



*For active full time
permanent employees*



Benefits & You

Your 2017 guide to benefits for your health



**Annual Open Enrollment Meetings will be held
at the Board of Education:**

- **October 20, 2016 from 4-6 PM**
- **October 27, 2016 from 4-6 PM**

Frances E. COE Administration Building Auditorium

Benefits & You

What You Need to Know for the Upcoming 2017 Annual Open Enrollment

The annual enrollment period begins on October 17, 2016 at 8 a.m. and **ENDS on November 4, 2016 at 5 p.m.**

- Beginning in 2017, the District is changing to a calendar plan year for benefits. Benefits from this annual enrollment will be effective January 1, 2017 - December 31, 2017.
- There are changes to copayments, deductibles, and out of pocket maximums for all three medical options. These changes are clearly outlined on page 2, 3, and 4 of this guide.
- If you wish to participate in a Healthcare Flexible Spending or Dependent Care Flexible Spending Account for 2017, you must access the system and enter your contribution amount during the enrollment window. This benefit **will not** continue based on previous elections.
- If you do not make any changes, your current benefit elections for Medical, Dental, Vision, Basic Life, and Long Term Disability will remain in place for the 2017 plan year; however, plan changes as described in this guide will be applicable.
- CIGNA will be the vision provider in 2017. New ID cards from CIGNA will be sent to enrolled employees.
- If you have used tobacco regularly since January 1, 2016, 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 # (please review the actual card for accuracy), and correct date of birth.

Choose your benefits wisely as there will not be another Annual Enrollment opportunity for 2017 benefits. Your next opportunity to make benefit changes will be the next Annual Enrollment period during the fall of 2017, for 2018 benefits, unless you experience a qualified life event change (i.e., birth of a child, marriage, etc.).

Once you review your benefit options and are ready to do your online enrollment, go to the Online Benefits website www.benefitsinsight.com between **October 17, 2016 – November 4, 2016** and use the convenient benefits enrollment tool. Please see pages 14 & 15 for more information on how to enroll.

Benefits that Require Re-enrollment

Shelby County Schools will continue to offer the following plan options for 2017. To continue to have coverage for the 2017 plan year, you must re-enroll 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 healthcare and/or dependent care expenses.

2017 Medical Plan Design Changes

The information below compares the benefit for 2016 vs. the benefit for 2017. Some **items are not reflected in this table as they did not change**. Complete 2017 medical plan details are found on page 6 of this guide.

OAP In-Network Plus*

*This is an In-Network only plan and does not offer any Out-of-Network Benefits.

Coverage Tier	Deductible		Out of Pocket Maximum	
	2016	2017	2016	2017
Employee only	\$150	\$500	\$2,500	\$3,000
Employee +1	\$300	\$1,000	\$5,000	\$9,000
Family	\$450	\$1,000	\$7,500	\$9,000

	2016	2017
Office Visit Copay	\$20-Primary Care Provider \$35-Specialist	\$25-Primary Care Provider \$40-Specialist
Co-insurance	0% after deductible	20% after deductible
Emergency Room Copay	\$150 after deductible	\$250 after deductible
X-ray, Labs, etc.	0% after deductible	20% after deductible
TeleHealth/MD Live	\$20	\$25
Behavioral Health Outpatient	\$35	\$40

	2016	2017
Prescriptions Preferred Brand	20% (\$20 min/\$50 max)	20% (\$25 min/\$60 max)
Prescriptions-Non-Preferred Brand	30% (\$45 min/\$75 max)	30% (\$50 min/\$80 max)

2017 Medical Plan Design Changes (continued)

The information below compares the benefit for 2016 vs. the benefit for 2017. Some **items are not reflected in this table as they did not change**. Complete 2017 medical plan details are found on page 6 of this guide.

OAP Basic

In-Network Benefits

Coverage Tier	Deductible		Out of Pocket Maximum	
	2016	2017	2016	2017
Employee only	\$500	\$1,000	\$4,000	\$4,000
Employee +1	\$750	\$2,000	\$8,000	\$12,000
Family	\$1,000	\$2,000	\$12,000	\$12,000

	2016	2017
Office Visit Co-pay	\$25 Primary Care Provider	20% after deductible
Emergency Room Copay	\$150 after deductible	\$400 after deductible
TeleHealth/MD Live	\$25	\$40 per visit until deductible is met and then 20% co-insurance
Urgent Care	\$75	20% after deductible
Behavioral Health Outpatient	\$35	20% after deductible

	2016	2017
Prescriptions Preferred Brand	20% (\$20 min/\$50 max)	20% (\$25 min/\$60 max)
Prescriptions-Non-Preferred Brand	30% (\$45 min/\$75 max)	30% (\$50 min/\$80 max)

Out-of-Network Benefits

Coverage Tier	Deductible		Out of Pocket Maximum	
	2016	2017	2016	2017
Employee only	\$1,000	\$2,000	\$12,000	\$8,000
Employee +1	\$1,500	\$4,000	\$24,000	\$24,000
Family	\$2,000	\$4,000	\$36,000	\$24,000

	2016	2017
Emergency Room Copay	\$150 after deductible	\$400 after deductible
Urgent Care	\$75 after deductible	50% after deductible

2017 Medical Plan Design Changes (continued)

The information below compares the benefit for 2016 vs. the benefit for 2017. Some **items are not reflected in this table as they did not change**. Complete 2017 medical plan details are found on page 6 of this guide.

Choice Fund HRA*

*This plan has an annual health fund to offset your deductible. In 2016 the District contribution to this fund was: Employee only-\$500, Employee +1-\$750, Family-\$1,000. In 2017 the district contribution to this fund will be: Employee only-\$500, Employee +1-\$1,000, Family-\$1,000. For more details on how the HRA fund operates see page 7.

In-Network Benefits

Coverage Tier	Deductible		Out of Pocket Maximum	
	2016	2017	2016	2017
Employee only	\$1,500	\$1,500	\$4,500	\$7,150
Employee +1	\$2,250	\$3,000	\$9,000	\$14,300
Family	\$3,000	\$3,000	\$12,700	\$14,300

	2016	2017
Office Visit Copay	20% after deductible	30% after deductible
Co-Insurance	20% after deductible	30% after deductible
Hospital Services- Inpatient, Outpatient, Emergency Room, and Urgent Care Co-Insurance	20% after deductible	30% after deductible
X-ray, Labs, etc.	20% after deductible	30% after deductible
TeleHealth/MD Live	\$38 copay -20%	\$40 per visit until deductible is met and then 30% co-insurance
Behavioral Health Inpatient/ Outpatient Services	20% after deductible	30% after deductible

	2016	2017
Prescriptions Preferred Brand	20% (\$20 min/\$50 max)	20% (\$25 min/\$60 max)
Prescriptions-Non-Preferred Brand	30% (\$45 min/\$75 max)	30% (\$50 min/\$80 max)

Out-of-Network Benefits

Coverage Tier	Deductible		Out of Pocket Maximum	
	2016	2017	2016	2017
Employee only	\$3,000	\$3,000	\$13,500	\$14,300
Employee +1	\$4,500	\$6,000	\$27,000	\$28,600
Family	\$6,000	\$6,000	\$38,100	\$28,600

	2016	2017
Emergency Room Copay	20% after deductible	30% after deductible
Urgent Care	20% after deductible	30% after deductible

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 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" requirement does NOT apply to spouses who:
 - are also employed or retired from Shelby County Schools and whose employer does NOT provide medical coverage; or
 - whose employer requires the employee to pay more than 50% of the cost of the coverage for their 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 and 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 introduced in 2015 will remain in place for the 2017 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, 2016. 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.*



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

Summaries of Benefits and Coverage ("SBCs"), as required by the Affordable Care Act, are available on the Employee Benefits webpage. Hard copies of the SBCs are also available at the Employee Benefits Department.

Medical Benefits – Cigna

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

*After deductible

**\$40 per visit until deductible is met; then co-insurance applies.

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

What You Need to Know 2017

- Employees enrolling in the Choice Fund HRA option have access to 100% of their Annual Health Fund on January 1, 2017.
- 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 2017 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' 2017 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 roll over 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 2017

- ✓ No changes to the Dental benefit options for 2017
- ✓ The DEPO plan is now called the DPPO Advantage plan
- ✓ Because the DPPO Advantage plan network is smaller, prior to receiving services please make sure your dentist is a participating provider in this network

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

*After deductible

Vision Benefits – Cigna

What You Need to Know for 2017

- ✓ New Vendor – Cigna
- ✓ Review the copays and benefits shown below

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

Voluntary Long-Term Disability (LTD) Insurance – The Standard

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

Plan Maximum Monthly Benefit: \$5,000
Plan Minimum Monthly Benefit: \$100 or 10 percent of the LTD benefit before reduction by deductible income, whichever is greater.

Benefits Waiting Period: If your claim for LTD benefits is approved by The Standard, benefits become payable after you have been continuously disabled for 180 days and remain continuously disabled. Benefits are not payable during the benefit waiting period.

Pre-existing Condition Exclusion: 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.

What You Need to Know for 2017

✓ No changes to the LTD plan

Employees who did not enroll for coverage when first hired by SCS, must complete an online Medical History Statement before coverage is effective. The link to the form is: http://www.standard.com/mybenefits/mhs_ho.html.

If you become insured, you will receive a group insurance certificate containing a detailed description of the 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 is an IRS Section 125 plan that provides the option of electing pre-tax payroll deductions for certain eligible health care and/or child/dependent care expenses. Because the expenses are paid with pre-tax dollars, the result is immediate tax savings.

What You Need to Know for 2017

✓ This benefit must be elected each plan year

2017 Contribution Limits

	<u>Annual Minimum</u>	<u>Annual Maximum (set by the IRS)</u>
Healthcare FSA	\$300	\$2,550
Dependent Care FSA	\$600	\$5,000

The plan year begins 1/1/2017 and ends on 12/31/2017 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
- Dental and eye care expenses
- Prescribed over-the-counter drugs and prescriptions
- Daycare expenses for dependents so you can work

For a comprehensive list of qualified expenses go to CPN's website: www.cpnflex.com

Available on the Corporate Planning Network (CPN) website is a worksheet that can help you determine how much money you'll save annually by participating in the Flexible Spending Account. The Section 125 brochure which includes a worksheet can be found on CPN's website under the FSA page: <http://www.cpnflex.com/fsa.html>. Use this worksheet to calculate your annual expenditures for healthcare expenses not paid for by insurance. The calculator can also be used to estimate your incurred dependent care expenses.

After you've decided how much money you want to set aside from each paycheck and how you want to spend it, enroll in the plan. Then when you're ready to use the money in your flex account, simply swipe your take care® Visa® flex benefits card for qualified purchases. When you use your take care® card for qualified purchases, the money is instantly deducted from your flex benefit account. You won't have to reach into your pocket to pay for qualified expenses, file a claim, and then wait to get reimbursed. If your provider does not accept Visa, you may pay your provider directly, then submit an explanation of benefits (EOB) or itemized statement and wait for a reimbursement check. You may also have the money deposited directly into your bank account.

How do I know how much is available for me to spend? Your balance and other account details are always available online www.cpnflex.com and click on Employee Login or by contacting CPN's customer service hotline by pressing option1 at (local) 901.756.8244 or (toll free) 800.737.0125. Or you may contact CPN via email: claims@cpnflex.com

Must money be deposited in my account before I file a claim? NO. The entire annual amount you elect for the Health Flexible Spending Account (FSA) is available on the first day and throughout the plan year. However, funds in the Dependent Care Account are available **ONLY** when they are deposited into your account.

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. **Concern** will be administering the EAP. Counselors are available at (901) 458-4000 or (800) 445-5011.



What You Need to Know for 2017

- ✓ Employees 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
- ✓ There are no changes to the LTD premiums

Employee Contributions

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

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

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

Voluntary Long-Term Disability

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

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

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

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

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

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

Having TROUBLE Logging In

1. Be sure you registered, click Register Now and enter the requested information. If you have registered, you will get a message stating that you have already registered.
2. If you have Registered-Use the Forgot your username or Forgot your password links onscreen to assist in resetting your username and or password.

Annual Enrollment – Step by Step Enrollment Instructions

1. Access the Enrollment site

Go to www.benefitsinsight.com

2. Register to use the Enrollment site

Benefits Insight is new as of May 2016, if you have not already registered, you will need to do so.

Click **Register Now** from the login page.

- Verify that you are an employee by providing your Social Security number, date of birth, and five-digit Zip code.
- Create a username and password that meets the security requirements noted. Re-enter your password for verification.
- Select a security question from the drop down menu and type in your answer. *You will be asked this question if you forget your username or password in the future.*
- Confirm your username, security question, and security answer. Then, click Continue to complete the registration process.

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 **START**.

4. Verify Your Personal Information and Add Dependents

- Review your personal information by placing your cursor on the smiley face above the name. A gray box will appear with details. You may edit information for your dependents.
- Corrections to your name, date of birth, or gender must be processed in the payroll system and will feed to Benefits Insight in 7-10 business days. Please contact Human Resources at 901-416-5304 for assistance in updating this information to the payroll system. Address corrections should be made through the employee portal and will feed to Benefits Insight in 7-10 business days.

- After you verify information about yourself, you can add or review information for eligible dependents.
 - Please note: Adding a dependent on the About 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 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 # (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.
- Throughout the enrollment process, to advance to the next screen you may need to scroll down where you will see the Continue and Back buttons. To complete and submit your enrollment, you **must** click **Continue** throughout the annual enrollment screens until you reach the confirmation page and click **SUBMIT** as shown below.

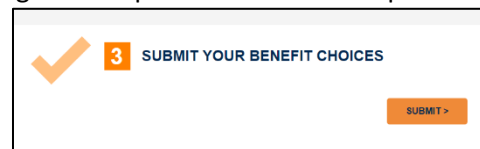
5. Review and Select Your Benefits

- You will start the enrollment process with your medical plan options, along with costs.
- See additional plan details by clicking on the **Select a Plan** 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 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. **You must select the smiley face icon for each dependent you wish to enroll.** You will be able to tell who is covered on screen as shown below.

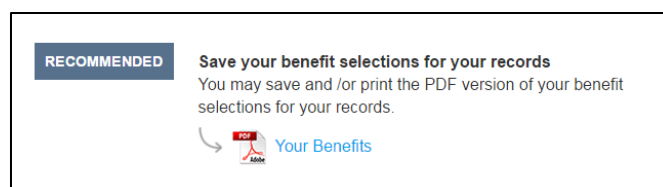


6. Review and Confirm Your Summary Information

- View the confirmation page of your elections and covered dependents carefully.
- Once you review your elections, click **Submit** at the bottom of the page to complete the enrollment process. **If you do not click Submit, your changes will not be processed!**
- If you need to make changes, you may do so throughout the enrollment period 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.



IMPORTANT If you return and make changes to this enrollment, you must submit your elections again in the checkout process. The changes will not be saved if this step is not completed.





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 2017. (This is known as “creditable coverage.”)

Why this is important. If you or a covered dependent are enrolled in any prescription drug coverage in 2017 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 2017. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

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

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. If the notice is not received within the 60-day period, the dependent or spouse will not be entitled to choose continuation coverage. You must provide this notice to Shelby County Schools (please see Plan Contact Information section of this notice).

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

How is COBRA Coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or

District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

NEWBORNS & MOTHER'S HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (901) 416-5300.

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL COVERAGE

If you have declined enrollment in a Shelby County Schools' health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in Shelby County Schools' medical plan without waiting for the next Annual enrollment period, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Shelby County Schools' health plan will also allow a special enrollment opportunity if you or your eligible dependents either:

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

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

Shelby County Schools Board of Education Privacy Notice

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

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

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

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

How the Plan may use or disclose your health information

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

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

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

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

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

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

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

- The Plan, or its insurer or HMO, may disclose “summary health information” to Shelby County Schools Board of Education, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Shelby County Schools Board of Education information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

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

Other allowable uses or disclosures of your health information

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

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

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

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

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

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

Your individual rights

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

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

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

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

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

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

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

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

The access or copies you requested

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

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

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

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

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

- For treatment, payment, or health care operations
- To you about your own health information

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

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

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

Right to obtain a paper copy of this notice from the Plan upon request

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

Changes to the information in this notice

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

Complaints

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

Contact

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

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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Shelby County Schools Board of Education		4. Employer Identification Number (EIN) 62-6000834	
5. Employer address 160 S. Hollywood Street		6. Employer phone number (901) 416-5300	
7. City Memphis	8. State TN	9. ZIP code 38112	
10. Who can we contact about employee health coverage at this job? Benefits Department			
11. Phone number (if different from above) (901) 416-5344		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:

☒ Some employees. Eligible employees are:

All full-time employees

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Outlined in the Annual Enrollment Guide.

☐ We do not offer coverage.

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

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

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

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

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

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

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

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

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

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



WHD Publication 1420 - Revised February 2013

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

748 Crescent Rd
Memphis, TN 38116
(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
Crandall Craigen – 901-261-5498

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- VOYA

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

Representatives

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

Great West- Empower

545 Mainstream Dr., Suite 407
Nashville, TN 37228
1.800.922.7772
Sarah.jones@empower-retirement.com

www.treasury.tn.gov/dc

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

Plan	Who to Call	Web Address	Phone Number
Medical	Cigna	www.mycigna.com	Annual Enrollment Questions: 1-800-401-4041 On-going Customer Service: 1-800-736-7568
Dental	Cigna	www.mycigna.com	
Vision	Cigna	www.mycigna.com	
Flexible Spending Accounts	Corporate Planning Network (CPN)	www.cpnflex.com	Customer Service Hotline: 1-901-756-8244 (option 1) or 1-800-737-0125
Life Insurance (for those currently enrolled for basic and/or supplemental coverage)	MetLife	www.mybenefits.metlife.com	Customer Service: <i>Basic Life Insurance</i> 901-416-5344 <i>Supplemental Life Insurance</i> 1-866-492-6983
Voluntary Long-Term Disability	Standard	www.standard.com/presentations/shelby_county/board_education/	1-888-937-4783
Employee Assistance Plan	Concern	www.concernonline.org	Counselors 1-901-458-4000 or 1-800-445-5011

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 Summary Plan Description (SPD), if applicable, or to the official policy relating to that benefit. Benefits described in this annual enrollment guide also constitute a Summary of Material Modifications (SMM) in years when a new SPD is not required. Both SPDs and policies are available upon request by contacting human resources.

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



Shelby County Schools
160 South Hollywood
Memphis, TN 38112