—and in some cases—a reduction, in cost.** This is a testament to the positive engagement of our workforce. The wellness activities you took part in over the past year played a large part in the positive financial experience our plans have seen. We hope that over the coming year you will continue to participate in initiatives that help us all build a strong and healthy work environment.

Below are the highlights for your 2018 benefits:

- Medical, dental, and vision premium rates will remain the same. There will be no increase.
- Long-term disability premiums are being reduced, and these rates will not change for the next three years.
- A short-term disability plan is being introduced with two different options to best suit your needs.
- Life insurance will continue to be offered at a steep discount, with no evidence of good health required to purchase.

The change we are most excited about is the introduction of a new **Flexible Spending Account** vendor, ConnectYourCare. ConnectYourCare has sophisticated mobile technology, including an online store, which allows you to use FSA funds to purchase items that are IRS-qualified.

We hope this is a small demonstration of our commitment to provide a benefits package that meets the evolving needs of our employees.

Again, thank you all for all that you do, and let’s have a great 2018.

Dorsey E. Hopson, II
Superintendent
Open Enrollment Benefits Fair
will be held on:
Thursday, November 2, 2017, from 4 – 6 PM
Board of Education’s Avery Auditorium
160 S. Hollywood

Benefits & You

What You Need to Know for the Upcoming 2018 Annual Open Enrollment

- The annual open enrollment period begins on Monday, October 30, 2017, and ends Friday, November 17, 2017.
- There is no change in employee contributions for medical, dental or vision coverage for 2018.
- If you wish to make a change during this period, it will be effective January 1, 2018, to December 31, 2018.
- A new group sponsored disability program, providing both short and long term disability, will be implemented through MetLife for 2018. You will automatically be enrolled for this coverage. You must opt out to decline coverage.
- Employees may continue their current payroll deducted supplemental benefits.
- During this open enrollment period, employees may elect basic and optional life insurance without evidence of insurability. This means you can elect life insurance without evidence of good health even if you have never purchased coverage before. You may also increase your coverage. Note, you must elect basic life insurance to participate in optional life coverage.
- If you wish to participate in a Healthcare Flexible Spending or Dependent Care Flexible Spending Account for 2018, you MUST access the system and enter your contribution amount during the enrollment window. This benefit will not continue based on previous elections. ConnectYourCare will begin administering SCS’ FSA program as of January 1, 2018.
- If you have used tobacco regularly since January 1, 2017, you will be subject to a premium surcharge until you successfully complete Cigna’s Quit Today program.
- Affordable Care Act Record Accuracy - SCS must report to the IRS information about coverage for 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.

Choose your benefits wisely as there will not be another Annual Open Enrollment opportunity for 2018 benefits. Your next opportunity to make benefit changes will be the next Annual Open Enrollment period – Fall 2018, 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 Cigna’s new Online Benefits website www.cgsmarketplace.com between October 30, 2017 – November 17, 2017, and use the convenient benefits enrollment tool. Please see pages 14 & 15 for more information on how to enroll.
Benefits that Require Re-enrollment
If you wish to use a flexible spending account to pay for healthcare and dependent care, i.e. childcare for your children under age 13, you must re-enroll for 2018 even if you are currently enrolled in one of these plans.

Flexible Spending Accounts for Healthcare and Dependent Care
You are able to put aside funds from your paycheck on a “pre-tax” basis to pay for health care and/or dependent care expenses. You must re-enroll if you want to have funds deducted from your paycheck. ConnectYourCare will begin administering SCS’ FSA program beginning January 1, 2018. Please visit their website at www.connectyourcare.com for more information about their easy to use reimbursement process and balance updates.

Your Benefits
This Annual Open Enrollment Guide provides highlights of benefits and features of the health care and other plans available to you as an employee of Shelby County Schools.

This booklet contains:
• Benefit plan descriptions
• Per paycheck rates for each benefit plan
• Instructions on how to enroll
• Annual notices
• Who to contact with questions

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:
  o are also employed or retired from Shelby County Schools and whose employer does NOT provide medical coverage; or
  o 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 Shelby County Schools’ health plan.

**Tobacco Surcharge**

The tobacco surcharge will remain in place for the 2018 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, 2017. 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.
Medical Benefits – Cigna – No changes in benefit options OR cost for 2018

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

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 for 2018

- Cigna’s Value Prescription Drug formulary will be effective in 2018. This means you may see changes in your prescription drug coverage. For example, you will pay the full cost of prescription drugs available “over the counter.” These are medications available without a prescription.

- Employees enrolling in the Choice Fund HRA option have access to 100% of their Annual Health Fund on January 1, 2018.

- 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 2018 plan year. Check out mycigna.com for more information.
  - “Quit Today” tobacco cessation program
  - “MDLive” allows you to access a physician online, saving you time and money
  - “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

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 for some of the costs 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’ 2018 contribution amounts for the HRA. 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 and identifies the amount due to the provider, including any discounts.
- Claims are deducted from your HRA account up to the balance of your account. Once the HRA fund balance has been exhausted, then ongoing claims are paid by the employee as part of the deductible. When those two parts have been exhausted, then the plan acts like a traditional major medical plan where the employer pays 70% and the employee picks up the remaining 30%, up to the out-of-pocket maximum.
- If you leave the plan or Shelby County Schools, your HRA account stays behind.
- You may rollover funds from one year to the next.
- **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.
## Dental Benefits – Cigna

### What You Need to Know for 2018

- No changes to the Dental benefit options OR cost for 2018.
- The DEPO plan is now called the DPPO Advantage plan.
- Because the DPPO Advantage plan network is smaller, please make sure your dentist is a participating provider in this network prior to receiving services.

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

*After deductible
## Vision Benefits – Cigna

### What You Need to Know for 2018
- No changes to vision benefits OR cost in 2018.
- Review the copays and benefits shown below.

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

You have the opportunity to enroll in SCS’ new comprehensive short- and long-term disability program. These new plans pay a benefit equal to 60% of your salary for up to 26 weeks for short term disability (STD) and up to five years for long term disability (LTD), as long as you are considered disabled. The new program is offered through MetLife and features lower cost, competitive group insurance rates. You do not need to provide proof of good health to enroll for coverage.

NEW STD & LTD PROGRAM FEATURES

- There are two STD options – one that begins paying your benefit after a 7 day waiting period, and one that begins benefit payments after a 30 day waiting period
- Both STD options provide benefits for 26 weeks (or 6 months)
- LTD benefits begin after you’ve been disabled for 6 months
- Both STD & LTD provide a benefit equal to 60% of your pre-disability earnings
- The maximum benefit is $1,500 per week or $6,500 per month
- A minimum benefit equal to the greater of $100 per month or 10% of your LTD benefit, after you’ve been disabled for 6 months, coverage is available through the LTD plan

Pre-existing Condition Exclusion: There is no pre-existing condition exclusion under the new STD plan. If you have been covered under The Standard LTD plan, there is no pre-existing exclusion for LTD coverage. If you have not been covered under The Standard LTD plan, treatment for an illness or injury 90 days prior to your insurance effective date will be excluded from coverage for a period of 12 months. There is no limitation after you’ve been insured for 12 months.

You do not have to provide evidence of good health to be covered on your initial enrollment date. If you decline coverage and want to enroll later, evidence of good health will be required.

You will automatically be enrolled in the 30-day STD and LTD plans, unless you decide to opt out of coverage. Below is a sampling of the monthly cost for the combined 30-day STD and LTD plan:

<table>
<thead>
<tr>
<th>Monthly Salary</th>
<th>STD 30 Day Waiting Period</th>
<th>STD 24 Pay Cost / Paycheck</th>
<th>LTD 24 Pay Cost / Paycheck</th>
<th>Total 24 Pay Cost / Paycheck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages:</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Pay Cost / Paycheck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,000</td>
<td>$3.81</td>
<td>$3.69</td>
<td>$5.65</td>
<td>$0.58</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1.00</td>
</tr>
<tr>
<td>$3,000</td>
<td>$5.71</td>
<td>$5.54</td>
<td>$8.48</td>
<td>$0.88</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1.50</td>
</tr>
<tr>
<td>$4,000</td>
<td>$7.62</td>
<td>$7.38</td>
<td>$11.31</td>
<td>$1.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2.00</td>
</tr>
</tbody>
</table>

You do have the option to purchase only STD coverage (either the 7-day or the 30-day plan), or only LTD coverage if you choose. After open enrollment, you will receive a group insurance certificate containing a detailed description of the STD and LTD 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 Flexible Spending Accounts is one relatively easy way to get more out of your pay. An FSA plan provides you the option of electing pre-tax payroll deductions for certain eligible health care and/or child/dependent care expenses for children under age 13. Because the expenses are paid with pre-tax dollars, the result is immediate tax savings.

2018 Contribution Limits

<table>
<thead>
<tr>
<th></th>
<th>Annual Minimum</th>
<th>Annual Maximum (set by the IRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare FSA</td>
<td>$300</td>
<td>$2,650</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>$600</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

The plan year begins 1/1/2018 and ends on 12/31/2018. Shelby County Schools does not allow a rollover of any unused funds 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 costs such as:

- Copays and doctor’s fees
- Prescribed over-the-counter drugs and prescriptions
- Dental and eye care expenses
- Daycare expenses (children under age 13)

A complete list of qualified expenses can be found at www.connectyourcare.com. New enhancements include the FSA Store.

You have until March 31, 2018 to receive reimbursement for any 2017 FSA expenses. These should be forwarded to CPN, SCS’ current FSA vendor. Any FSA expense incurred in 2018 will be processed by ConnectYourCare.

Employee Assistance Plan (EAP)

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

Employee Basic & Optional Life Insurance – Open Enrollment

An open enrollment is being held for the 2018 plan year for employee basic and optional life insurance. If you have not elected basic life insurance in the past, you can elect coverage of two times your pay without providing evidence of good health.

If you have never purchased optional life insurance in the past, you can elect up to $10,000 without evidence of good health. Current optional life insurance participants are able to increase their coverage by $10,000 without evidence of good health. **You must purchase basic life insurance to be able to elect optional life insurance.**
What You Need to Know for 2018

- **THERE ARE NO CHANGES IN THE MEDICAL, DENTAL OR VISION COSTS FOR 2018.**
- Employee contributions will be deducted over 24-pay periods 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.

## Employee Contributions

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>20-Pay Premiums</th>
<th>24-Pay Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Tobacco</td>
<td>Tobacco</td>
</tr>
<tr>
<td>OAP IN-NETWORK PLUS Option</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$125.81</td>
<td>$155.81</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$280.39</td>
<td>$310.39</td>
</tr>
<tr>
<td>Family</td>
<td>$391.13</td>
<td>$421.13</td>
</tr>
<tr>
<td>OAP BASIC Option</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$88.09</td>
<td>$118.09</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$215.32</td>
<td>$245.32</td>
</tr>
<tr>
<td>Family</td>
<td>$300.36</td>
<td>$330.36</td>
</tr>
<tr>
<td>CHOICE FUND HRA Option</td>
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<td></td>
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<tr>
<td>Employee</td>
<td>$55.80</td>
<td>$85.80</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$147.76</td>
<td>$177.76</td>
</tr>
<tr>
<td>Family</td>
<td>$206.12</td>
<td>$236.12</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>20-Pay Premiums</th>
<th>24-Pay Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$3.06</td>
<td>$2.55</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$5.86</td>
<td>$4.89</td>
</tr>
<tr>
<td>Family</td>
<td>$9.50</td>
<td>$7.92</td>
</tr>
</tbody>
</table>
Short Term Disability Rates – MetLife

7-Day Option - STD Plan Rates per $10 of Weekly Benefit

<table>
<thead>
<tr>
<th>Age Bands</th>
<th>&lt;24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-pay rate</td>
<td>$0.25</td>
<td>$0.27</td>
<td>$0.27</td>
<td>$0.25</td>
<td>$0.27</td>
<td>$0.33</td>
<td>$0.40</td>
<td>$0.49</td>
<td>$0.58</td>
<td>$0.70</td>
</tr>
<tr>
<td>24-pay rate</td>
<td>$0.21</td>
<td>$0.22</td>
<td>$0.23</td>
<td>$0.20</td>
<td>$0.22</td>
<td>$0.27</td>
<td>$0.33</td>
<td>$0.41</td>
<td>$0.48</td>
<td>$0.58</td>
</tr>
</tbody>
</table>

30-Day Option - STD Plan Rates per $10 of Weekly Benefit

<table>
<thead>
<tr>
<th>Age Bands</th>
<th>&lt;24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-pay rate</td>
<td>$0.16</td>
<td>$0.16</td>
<td>$0.17</td>
<td>$0.15</td>
<td>$0.16</td>
<td>$0.20</td>
<td>$0.25</td>
<td>$0.30</td>
<td>$0.36</td>
<td>$0.43</td>
</tr>
<tr>
<td>24-pay rate</td>
<td>$0.13</td>
<td>$0.13</td>
<td>$0.14</td>
<td>$0.13</td>
<td>$0.13</td>
<td>$0.16</td>
<td>$0.20</td>
<td>$0.25</td>
<td>$0.30</td>
<td>$0.35</td>
</tr>
</tbody>
</table>

To calculate your 20- or 24-pay period cost, please use the following formula. Your rate is based on your age:

\[
\text{Your Pay period cost} = \left( \frac{\text{Your Annual Earnings}}{52} \right) \times 0.6 \div 10 \times \text{20- or 24-pay Rate from above}
\]

Examples of Cost Per Pay Period for the 30-Day STD Option:

Mary earns $52,500 annually and is 30 years of age. She is paid 24-pays per year. Based on her age, the STD rate for the 30-day STD option is $0.14.

\[
\frac{52,500}{52} \times 0.6 \div 10 \times \frac{0.14}{20} = 8.48
\]

Richard earns $75,000 annually and is 58 years of age. He is paid 20-pays per year. Based on his age, the STD rate for the 7-day STD option is $0.49.

\[
\frac{75,000}{52} \times 0.6 \div 10 \times \frac{0.49}{20} = 25.95
\]

To make the best choice of disability coverage, make sure you compare the cost you've calculated here to any other supplemental disability programs offered to you. You will automatically be enrolled in the 30-Day STD Plan and LTD Plan unless you opt-out.
Long Term Disability Rates – MetLife

LTD Plan Rates per $100 of Covered Salary

<table>
<thead>
<tr>
<th>Age Bands</th>
<th>&lt; 24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-pay rate</td>
<td>$0.01</td>
<td>$0.02</td>
<td>$0.04</td>
<td>$0.04</td>
<td>$0.06</td>
<td>$0.09</td>
<td>$0.12</td>
<td>$0.13</td>
<td>$0.14</td>
<td>$0.14</td>
</tr>
<tr>
<td>24-pay rate</td>
<td>$0.01</td>
<td>$0.01</td>
<td>$0.03</td>
<td>$0.03</td>
<td>$0.05</td>
<td>$0.07</td>
<td>$0.10</td>
<td>$0.11</td>
<td>$0.11</td>
<td>$0.12</td>
</tr>
</tbody>
</table>

To calculate your 20- or 24-pay period cost, please use the following formula. Your rate is based on your age:

\[
\frac{\text{Your Annual Earnings}}{12} \div 100 = \frac{\text{Your Monthly Earnings}}{\text{20- or 24-pay Rate from above}} \times \text{Your Pay period cost}
\]

Examples of Per Pay Period Cost:

**Carla** earns $30,000 annually and is 25 years of age. She is paid 24-pays per year. Based on her age, the LTD rate is $0.01.

\[
\frac{\$30,000}{12} \div 100 = \frac{\$2,500}{\$25.00} \times \$0.01 = \$0.25
\]

**Tonya** earns $50,000 annually and is 55 years of age. She is paid 20-pays per year. Based on her age, the LTD rate is $0.13.

\[
\frac{\$50,000}{12} \div 100 = \frac{\$4,167}{\$41.67} \times \$0.13 = \$5.42
\]

To make the best choice of disability coverage, make sure you compare the cost you’ve calculated here to any other supplemental disability programs offered to you. You will automatically be enrolled in the 30-Day STD Plan and LTD Plan unless you opt-out.

Life Insurance Rates – Minnesota Life

The cost for Basic Life & AD&D coverage is $0.0324 per $1,000 of coverage for 20 pay periods, and $0.027 per $1,000 of coverage for 24 pay periods. Optional Life insurance rates per $1,000 of coverage are outlined below.

<table>
<thead>
<tr>
<th>Optional Life</th>
<th>&lt; 30</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-pay rate</td>
<td>$0.026</td>
<td>$0.037</td>
<td>$0.045</td>
<td>$0.047</td>
<td>$0.068</td>
<td>$0.105</td>
<td>$0.196</td>
<td>$0.301</td>
<td>$0.580</td>
<td>$0.939</td>
</tr>
<tr>
<td>24-pay rate</td>
<td>$0.022</td>
<td>$0.031</td>
<td>$0.038</td>
<td>$0.039</td>
<td>$0.057</td>
<td>$0.088</td>
<td>$0.164</td>
<td>$0.251</td>
<td>$0.483</td>
<td>$0.783</td>
</tr>
</tbody>
</table>
Annual Enrollment – Instructions for New Enrollment Site

1. **Access the new Cigna Guided Solutions Enrollment site**
   Go to [www.cgsmarketplace.com](http://www.cgsmarketplace.com)

2. **Access or Register to use the Enrollment site**
   **Do one of the following:**
   - If you have been a Cigna customer, 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 Cigna customer, or were an existing Cigna customer 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 1.855.221.0273.

   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 Annual 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 for 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 spending accounts, employee basic life, supplemental life, short term, 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 to coverage.

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!**

   **CHECKOUT**
   
   Review and/or edit your benefit choices, and then submit to complete your enrollment. You’ll have another opportunity to view and print your enrollment details after you submit.
   
   **SUBMIT YOUR BENEFIT CHOICES**

   - If you need to make changes, you may do so throughout the enrollment period, but 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.
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 2018. (This is known as “creditable coverage.”)

Why this is important. If you or a covered dependent are enrolled in any prescription drug coverage in 2018 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 2018. 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:

- 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](http://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 August 10, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
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<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tbody>
<tr>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIP)</td>
</tr>
<tr>
<td>Website: <a href="http://myakhhipp.com/">http://myakhhipp.com/</a></td>
<td>Phone: 404-696-4597</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td></td>
</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myarhhipp.com/">http://myarhhipp.com/</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-438-4479</td>
</tr>
<tr>
<td></td>
<td>All other Medicaid</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
</tr>
<tr>
<td></td>
<td>Phone 1-800-403-0864</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>IOWA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
<td>Phone: 1-888-346-9562</td>
</tr>
<tr>
<td>CHP+: Colorado.gov/HCDF/Child-Health-Plan-Plus</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Website</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Kentucky – Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
</tr>
<tr>
<td>Louisiana – Medicaid</td>
<td><a href="http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331">http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
</tr>
<tr>
<td>Missouri – Medicaid</td>
<td><a href="http://www.dss.mo.gov/mbd/participants/pages/hipp.htm">http://www.dss.mo.gov/mbd/participants/pages/hipp.htm</a></td>
</tr>
<tr>
<td>Montana – Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP</a></td>
</tr>
<tr>
<td>Nevada – Medicaid</td>
<td><a href="https://dwws.nv.gov/">https://dwws.nv.gov/</a></td>
</tr>
<tr>
<td>New Jersey – Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahlhs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahlhs/clients/medicaid/</a></td>
</tr>
<tr>
<td>North Carolina – Medicaid</td>
<td><a href="https://dhs.ncdhhs.gov/">https://dhs.ncdhhs.gov/</a></td>
</tr>
<tr>
<td>Oklahoma – Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
</tr>
<tr>
<td>Rhode Island – Medicaid</td>
<td><a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
</tr>
<tr>
<td>South Carolina – Medicaid</td>
<td><a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
</tr>
<tr>
<td>SOUTH DAKOTA – Medicaid</td>
<td>WASHINGTON – Medicaid</td>
</tr>
<tr>
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</tr>
<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
</tr>
<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
</tr>
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<thead>
<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</td>
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</tbody>
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<tr>
<th>UTAH – Medicaid and CHIP</th>
<th>WISCONSIN – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-877-543-7669</td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
</tr>
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<tr>
<td>Phone: 1-800-250-8427</td>
<td>Phone: 307-777-7531</td>
</tr>
</tbody>
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<thead>
<tr>
<th>VIRGINIA – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Website: <a href="http://www.coverva.org/programs/premium_assistance.cfm">http://www.coverva.org/programs/premium_assistance.cfm</a></td>
</tr>
<tr>
<td>Medicaid Phone: 1-800-432-5924</td>
</tr>
<tr>
<td>CHIP Website: <a href="http://www.coverva.org/programs/premium_assistance.cfm">http://www.coverva.org/programs/premium_assistance.cfm</a></td>
</tr>
<tr>
<td>CHIP Phone: 1-855-242-8282</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor
  Employee Benefits Security Administration
  [www.dol.gov/agencies/ebsa](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ compensation</td>
<td>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.</td>
</tr>
<tr>
<td>Necessary to prevent serious threat to health or safety</td>
<td>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.</td>
</tr>
<tr>
<td>Public health activities</td>
<td>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.</td>
</tr>
<tr>
<td>Victims of abuse, neglect, or domestic violence</td>
<td>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 if 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).</td>
</tr>
<tr>
<td>Judicial and administrative proceedings</td>
<td>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).</td>
</tr>
<tr>
<td>Law enforcement purposes</td>
<td>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.</td>
</tr>
<tr>
<td>Decedents</td>
<td>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.</td>
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</tbody>
</table>
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

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.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelby County Schools Board of Education</td>
<td>62-6000634</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>160 S. Hollywood Street</td>
<td>(901) 416-5300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memphis</td>
<td>TN</td>
<td>38112</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?
Benefits Department

11. Phone number (if different from above)
(901) 416-3344

12. Email address
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:

  [x] Some employees. Eligible employees are:
  All full-time employees

  - With respect to dependents:
    [x] 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. 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 employers 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)
   - 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? $________

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? $________

* 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)(i) 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 service member’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 service member with a serious injury or illness.

An employee does not need to use leave in one block. Where 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. An employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer’s normal paid leave policies.

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 an employee 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.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS
An employee who works for a covered employer must meet these 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 possible to give 30 days’ notice, or employee must notify the employer as soon as possible and, generally, follow the employer’s usual procedures.

Employers do not have to provide 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 the employee 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 the employee 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
(1-866-487-6243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division

WHI 420 REV 04’10
Shelby County Schools
403(b) Vendors
Address & Agents

**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 – (316) 774-8948
Robert Stagoski – (901) 683-8146
Season Caulkins – (901) 489-9486
Allan Phillips – (601) 954-7396

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

**Representatives**
Stephen Boyd
Jim Gammon
Nedia Brassell

**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
(901) 758-1321 Ext.#135

Representatives
Van D. McClain-(901) 378-6444
Ken Hanna-(901) 734-7099
Johnnie Elliott – (901) 579-9937

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
Scott Powers
Mitch Powell
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

Great West (EMPOWER)
545 Mainstream Dr., Suite 407
Nashville, TN 37228
1.800.922.7772

Rosaline Banks
Rosaline.Banks@empower-retirement.com

403(b) Vendors Contact Information

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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.
## Who to Contact with Questions

<table>
<thead>
<tr>
<th>Plan</th>
<th>Who to Call</th>
<th>Web Address</th>
<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td>Medical</td>
<td>Cigna</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
<td><strong>Annual Enrollment Questions:</strong> 1-800-401-4041</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>On-going Customer Service:</strong> 1-800-736-7568</td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Cigna</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
<td></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>ConnectYourCare</td>
<td><a href="http://www.ConnectYourCare.com">www.ConnectYourCare.com</a></td>
<td><strong>Customer Service:</strong> 1-877-292-4040</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Minnesota Life</td>
<td><a href="http://www.securian.com">www.securian.com</a></td>
<td><strong>Customer Service:</strong> 1-866-293-6047</td>
</tr>
<tr>
<td>Short and Long Term</td>
<td>MetLife</td>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
<td><strong>Claims:</strong> 1-800-300-4296</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td><strong>Questions:</strong> 1-800-GET MET8 (1-800-438-6388)</td>
</tr>
</tbody>
</table>

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.