



CERTIFICATED BENEFIT PLANS HANDBOOK

Active Employees
July 2009

TABLE OF CONTENTS

INTRODUCTION	6-12	HEALTH PLAN	30-43
7	What Is This Information And Why Do I Need It?	31	What Are The Distinguishing Features Of Each Healthcare Option?
8	Who Governs the Group Insurance Program?	31	What Will The Plan Cover?
9	Telephone Numbers You May Need	31	How Much Will I Have To Pay For Medical Care?
10	Member Privacy	35	How Does The Plan Control Cost?
		36	Are There Any Special Benefits?
		38	What Are The Behavioral Health Benefits?
		39	How Is Incorrect Information Handled?
		40	What If A Mistake Was Made In Paying My Claim?
		40	Is There An Appeal Process?
ELIGIBILITY	12-29	VISION	44-47
13	Who is Eligible?	45	What Is The Vision Plan?
13	How Do I Pay for Coverage?	45	What Services Are Available?
14	What Types of Health Coverage Are Available?	46	How Much Will It Cost Me?
14	When Does Coverage Begin?	47	How Do I Schedule an Appointment?
15	What If I Need to Change My Coverage?	47	How Do I Get Questions Answered?
15	What Dependents Are Eligible?		
16	What Dependents Are Not Eligible?	HEALTHCENTERS	48-51
17	How Do I Add Dependents to My Coverage?	49	What Are The Healthcenters?
17	How Do I Terminate a Dependent's Coverage?	49	What Services Are Available?
18	What If I Don't Enroll in Health Coverage When First Eligible?	51	How Much Will It Cost Me?
20	What is the Annual Open Enrollment Period?	51	How Do I Schedule An Appointment?
20	How Do I Terminate Coverage?		
21	What If I Have Other Insurance?	DENTAL	52-55
22	What Can I Expect If I Terminate Employment?	53	What Is The Dental Plan
22	How Do I Continue Coverage?	53	What Are The Distinguishing Features Of The Dental Plan?
26	What If I Go On Leave?	54	What Will The Plan Cover?
28	What If I Retire?	54	How Much Will I Have To Pay For Dental Care?
29	What Happens To My Covered Dependents If I Die?	55	How Do I Get Questions Answered?

EAP**56-59**

- 57 What Is The Employee Assistance Program?
- 57 What Services Are Available?
- 59 How Do I Access Services?
- 59 How Much Does it Cost?

RETIREMENT**72-76**

- 73 What Retirement Plans Are Available?
- 73 What Are My Retirement Benefits?
- 74 When Can I Retire?
- 75 Can I Contribute To A Retirement Account?

FLEXIBLE BENEFITS**60-65**

- 61 What Are Flexible Benefits?
- 61 Pre-Tax Premium Payments
- 62 Medical Flexible Reimbursement Accounts
- 63 Dependent Care Reimbursement Accounts
- 63 Reimbursement Account Rules
- 64 How Does The Reimbursement Account Work?
- 65 How Do I Get Reimbursed?

LIFE INSURANCE**66-71**

- 67 What Life Insurance Is Available?
- 68 What Does Accidental Death & Dismemberment Cover?
- 69 When Can I Purchase Additional Life Insurance?
- 69 What Happens if I Become Disabled?
- 70 If I Become Terminally Ill Can I Access My Life Insurance?
- 70 What If I Die While Traveling?
- 70 Who Can Help My Beneficiaries?

This handbook does not outline every limitation or exclusion of the MNPS-sponsored plans. The Plan Documents are the legal publications that define eligibility, enrollment, benefits and administrative rules. Copies of the Plan Documents can be obtained from the Employee Benefit Services Department or from the Department's web site, <http://www.mnps.org/Page3424.aspx>.

The information contained in this handbook is accurate at the time of printing; however, The Board of Education may change the plans at their discretion. The benefits described in this handbook cannot be modified by any oral statements.

INTRODUCTION

What Is This Information And Why Do I Need It?	7
Who Governs The Group Insurance Program?	8
Telephone Numbers You May Need	9
Member Privacy	10

What Is This Information And Why Do I Need It?

Employee Assistance Program (EAP)
is a confidential counseling and referral service for all full-time employees and their dependents, regardless of whether you are enrolled in health coverage.

This *Benefits Handbook* has been provided to help you understand what benefits are available to you as a MNPS Certificated Employee. Familiarize yourself with topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

If you meet the eligibility requirements listed on page 13, you will have the following benefits available to you:

- Health Insurance
- Vision Insurance
- Dental Insurance
- Flexible Spending Account
- Basic Life and Accident Insurance
- Optional Term Life Insurance
- Optional Long Term Disability
- Leave Time
- Retirement
- MNPS Employee & Family Healthcenters

In addition, all full-time and part-time employees receive the benefits of:

- Employee Assistance Program
- Injury On Duty Program

Flexible Benefits or Section 125 plan
is a benefit plan that allows participants to re-direct some of their earnings into a customized spending account. Flexible benefits allow you to pay for medical and dependent care expenses which can be paid with tax free money

Regardless of which benefits you select, the eligibility section of this handbook applies to you.

The Employee Benefit Services Department is responsible for administering and/or overseeing all components of the group insurance coverage.

MNPS' healthcare options are self-insured which means claims are paid from funds controlled by the Insurance Trust which consists of employee contributions and the Board's contributions.

Words or phrases that may be unfamiliar to you, and are not explained in the text, are defined in the side margin. We hope you will find this information helpful, useful and easy to understand. Please contact the Employee Benefits Department if you have comments or suggestions related to this publication or if you require this publication in an alternative format.

Who Governs The Group Insurance Program?

The MNPS Board of Education established an Insurance Trust to oversee certificated employee benefit plans. The Trusteeship is composed of 8 members and includes:

- Three members of the Board of Education, appointed by the Chairman of the Board
- Three elected employee representatives;
- One elected retiree representative;
- Assistant Superintendent of Human Resources;

The Trustees may recommend to: (1) change or end any coverage offered through the MNPS' group insurance program, (2) change or discontinue benefits, (3) establish premiums, and (4) change the rules for eligibility at any time, for any reason. Their recommendations are forwarded to the Board of Education who makes the final determination.

Telephone Numbers You May Need

Services

MNPS Employee & Family Health Centers	(615) 259-8755
Employee Assistance Program www.horizoncarelink.com Login ID: MNPS Password: eap	1-866-563-8762 24/7 Counselors are available
Precious Cargo Prenatal Program	1-800-395-BABY

Vendors

Blue Cross Blue Shield of Tennessee 24/7 claims, eligibility, enrollment info, provider directories, along with medical advice at www.bcbst.com/members/metro-teachers	1-800-376-4695 8am to 5pm CST, M-F
Delta Dental Claims assistance, eligibility, provider assistance http://www.deltadentaltn.com/mnps	1-800-223-3104, Or 255-3175
CompBenefits (Vision Insurance) Eligibility, enrollment info, provider directories at http://www.compbenefits.com/custom/mnps	1-800-416-4369
MetLife Resources (403b)	1-877-948-4638
Minnesota Life (Life Insurance) https://web1.lifebenefits.com/grppd/MNPS010563/PlanOverview.do	1-866-293-6047
FBMC (Flexible Benefits) Download claim forms and get valuable information at www.myfbmc.com/customers/mnuaccounts.aspx	1-800-342-8017 8am to 5pm CST, M-F Fax: 1-850-425-4608

Administrators

MNPS Employee Benefit Services www.mnps.org/Page3343.aspx	259-8463
Tennessee Consolidated Retirement System www.treasury.state.tn.us/tcrs	(615) 741-1971

Member Privacy

The MNPS Certificated Employee group insurance program considers your protected health information (PHI) private and confidential. In accordance with the federal Health Insurance Portability and Accountability Act (HIPAA), policies and procedures are in place to protect such information against unlawful use and disclosure. PHI is individually identifiable health information. This includes demographics such as age, address, e-mail address and relates to your past, present or future physical or mental health condition. We are required by law to make sure your PHI is kept private.

When necessary, your PHI may be used and disclosed for treatment, payment and healthcare operations. For example, your PHI may be used or disclosed, including, but not limited to:

- In order to provide, coordinate or manage your healthcare
- To pay claims for services which are covered under your health insurance
- In the course of the operation of the Certificated Employees group insurance program to determine eligibility, establish enrollment, collect or refund premiums, and conduct quality assessments and improvement activities
- To coordinate and manage your care, contact healthcare providers with information about your treatment alternatives
- Conduct or arrange for medical review, auditing functions, fraud and abuse detection, program compliance, appeals, right of recovery and reimbursement/subrogation efforts, review of health plan costs, business management and administrative activities
- To contact you with information about your treatment or to provide information on health-related benefits and services that may be of interest to you

To obtain a copy of the Health plan's privacy notice describing in greater detail the practices concerning use and disclosure of your health information, visit our web site or you may obtain a copy from Employee Benefit Services.

ELIGIBILITY

Who is Eligible?	13
How Do I Pay For Coverage?	13
What Types Of Health Coverage Are Available?	14
When Does Coverage Begin?	14
What If I Need To Change My Coverage?	15
What Dependents Are Eligible?	15
What Dependents Are Not Eligible?	16
How Do I Add Dependents To My Coverage?	17
How Do I Terminate A Dependent's Coverage?	17
What If I Don't Enroll In Health Coverage When First Eligible?	18
What Is The Annual Open Enrollment Period?	20
How Do I Terminate Health Coverage?	20
What If I Have Other Insurance?	21
What Can I Expect If I Terminate Employment?	22
How Do I Continue Coverage?	22
What If I Go On Leave?	26
What If I Retire?	28
What Happens to My Covered Dependents If I Die?	29

Who is Eligible?

To be eligible for the Certificated Employee Benefits you must belong to the following category.

- All Active Full-Time Certificated Employees regularly scheduled to work at least 18 hours per week.

How Do I Pay For Coverage?

***Non-Returning
Board of
Education
employees
BOE employees
who pay their
annual premiums
in 10 month
increments.
Employees who
do not return the
following school
year will have
their insurance
terminated at the
end of August.***

The insurance contributions deducted from your paycheck include payment for your health, dental, vision, and voluntary insurance coverage. Employee Benefit Services can provide you with information regarding your current deductions.

Most Certificated employees pay their annual contributions in 10 month increments. Benefit deductions are not collected in over the summer months. Employees who do not return the following school year will have their insurance terminated at the end of August.

MNPS contributes 75% of the cost of your basic (health, dental, and vision) benefits. Your contributions equate to the other 25% of the cost. In addition to this, MNPS pays 100% of the cost for \$50,000 of life insurance on each full-time Certificated Employee. MNPS also contributes 75% of the cost of life insurance for dependents enrolled on the health plan.

NOTE: Employees on an approved leave without pay must arrange to make payment for your contributions. Contact Employee Benefits Services for payment information. Call 259-8484

MNPS pays the full cost of providing employees with \$50,000 basic term life insurance and basic special accident insurance. You are given the opportunity to purchase additional life insurance on yourself and your dependents. The employee is responsible for the cost of additional insurance beyond the amount provided by MNPS.

The plans permit a 30-day grace period for remittance of premiums. If the premium is not paid at the end of this deferral period, coverage will be canceled retroactive to the date you last paid a premium with no provision for reinstatement of coverage.

To obtain health, vision and dental coverage again, you will have to wait for the annual open enrollment period.

You may also apply for life and disability coverage during open enrollment, but would have to provide evidence of insurability and be approved by the carriers to receive coverage.

What Types Of Health Coverage Are Available?

- Single: Covers Employee only
- Employee and Spouse: Covers employee and eligible Spouse only, does not include coverage for Dependent Child(ren).
- Employee and Child(ren) – Covers employee and Dependent Child(ren) only. Does not include coverage for a spouse.
- Family: Covers Employee, Spouse and all eligible Dependent Child(ren)

NOTE: An individual who is also an eligible certificated employee may not be covered as a dependent under a spouse's enrollment, but must enroll as an Employee.

When Does Coverage Begin?

Special Enrollment
Federal law mandates that health plan allow eligible employees and dependents to enroll in the plan if they lose coverage due to certain qualifying events. See page 18.

You have 60 days from the first day of employment to submit your enrollment application. **Coverage begins on the first day following one (1) month of active employment, provided completed enrollment forms are filed with Employee Benefit Services on or before your first day of employment.**

Otherwise, coverage begins on the first day following one (1) month from the date completed enrollment forms are filed with Employee Benefit Services.

If you fail to enroll in health coverage by the end of your enrollment period, you will only be eligible by satisfying one of the special enrollment provisions on page 17 or by applying for coverage during the next open enrollment period.

A dependent's coverage is effective on the same date as yours unless newly acquired.

Newly acquired dependents will become effective on the date they were acquired if you have family coverage. You may also choose

to have coverage effective the first day of the following month if you are changing from single to family coverage.

Coverage for an adopted child begins when appropriate documentation reflecting legal obligation of support of such child is submitted to Employee Benefit Services. See complete definition of dependents on page 14.

You will receive an identification card at your home address within four weeks after the effective date of your coverage. You may call BCBST to request additional cards.

What If I Need To Change My Coverage?

To make a change in your coverage (add or terminate a dependent, etc.), contact Employee Benefit Services and request an enrollment/change application. Return the completed form to the Employee Benefit Services. The eligibility requirements for dependents listed on pages 15-16 apply.

What Dependents Are Eligible?

Qualified Medical Child Support Order (QMCSO) – a court ruling providing continued and uninterrupted medical insurance coverage of the child of the insured parent as a part of the final decree in a divorce.

- Your spouse (legally married), provided your spouse is not an active certificated MNPS employee.
- Natural or adopted children under 25 years of age (regardless of where they live) for whom the employee has legal custody or is legal guardian.
- Stepchildren are eligible provided the employee or spouse has legal custody or joint parenting, and provided the natural parent has no access to other employer group insurance. These children must live in your home in a parent –child relationship and depend on the employee for at least 51% of their support.
- Adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption — the obligation may be determined by court records, federal income tax records or other appropriate documentation.
- The residency requirement is waived if the employee is obligated by divorce decree to pay for the child’s medical expenses or pay for the child’s health insurance.

Should a change in your dependent's eligibility status occur, notify Employee Benefit Services to terminate coverage.

All dependents must be listed by name on the appropriate enrollment/change application. Benefits are not provided for dependents not listed on this form. A dependent can only be covered once within the same plan.

Unmarried dependent children are eligible for coverage through the last day of the month of their 25th birthday. Proof of a dependent's eligibility may be required.

Incapacitated children (mentally or physically disabled and incapable of earning a living) may continue health or dental, if applicable, coverage beyond age 24 as long as the incapacity existed before their 25th birthday and they were already insured under the MNPS Certificated Employee's group insurance program. The child must meet the requirements for dependent eligibility previously listed. ***A request for extended coverage must be provided to Employee Benefit Services within 31 days of the dependent's 25th birthday.*** Additional proof may be required periodically. Approval of the incapacitation request is determined by the claims administrator for your health insurance company. Coverage will not continue and will not be reinstated once the child is no longer incapacitated.

What Dependents Are Not Eligible?

- Ex-spouse (even if court ordered)
- Married children, regardless of age
- Parents of the employee or spouse
- Step children who do not reside with you
- Children in the armed forces on a full-time basis
- Children over age 25 (unless they meet qualifications for incapacitation)
- Live-in companions who are not legally married to the employee

How Do I Add Dependents To My Coverage?

An enrollment/change application must be completed within 60 days of the date a dependent is acquired. The “acquire date” is the date of birth, marriage, change of student status, or, in case of adoption, the legal obligation and support of such child. Changes in type of coverage (single to family) are effective on the date the dependent was acquired. If you maintained family coverage on the date the dependent was acquired, the effective date may be retroactive to the dependent’s acquire date even if beyond the 60 day enrollment period.

An employee’s child named under a qualified medical support order must be added within 60 days of the court order, if a court so stipulates.

If you have single coverage and do not notify Employee Benefit Services within 60 days of acquiring a dependent, the new dependent can only enroll if they meet one of the special enrollment provisions listed on page 17 or by applying during the annual open enrollment period.

How Do I Terminate a Dependent’s Coverage?

To remove a dependent from your coverage, complete an enrollment/change application and return it to Employee Benefit Services. When you request cancellation, a dependent’s coverage will terminate on the date you indicated on the form. In the case of ineligibility, the dependent is covered until midnight on the last day of the month that the ineligibility occurs. For adopted children, coverage terminates upon the termination of legal obligation. In the event of a divorce for any reason other than irreconcilable differences, your spouse cannot be removed from coverage until the divorce is final. ***All claims paid for ineligible dependents will be recovered. As the head of contract, you are responsible for reimbursing the plan for incorrect claims payments.***

You can change your type of coverage by completing an enrollment/change application. Keep in mind that deleting a dependent may change your type of coverage.

To verify claim payments are paid only for eligible dependents aged 19–25, the health insurance vendors are required by MNPS to request a verification of dependent status annually. Claims cannot be paid until the form is returned to the vendor.

Employee Benefit Services reserves the right to request documented proof of eligibility of dependents. Failure to provide the requested proof will result in suspension of the dependent's coverage until such proof is provided.

If the dependent becomes ineligible, it is your responsibility to notify Employee Benefit Services.

What If I Don't Enroll In Health Coverage When First Eligible?

If you do not elect health coverage for yourself and/or your dependents when first eligible, (see page 12) and you later decide to enroll, you and/or your dependents will not be allowed to enroll until the annual open enrollment period. Open enrollment is conducted during November with requested changes in coverage to be made effective January 1.

Any one who does not enroll when first eligible is considered a "Late Enrollee".

Special Enrollment Provisions

The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse. The required documentation must be submitted to Employee Benefit Services and coverage applied for within 60 days of loss of health coverage.

Employee NOT currently enrolled acquires a new eligible dependent (spouse, newborn or adoptee)

- Copy of the birth certificate, marriage certificate or adoption documents, and social security card.

Death

- Copy of death certificate and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended

Divorce

- Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Legal separation

- Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing the names of covered participants, date coverage ended and the reason why coverage ended

Loss of eligibility (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause)

- Written documentation from the employer or insurance company on company letterhead providing names of covered participants, date coverage ended and the reason for the loss of eligibility

Loss of coverage due to exhausting lifetime benefit maximum

- Written documentation from the insurance company on company letterhead providing names of covered participants, date coverage ended and stating that lifetime maximum has been met

Loss of TennCare (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis)

- Certificate of coverage from TennCare stating that coverage has been, or will be terminated

Termination of employment (voluntary and non-voluntary)

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

The reduction in the number of hours that caused loss of eligibility

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Employer's discontinuation of contributions to the spouse, ex-spouse or dependent insurance coverage (total contribution not partial)

- Written documentation from the employer on company letterhead providing names of covered participants and verifying the employer's discontinuation of total contribution toward health insurance coverage. The effective date of

coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month or subsequent month following approval by the Insurance Department; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period.

What Is The Annual Open Enrollment Period?

During the fall of each year you have the opportunity to transfer your existing MNPS Certificated Employee group health insurance coverage if you are currently enrolled, or to enroll in health insurance if you or your eligible dependents are not currently covered. Benefit information is mailed to your home address and you should review this information carefully to make the correct decision for you and your family. If you decide to transfer to another healthcare option, coverage will be effective on the following January 1, and you must remain enrolled in that healthcare option until the next year.

You may also enroll in the optional insurance plans, and enroll in medical and/or dependent care savings accounts. If you apply for life or disability benefits, you will have to submit evidence of insurability and be approved by the carriers prior to receiving coverage.

How Do I Terminate Health Coverage?

If you wish to terminate insurance coverage, you must

- Complete an enrollment/change application
- Return the completed application to Employee Benefit Services **before** the day the termination is to be effective

A dependent's insurance will be canceled on the last day of the month when he/she becomes ineligible for coverage. It is your responsibility to notify Employee Benefit Services if your dependent no longer meets the dependent eligibility rules.

When canceled, either voluntarily or by work hours being reduced below the eligibility requirements (i.e., going full-time to part-time), insurance coverage ends at midnight on the last day of the month for which you paid your premium. All forms must be completed by the last day of the month to terminate coverage for the following month. For example, if you do not want coverage for the month of December, you must cancel the coverage in writing by the end of November. You cannot cancel coverage for the month of December once the month begins. ***Most employees pay their premiums on a pre-tax basis, please check with Employee Benefit Services before canceling coverage.***

Any insurance continued for an ***incapacitated dependent child*** ends when he/she is no longer incapacitated, or at the end of the 31-day period after any requested proof is not furnished.

In the event of an employee's death, covered dependents may be eligible to continue coverage through an extension of coverage (see page 29).

What If I Have Other Insurance?

If you are covered under more than one insurance plan, benefits will be coordinated for reimbursement if you follow the guidelines for your medical plan. At no time should reimbursement exceed 100 percent of charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, should you have other health coverage as the head of contract (not dependent coverage) on your self, the oldest plan is considered your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his or her employer, that coverage will be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage.

The health insurance providers have the right to subrogate claims. This means they can recover any payments made as a result of injury or illness caused by the action or fault of another person, or lawsuit settlement from payments made by a third party insurance company. ***This would include automobile or homeowners***

insurance, whether yours or someone else's. You are required to assist in this process.

The plans require an annual verification of other coverage. This information must be returned to your health insurance provider in order to process claims. Claims will not be processed until this information is received.

On the Job Injuries

The plan is responsible for expenses for injuries or illnesses occurring in conjunction with employment with MNPS. Any other on the job injuries are excluded.

What Can I Expect If I Terminate Employment?

Your insurance coverage will cancel automatically when your employment is terminated and this information is provided to Employee Benefit Services. You will receive a COBRA notification to continue your health coverage, if eligible, and optional life insurance conversion notices, if applicable, at your home address. **Make sure your correct address is on file with Employee Benefit Services and Human Resources.**

How Do I Continue Coverage?

You may be able to continue medical (if eligible), vision and dental coverage under the Consolidated Omnibus Budget Reconciliation Act, a federal law referred to as COBRA. This law allows employees and eligible dependents, whose medical insurance would otherwise terminate, to continue the same medical benefits for specific periods of time under certain conditions. Covered individuals may continue the medical insurance if **all** of the following conditions are met:

1. Coverage is lost due to one of the “qualifying events” outlined on pages 24-25.
2. Covered individuals are not insured under another group medical plan as an employee or dependent. (This restriction is waived if you or your dependent enrolls in another group medical plan that has a preexisting conditions clause, and a condition exists that is not covered by the other plan.) In this

situation, you must provide the following to Employee Benefit Services:

- A letter from the new employer or claims administrator explaining that plan's preexisting condition clause and how long it applies
- A letter from your physician stating your preexisting condition

The COBRA Administrator will send a COBRA notification packet to your home address after being notified there has been a termination of coverage. This will occur after all leave has been used, and there has been one of the qualifying events described below. COBRA eligible members have 60 days from the date of receipt of the COBRA notification packet to return the application to the Administrator. Coverage will be reinstated immediately as of the termination date if premiums are returned with the application. Please make sure your correct home address is on file with Human Resources. If you do not receive your notification letter within 30 days after your insurance terminates, you should contact Employee Benefit Services.

You or one of your family members must notify Employee Benefit Services if a dependent wants to continue coverage under COBRA because:

- Of a divorce
- A dependent child is no longer eligible for medical or dental coverage because of a loss of dependent status

How is a COBRA Event Reported?

When one of these two circumstances (divorce or loss of dependent status) occur, you or your dependent has 60 days from the date of the qualifying event or the date the insurance will terminate due to the qualifying event (whichever is later), to notify Employee Benefit Services.

Failure to notify Employee Benefit Services within 60 days of the loss of coverage will eliminate any rights to COBRA continuation. Employee Benefit Services will only accept written notification and will supply you with a "COBRA Event Notice" form for completion.

The COBRA Administrator will then send your dependent the COBRA enrollment packet to your address. Restrictions for returning the enrollment form (when premiums must be paid and

other provisions) are outlined in the COBRA packet. Failure to report a dependent becoming ineligible to continue coverage within 60 days of the loss of eligibility will result in the dependent not being offered the opportunity to continue coverage under COBRA as their 60-day eligibility period will have lapsed.

There may also be a requirement for you to notify Employee Benefit Services in the event of a disability determination by the Social Security Administration. Additional information regarding disability extensions is provided further in this section.

How Long Does COBRA Last?

If you qualify for COBRA, the maximum length of time coverage may continue is based on which qualifying event causes your loss of medical coverage.

Qualifying Events for Employees

You may continue your single or family medical coverage for a **maximum of 18 months** if coverage is lost due to one of the following qualifying events:

- Employment is terminated for any reason other than gross misconduct
- Work hours are reduced below 30 hours
- Changes in your job appointment make you ineligible for coverage (example: changing to a part-time position)

Qualifying Events for Dependents

Dependents may also continue their medical or dental coverage under COBRA for **18 months** based on the events listed for employees. Furthermore, dependents may continue medical or dental coverage for an **additional 18 months**—maximum of 36 months—if coverage is lost due to one of the qualifying events listed below.

- Your death
- Your divorce from your spouse
- You become entitled to Medicare prior to enrolling in COBRA (the 36-month period is retroactive to the date of Medicare entitlement)
- Your dependent child is no longer eligible as a dependent (married, in the armed forces on a full-time basis, over age 24 unless meeting qualifications for incapacitation, etc.)

A child born to, or placed for adoption with you during a period of COBRA continuation coverage is also eligible for continuation of coverage provided coverage is requested within the 60-day time period.

How Much Are COBRA Premiums?

COBRA premiums are equal to 102 percent of the total monthly premium. (Total monthly premium includes employee and employer contributions.) Premiums are not prorated. When your coverage through COBRA ends, you may be eligible to convert to a private, direct-pay plan with your health provider.

If you or your dependents are on an 18-month COBRA extension and were disabled when you originally lost coverage or within 60 days of when you or your dependent's coverage started, you and your dependents may continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payments after the 18th month. In order to qualify, an award letter from the Social Security Administration (SSA) must be sent by the COBRA participant to the Insurance Department within 60 days of your receiving SSA's disability letter. You will be notified if the additional 11 months are approved.

When Does COBRA Coverage End?

Any COBRA coverage ends on the earliest of the following:

- The required premium is not paid by the due date
- You or your dependents become insured under another group health plan after the date you elect COBRA coverage under this plan. (However, your COBRA coverage will not be terminated if, on the date you obtained the other coverage, the other group health plan contained a preexisting condition clause that applies to, or is not otherwise satisfied by, you or your dependent by reason of the provisions of HIPAA. Please contact the Insurance Department if you believe this applies or if you have questions).
- You or your dependent becomes entitled to Medicare after the date you elect COBRA coverage under this plan
- Coverage has been extended for up to 29 months due to a disability and there has been a final determination during the 11-month extension period that the individual is no longer disabled
- On the last day of the appropriate 18-, 29- or 36-month period

Note: It is your responsibility to share this explanation of COBRA benefits with your covered dependents.

What If I Go on Leave?

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees to take up to 12 weeks of leave during a 12-month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to receive MNPS support of your health insurance premium. Initial approval for family and medical leave is at the discretion of the Human Resources Department. Employees must have completed a minimum of 12 months of employment and worked 1,250 hours in the 12 months immediately preceding the onset of leave. Leave may be paid, unpaid, or a combination of paid and unpaid leaves depending on the circumstances of the leave.

Under current MNPS policy, the employee pays a portion of the health care premium. While on paid FMLA leave, MNPS will continue to make payroll deductions to collect the employee's share of the premium. In addition, individuals will continue to accrue annual and sick leave benefits as long as they are on paid leave.

While on unpaid FMLA leave, the employee must continue to make his or her share of the premium either in person or by mail. The payment must be received in Employee Benefit Services office by the 10th day of each month. If the payment is more than 30 days late, the employee's health care coverage may be dropped for the duration of the leave.

If the employee contributes to a life insurance or disability plan, the employer will continue making payroll deductions while the employee is on paid leave. While the employee is on unpaid leave, the employee may request continuation of such benefits, and pay their portion of the premiums. If the employee does not continue these payments, MNPS may discontinue coverage during the leave. If your health benefits are terminated because of failure to pay premiums, you will not be able to resume benefits until you return to active employment. Upon return to active employment, you must re-apply for benefit coverage within 60 days. Coverage effective dates are the same as newly hired employees (see page 14).

See your employee handbook for the detailed Family Medical Leave policy.

Leave Without Pay – Insurance Continued

If you choose to continue coverage while on an approved leave of absence, you will be responsible for the total monthly premium (**employee and employer share**) once you have been without pay for one full calendar month. You will need to contact Employee Benefit Services to arrange premium payment. The maximum period for a leave of absence is one (1) year (maternity leave maximum is two years, but life insurance is discontinued after the first year). At the conclusion of the one year of leave, you must immediately report back to work for a period of no less than six full calendar months to be eligible for an additional year of insurance continuation under the leave without pay category. If you do not immediately return to work upon the expiration of the leave of absence, coverage is terminated and COBRA eligibility will not apply.

Leave Without Pay – Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. You may reinstate coverage when you return to work. Upon return to active employment, you must re-apply for benefit coverage within 60 days. Coverage effective dates are the same as newly hired employees (see page 14).

To Reinstate Coverage After You Return to Work

Prior to your return to work, you must submit a completed enrollment/change application to Employee Benefit Services, enrolling in the same health option you had previously. If you do not enroll within 30 days of your return to work, you can only re-enroll by meeting one of the special enrollment provisions or through the annual open enrollment process. The following guidelines apply:

Effective Date of Coverage

- No waiting period, coverage is effective on the day following completion of one month of active full-time employment, providing completed enrollment forms are received on or before the date of employment. Otherwise coverage is effective on the day following on (1) month from the date completed enrollment forms are received in the MNPS employee Benefit Services office.

If you and your spouse are both insured with the MNPS Certificated Employee group insurance program, you can be

covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract.

To transfer coverage, submit an enrollment/change application to suspend your coverage. Your spouse would submit an enrollment/change application to change coverage adding you as a dependent. Employee Benefit Services must be contacted to coordinate this change and to transfer deductibles and out-of-pocket expenses.

Leave Due to a Work-Related Injury

If you experience a work-related injury or illness, contact Employee Benefit Services about how this will affect your insurance. It is your responsibility to keep insurance premiums current until you return to work.

What If I Retire?

All covered employees who meet the qualifications may continue medical insurance at retirement on themselves and covered eligible dependents. You will be enrolled in retiree coverage at your current level of coverage unless you notify the Benefits Office of your desire to change or terminate coverage.

How Do I Qualify to Continue Health Coverage?

You qualify to continue health coverage if you:

- Have at least 10 years of active service with MNPS, and
- Have participated in the group benefits package for at least three (3) years immediately prior to retirement, and
- You begin receiving a monthly retirement check immediately following termination of active employment with MNPS. (An individual who has at least 20 years of service in MNPS may defer commencement of pension and re-enroll when his/her monthly pension begins.)
- You may change medical plan options during annual open transfer. Dependent coverage can be continued but not added.

What If I Don't Qualify?

Retired employees who cannot continue health insurance coverage because of the service requirements previously listed

may convert to a private direct payment plan or may be eligible to continue coverage through COBRA. Eligibility requirements for COBRA can be found on page 22. You may be eligible to continue your optional life programs on a direct-bill basis.

What Happens To My Covered Dependents If I Die?

If You Are an Active Employee

Your covered dependents may under COBRA guidelines for a maximum of 36 months as long as they remain eligible. Dependent optional life insurance coverage, if applicable, will terminate at the end of the month of the death of the employee; the dependents may be eligible to convert the life insurance to a direct-pay basis.

If You Are a Covered Retiree or An Active Employee Eligible for Retirement Benefits at the Time of Death

Dependents may continue to be covered as long as they continue to meet eligibility guidelines, and pay the full cost of the insurance coverage.

If You Are Covered Under COBRA

Your covered dependents may continue health coverage under COBRA guidelines if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

HEALTH PLAN

What Are The Distinguishing Features Of Each Healthcare Option?	31
What Will The Plan Cover?	31
How Much Will I Have To Pay For Medical Care?	31
How Does The Plan Control Cost?	35
Are There Any Special Benefits?	36
What Are the Behavioral Health Benefits?	38
How Is Incorrect Information Handled?	39
What If A Mistake Was Made in Paying My Claim?	40
Is There An Appeal Process?	40

What Are The Distinguishing Features Of Each Healthcare Option?

Primary Care Physicians (PCP's)

Primary Care Physicians are General Practitioners, Family Practitioners, Internal Medicine, Pediatricians, and Ob-Gyn's.

The MNPS Certificated Employees Health Plan provides two Preferred Provider Organization health plans from which to choose. These plans have all features in common except how they handle in-network physician Office visits

Copay Plan

Office Visits: \$0 MNPS Health Centers; \$25 Primary Care Provider co-pay per visit in-network; \$35 Specialist co-pay per visit in-network

Coinsurance Plan

Office Visits: 100% MNPS Health Centers; 90% in-network after deductible is satisfied

What Will the Health Plan Cover?

The MNPS Certificated Employees Health Plans cover medical treatments and services provided by recognized medical providers as outlined in the Plan Document. This handbook provides a summary of those benefits but does not outline every limitation or exclusion of the Certificated Employee sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. Copies of the Plan Document can be obtained from Employee Benefit Services or from the Blue Cross Blue Shield MNPS web site, www.bcbst.com/members/metro-teachers.

How Much Will I Have to Pay For Medical Care?

In-Network and Out-of-Network Services

Our Plans use a Preferred Provider Organization (“PPO”). The PPO is a list of medical providers that have met quality standards, agreed to discounted rates, and have signed contracts where they agree to write-off certain non-covered items such as charges over the maximum allowable amounts listed in their contract. By using PPO providers, you help us control our health cost while securing a better value for yourself.

PPO providers are reimbursed at a higher percentage (90%) than non-network providers (70%). Additionally, out-of-network providers can charge you for services non-covered by the health plan.

Co-payments

A co-payment is a set dollar amount you pay for a service or product provided. Under our plans, preventive examinations have a \$25 co-payment (\$35 for Specialist), and prescriptions have co-payments ranging from \$5 to \$50. Under the Copay Plan, Primary Care physician (General Practitioner, Family Practitioner, Internal Medicine, Pediatrician, and Ob-Gyn) office visits have a \$25 co-payment; Specialist office visits have a \$35 co-payment. **Care provided by the MNPS Health Centers has a \$0 copayment.**

If a co-payment is charged, the deductible does not apply. The plan provides benefits for services even though your deductible is not satisfied.

Co-payments do not help you satisfy your deductible, nor do they apply to your plan maximums. Amounts paid in co-payments will not be applied to your annual out-of-pocket maximum.

Deductibles and Coinsurance

Most services are subject to annual deductibles that have to be satisfied before benefits are paid. Only the cost for covered services can be applied toward satisfying the deductible.

Our plans have individual and family deductibles. Family deductibles are three times the amount of the individual deductible. The family deductible serves as a cap which limits the employee deductible cost if he/she covers more than one dependent on the health plan.

Our plans have different and lower deductibles for network providers than for non-network providers. **Care provided by the MNPS Health Centers is not subject to deductibles.**

Out of Pocket Maximums

Once an individual reaches a certain amount of out-of-pocket expenses (deductible plus coinsurance) in a calendar year, the plan will provide 100% reimbursement for covered expenses for the remainder of that calendar year.

Co-payments do not apply toward the out-of-pocket maximum.

Our plans have different and lower out-of-pocket maximums for network providers than for non-network providers.

Pharmacy Benefits

Our plan covers medically necessary prescription medications that:

- Have been approved by the Food and Drug Administration
- Have been prescribed by a licensed Physician
- Have been dispensed by a licensed Pharmacist
- Are not available for purchase without a prescription (over-the-counter)

Prescription drugs are not subject to the deductible and as listed above. Drugs are reimbursed based on their classification. Your co-pay for drugs is:

- Generic \$5
- Preferred Brand \$20
- Non-Preferred Brand \$50

To get a list of what Brand drugs are considered Preferred go to <http://www.bcbst.com/drugsearch/start.do> and enter the drug name. You may also contact BCBST customer service for this information at 1-800-376-4695.

Pharmacy Out-Of-Pocket Maximum. If in a calendar year, you pay more than \$1,500 in pharmacy copayments, your pharmacy copays will be waived for the rest of the year. Your prescriptions will be paid at 100%.

Lifetime Maximum Benefit

Our health plan provides an unlimited lifetime benefit.

Schedule of Benefits

After the deductible has been satisfied, the plan will pay the following services at the described percentages until the out-of-pocket maximums have been met.

Service	In-network	Non-network
Copay Plan Physician Office Visit	\$0 MNPS Health Centers \$25 Primary Care Provider \$35 Specialist	70%
Coinsurance Plan Physician Office Visit	100% MNPS Health Centers 90% Coinsurance other Providers	70%
Copay Plan Lab work at Physician office	100% Included in the co-pay	70%
Coinsurance Plan Lab work at Physician office	90% Coinsurance	70%

Service (Both Plans)	In-network	Non-network
Calendar Year Deductible	\$250 individual \$750 Family	\$325 indiv. \$975 Family
Calendar Year Out-of-Pocket Maximum	\$2,000 individual	
Preventive Care	\$0 MNPS Health Centers \$25 co-pay Primary Care Provider/\$35 Specialist both plans	70%
Hospital Care	90%	70%
Emergency Room (Copay waived if admitted to hospital)	\$75 Copay then 90%	\$75 Copay then 70%
Physical/Occupational Therapy	90%	70%
Ambulance Services	90% - independent and network 70% - out of network	
Chiropractic Care	90% - 24 visits annually. No out of network benefit.	
Pre-admission testing	90%	70%
Second Surgical Opinions	90%	70%
Home Health	90%	70%
Skilled Nursing Facility	90%	70%
Mental Health Inpatient	90% 50 day annual limit	70%
Mental Health Outpatient	90% 30 visit annual limit	70%
Substance Abuse Inpatient	90% 50 day annual limit	70%
Substance Abuse Outpatient	90% 30 visit annual limit	70%
Prescription Drugs	Generics - \$5 Co-pay Preferred Drugs – \$20 Co-pay Non-Preferred Drugs – \$50 Co-pay	

How Does the Plan Control Cost?

In order to control cost, our health plan uses various strategies.

Preferred Provider Network

All Providers in our Network agree to discounted fees and to abide by certain quality standards. These arrangements insure better quality of care at better rates.

Preadmission Certification/Authorization

Before you enter a hospital for an elected admission or before you receive certain outpatient tests or procedures, information has to be sent to our Claims Administrator for review and approval. If you use a network provider, it is his responsibility to get the proper authorizations, and you will be held harmless if he fails to do so.

If you go out of network, it is your responsibility to get care authorized. If you fail to get an inpatient admission authorized, benefits for the Non-Preferred admitting Physician will be reduced to 70% of eligible charges after any applicable deductible is satisfied. Balances of charges after the benefit reduction will not apply toward any Out-of-Pocket limits in the covered person's coverage.

Medical Necessity Review

The health plan only provides for medical services, treatments or supplies that are considered medically necessary. To be eligible for benefits, the care needs to be

- Provided or under the direction of a hospital or physician
- Consistent with the symptoms or diagnosis of the person's medical condition
- Appropriate according to the standards of good medical practice
- Not solely for the convenience of the patient, physician or hospital
- And the most appropriate care that can be safely administered

Our Claims Administrator routinely reviews care to make sure we cover only medically necessary treatments. If you use a network

provider, it is his responsibility to provide only medically necessary care or to advise you if the treatment would not be covered by the health plan. You will be held harmless if he fails to do so.

If you go out of the network, it is your responsibility to insure that the care you receive is considered medically necessary. If you have a question regarding a treatment you should contact BCBST to verify coverage.

Are There Any Special Benefits?

Case Management

In cases where the patient's condition is expected to be or is of a serious nature the Plan Administrator may at its discretion arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. Alternative care will be determined on the merits of each individual case.

Chiropractic Care

Chiropractic Care is covered up to a maximum of 24 visits per year. Only in-network chiropractic services are covered. No benefits are provided for out-of-network chiropractors.

Home Health Care

Skilled Services provided by a Home Health Care Agency are covered by the Plan. These services include nursing care, therapy, oxygen and its administration and diagnostic services.

Hospice

Benefits for Hospice Providers will be provided for services related to the care of a terminally ill Patient (where life expectancy is six (6) months or less). Benefits will be paid at 90% in-network, 70% out-of-network. Prior authorization is required for in-patient services.

Preventive Care

In order to encourage early detection and prevention, the health plan provides for routine physicals, well child visits and other routine preventive care tests and immunizations for a \$25 co-pay

through an in-network provider (\$35 Specialist). Preventive care provided by non-network providers is covered at 70% and subject to the deductible. ***Preventive care provided by the MNPS Health Centers has a \$0 copayment.***

Maternity Care

Benefits are payable for pregnancy-related expenses on the same basis as for any other condition.

Under Federal Law, our health plan cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours or ninety-six (96) hours as applicable. In any case, our plan does not require that a provider obtain authorization for lengths of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

Precious Cargo - Healthy Babies Program

It's never too early to start taking care of a baby and our health plan believes in being very proactive in helping babies be healthy – moms, too. That's why as soon as your doctor says, "*Congratulations, you're expecting,*" you can enroll in the Precious Cargo Program.

As a participant in the Precious Cargo Program, you will have opportunities for education and support through your entire pregnancy – and after. You also receive a gift certificate.

Special features of Precious Cargo include:

- Support from a registered nurse case manager for moms and babies with special health care needs. These nurses are just a toll-free call away and can provide you with education on risk factors as well as offer access to services that can help you have a healthy delivery and baby.
- A gift certificate and free educational materials.

- Round-the-clock access to a valuable toll-free information line staffed by experienced registered nurses.

Enrollment in Precious Cargo is as easy as calling the toll-free number on your BCBST ID card, or 1-800-395-BABY (2229)

Medical Emergencies

Emergency services are medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

When faced with a medical emergency you need go to the nearest provider who can provide the care you need. Independently operated, or network facility operated ambulance charges will be treated as in-network. The first visit to a non-network emergency room provider in the event of an accident will be treated as in network.

A \$75 copayment does apply to Emergency Room use. If you are admitted to the hospital as an inpatient, the copayment will be waived.

Skilled Nursing Facilities/Rehabilitation Facilities

Confinements to Skilled Nursing or Rehabilitation Facilities are covered at the network levels after receiving prior authorization approval.

What Are the Behavioral Health Benefits?

Treatment of mental and nervous conditions and charges for alcoholism or chemical dependency treatments are paid at 90% after your deductible is satisfied as long as you use a network provider. Benefits for care received at non-network mental health providers are limited to 70% reimbursement after your deductible is satisfied.

Benefits are limited to 50 inpatient days and 30 outpatient visits per calendar year.

In addition to the Behavioral Health benefits provided under the Medical plan, MNPS provides counseling through the Employee Assistance Program (EAP) at no charge to employees and members of their household see pages 57-60.

How Is Incorrect Information Handled?

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. Eligibility requirements for employees and dependents are covered in detail in this book.

If your covered dependent(s) becomes ineligible, it is your responsibility to inform Employee Benefit Services and complete an enrollment/change application within one full calendar month of that dependent losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, even if you are under court order to continue to provide coverage. If there is any kind of error in your coverage or an error affecting the amount of your premium, it is your responsibility to notify your insurance preparer. Any refunds of premiums are limited to three months from the date a notice is received by Employee Benefit Services. Claims paid in error for any reason will be recovered from the employee.

Fraud, Waste and Abuse

Financial losses as a result of fraud, waste or abuse have a direct effect on you as a plan member. When fraudulent claims are paid or benefits provided to an individual that is not eligible for coverage, this reflects in the cost you and your employer pay for health care. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or participant fraud. You can help prevent fraud and abuse of the plan by working with us to fight those individuals who engage in fraudulent activities.

How You Can Help

- Pay close attention to the Explanation of Benefits (EOB) forms sent to you when a claim is filed under your contract and always call the toll-free number on the reverse side of your identification card to question any charge that you do not understand — this will prevent providers from billing for

services not provided to you or your dependents or misrepresenting the date of service, the amount charged or the type of service provided

- Report anyone who permits a relative or friend to “borrow” his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who fabricates claims or alters amounts charged on claim forms
- Please contact Employee Benefit Services to report fraud, waste, or abuse of the plan. All calls are strictly confidential.

What If a Mistake Was Made in Paying My Claim?

- If you believe an error was made in processing your claim
- If you have a question about your health coverage
- If you are unsure if a claim has been filed, or
- If you have a question regarding a dependent's eligibility

First call BCBST at 1-800-376-4695. If they are unable to answer your questions, contact Employee Benefit Services at 615-259-8463.

Is There an Appeal Process?

Claims Appeal

If you are appealing the denial of a service, first have your physician appeal the denial to BCBST.

Before initiating a health claims-related appeal, you should first contact the insurance company to get an explanation of the claims payment. If you are unable to resolve your issue, you may then request an appeal.

Appealing to the Insurance Company

Our insurance company has their own internal appeals process that must be followed prior to appealing to the Insurance Trust. Your first step is to contact BCBST at 1-800-376-4695.

Administrative Appeal

You may also request a review of administrative issues, including certain decisions made on behalf of the plans. To file this type of appeal, provide Employee Benefit Services with a letter detailing the circumstances of your situation. Your correspondence will be reviewed and you will receive a written response to your request.

Appealing to the Plan Administrator

This level of appeal is available to you if you have already been through the internal appeals process offered by your insurance company without a satisfactory resolution.

The appeal should be in the form of a letter (from the employee) detailing the events leading to the denial of the insurance claim. Copies of all correspondence and explanation of benefits relating to the claim should accompany the letter. Also include any other documented information, such as names of personnel you have talked with, dates of the communications, physicians' statements, etc. It is very important that you provide a phone number or email address where you can be reached during business hours so that you can be contacted with questions or information about your appeal. The deadline for filing an appeal is two years after claim rejection.

Appeal Review

When Employee Benefit Services receives your information, it will be thoroughly reviewed to determine the exact nature of your appeal. The majority of requests for appeals require additional review by the insurance company. The appeals coordinator will request that the insurance company provide (in writing) the criteria used in making its determination of benefits. The average review takes approximately 30 days to complete. Some cases take longer depending on whether additional information is needed, the response time for the requested information and the complexity of the medical condition.

Some cases may also require review by an independent medical consultant. The determination to request such a review will be made by the appeals coordinator.

Many appeals are resolved during this review phase of the process. If, however, your appeal is not resolved, it may be scheduled for presentation to the Review Committee.

Review Committee

The Review Committee is composed of two members of Employee Benefit Services and one member of the Insurance Trust. The Review Committee meets as needed to review appeals that have not been resolved. Prior to the Review Committee meeting, you will have the opportunity to notify Employee Benefit Services if you feel that any information in the file is incorrect or incomplete. The Review Committee has empowered by the Insurance Trust to resolve appeals.

VISION

What Is The Vision Plan?	45
What Services Are Available?	45
How Much Will It Cost Me?	46
How Do I Schedule an Appointment?	47
How Do I Get Questions Answered?	47

What is the Vision Plan?

The MNPS Certificated Employees Insurance Trust has purchased a vision plan for all active employees who are enrolled in the medical plan. It is added automatically, and there is no additional premium for this coverage charged to you. This plan is provided by CompBenefits, and is a network-based plan.

You may choose the eye care professional of your choice. To receive the highest level of benefits, you and your dependents must select an eye care provider from CompBenefits' list of participating eye care providers. When you select a participating eye care provider, your out-of-pocket costs for covered eye care services are limited to the co-payment amounts shown on your Schedule of Benefits.

What Services are Available?

Vision examinations – Each member is eligible for a comprehensive eye examination which shall include: 1) personal and family ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) papillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect recording cup disc ratio, blood vessel status and any abnormalities; 7) cover test; 8) tonometry; 9) refraction; 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. One such service will be covered in any 12 month period.

Materials – Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such materials will be covered, together with certain services as necessary. Services include but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses – One pair of prescription lenses once in any 12 month period.

Frames – One new frame once in any 24 month period. The VisionCare Plan Network Provider will show the member the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the

amount the Plan covers, the member is responsible for the difference in cost.

Contact lenses when elective – Benefits include: (1) The cost of an annual vision examination, subject to the Co-payment; and (2) the cost of contact lenses, any fitting costs and follow-up visit to a maximum of \$120.00, not subject to the Co-payment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any 12 month period.

Contact lenses when necessary – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and aesthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and /or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any 12 month period and only if prior authorization is obtained from the Plan. The Co-payment is waived.

How Much Will It Cost Me?

Co-payment – Co-payments are:

- | | |
|-----------------------|------|
| 1. Vision Examination | \$10 |
| 2. Materials | \$10 |

Allowance – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule:

Vision Examination	\$45
Single Vision Lens	\$40
Bifocal Lens	\$55
Trifocal Lens	\$70
Lenticular Lens	\$90
Contact Lenses (elective)	Exam+ \$120
Contact Lenses (medically necessary)	\$120
Frame	\$50

How Do I Schedule an Appointment?

Call to schedule an appointment with a CompBenefits participating provider and give your name, ID number, group number and the name of the group. The ID number and group number can be found on your CompBenefits ID card. After scheduling the appointment, the provider's office verifies your eligibility and benefits before performing the exam. There are no forms for you to complete. You simply pay the participating provider for any applicable co-payments and any extra costs for services and materials not covered by you at the time the services are rendered.

If you choose to receive covered services from a provider other than a CompBenefits participating provider, your benefits are based upon the allowances shown above. You must pay the provider in full at the time the services are rendered and then submit to us an allowance as shown in the Schedule of Benefits, and any services or materials NOT covered under your plan.

How Do I Get Questions Answered?

Should you have questions about your vision plan, you can call CompBenefits at 1-866-416-4369, or go online at www.compbenefits.com/custom/mnps

EMPLOYEE & FAMILY HEALTH CENTERS

What Are The Employee & Family Health Centers?	49
What Services Are Available?	50
How Much Will It Cost Me?	50
How Do I Schedule an Appointment?	51

What are the Employee & Family Health Centers?

One of the benefits of being enrolled in the MNPS' Health Plan is the ability to receive services from the Onsite Medical Clinics. The Clinics are run by an independent company, University Community Health Services. They are located around Metro Nashville and provide primary care exclusively to Metro retirees, employees and their dependents that are enrolled in the Health Plans.

Frequently Asked Questions

Who may use the Centers?

All employees of MNPS and Metro along with their dependents—MNPS and Metro retirees and dependents covered under the MNPS or Metro retiree health plans.

Can MNPS employees not covered under the MNPS or Metro health plans use the clinics?

Yes! Other insurance carriers will be billed.

University Community Health Services (“UHCS”) is closely affiliated with Vanderbilt School of Nursing and Vanderbilt Medical Center, and many of its staff also serve on the faculty of the nursing school.

The Clinics are staffed by highly qualified Family Nurse Practitioners with experience in the areas of Primary Care, Family Practice and Women’s Health. These Practitioners work under the supervision of the Clinic’s physician medical director.

Locations and Hours

The Health Centers are conveniently located with five facilities in Davidson county, close to your home or work.

North	Taylor Stratton Elementary 310 Old Hickory Blvd
Northeast	Two Rivers Middle 2991 McGavock Pike
Southeast	Mt View Elementary 3820 Murfreesboro Rd
West	Brookmeade Elementary 1015 Davidson Drive
Central	Administrative Complex 2601 Bransford Ave

Health Center Hours are:

Mon-Fri: 8am-6pm (all locations)
Saturday: 8am-12pm (Bransford)
Same day appointments when needed

What Services Are Available?

Primary Care

Frequently Asked Questions

Are you like drug store clinics?

NO! Care is given for chronic illnesses such as diabetes, hypertension, elevated cholesterol as well as minor illnesses and injuries. They can be your primary healthcare provider if you choose.

The Health Centers provide same day appointments for acute illness and minor injuries. Acute and chronic condition can be treated at the Health Centers, and the “appointment only” policy insures prompt treatment with little to no wait. The Center’s providers can treat you for conditions such as:

- Colds, flu, sore throat
- Respiratory infections
- High blood pressure
- Arthritis
- Allergies
- Diabetes
- Asthma
- And more

Our Family Nurse Practitioners are also a great resource for:

- Women’s health
- Annual physicals
- Sports physicals
- And Immunizations

How Much Will It Cost Me?

If enrolled under the MNPS Certificated Employee’s Health Plan, there is no cost for Health Center services.

If you are not enrolled under the MNPS Certificated Employee’s Health Plan, you can still receive care at the Centers and be billed for the balance due after your health plan pays. The Health Centers open to all MNPS and Metro employees, retirees and their dependents.

How Do I Schedule An Appointment?

Call 259-8755

Frequently Asked Questions

What happens if I need a specialist?

You will be referred to an appropriate specialist at the facility of your choice, or they can expedite a referral to Vanderbilt Medical Group.

What happens if I need to speak to a provider after hours?

A Nurse Practitioner is on call 24 hours a day/seven days a week.

Can you perform my annual physical or my child's physical or sports physical?

Yes, they provide excellent comprehensive preventive care and physical exams for patients of all ages.

DENTAL

What is the Dental Plan?	53
What Are The Distinguishing Features of Each Dental Option?	53
What Will The Plan Cover?	54
How Much Will I Have To Pay For Dental Care?	54
How Do I Get Questions Answered?	55

What is the Dental Plan?

The MNPS Certificated Employees Insurance Trust has purchased a dental plan for all active employees who are enrolled in the medical plan. It is added automatically, and there is no additional premium for this coverage charged to you. This plan is provided by Delta Dental, and is a network-based plan.

You may choose the dentists of your choice. To receive the highest level of benefits, you and your dependents must select a dental provider from Delta Dental's list of participating providers. When you select a participating provider, your out-of-pocket costs for covered services are limited to the co-insurance amounts shown on your Schedule of Benefits.

What Are The Distinguishing Features of the Dental Plan?

Benefit	Delta Preferred / Premier	
	In-Network	Out-of-Network
Annual Deductible	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Calendar Year Maximum (Class I, II, and III)	\$1,000 per covered individual	\$1,000 per covered individual
Class I – Preventive and Diagnostic	100%, no deductible	100%, no deductible
Class II – Basic Restorative	80%, after deductible	60%, after deductible
Class III – Major Restorative	50%, after deductible	50%, after deductible
Class IV – Orthodontia	50%, after deductible	50%, after deductible
Orthodontia Lifetime Maximum	\$1,000	\$1,000

What Will the Dental Plan Cover?

Class I expenses include: Oral exams, cleanings, bitewing x-rays, fluoride applications, sealants, and space maintainers (limited to non-orthodontic treatment).

Class II expenses include: Full mouth x-rays, panoramic x-rays, emergency care to relieve pain, fillings, and oral surgery – simple extractions.

Class III expenses include: Oral surgery – all except simple extractions, surgical extraction of impacted teeth, anesthetics, major periodontics, minor periodontics, root canal/therapy, relines rebases and adjustments, repairs – bridges, crowns, inlays and dentures, crowns, dentures, bridges, and histopathologic exams.

Class IV expenses include: Orthodontia.

This is not a full listing of benefits or exclusions, please refer to the Certificate of Coverage (COC) on the MNPS Employee Benefits website for detailed information. That web address is:

www.deltadentaltn.com/mnps

How Much Will I Have To Pay For Dental Care?

Payment for a service delivered by a Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Illustration above. The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the provider's actual charge.

Employees have access to both Delta Preferred and Delta Premier Providers. Using the Delta Preferred providers will lower an employees out of pocket expenses because those providers are accepting a lower Contracted Fee. When the percentage that you owe is multiplied by a lower amount, you save.

How Do I Get Questions Answered?

If you have questions regarding the Delta Dental Plan, you can call Delta Dental at 1-800-223-3104, or 615-255-3175, or go online at www.deltadentaltn.com/mnps to get answers.

EMPLOYEE ASSISTANCE PROGRAM

What Is The Employee Assistance Program?	57
What Services Are Available?	57
How Do I Access Services?	59
How Much Does It Cost?	59

What is The Employee Assistance Program?

The Employee Assistance Program (EAP) is a confidential counseling and referral service for all full-time employees and their dependents, regardless of whether you are enrolled in health coverage. Retirees covered under a MNPS-sponsored plan are also eligible. The EAP can handle problems related to

- emotional • financial • stress
- family • mental health • family/marital
- workplace • substance abuse • chronic illness
- grief • legal • elder care

Workshops and seminars are offered to employees on a regular basis at locations across Metro Nashville. Others are available upon request.

What Services Are Available?

- **24-Hour Member Advocate Line**—Members have 24/7 live access to master’s level Member Advocates for telephonic consultation, provider referral, and appointment scheduling assistance with specialists for legal, financial, or clinical issues. **1-866-563-8762.**
- **Goal and Success Planning Consultation**—Consultation and resource services to assist employees and families in achieving personal success and well-being.
- **Personalized Resource Materials**—Reinforcement for each consultation by providing members with informative materials, including educational literature that address the special needs of the employee as identified through the phone consultation.
- **Assessment and Counseling**—**MNPS** employees and their family members may receive short-term, in-person counseling sessions for assessment, problem solving, and referrals to additional resources.
- **National Network**—Nationwide coverage from anywhere in the United States, with more than 18,000 contracted and credentialed providers in our network.
- **HorizonCare™ Online**—Horizon’s website offers content, self-assessments, interactive tools, and educational guides.
www.horizoncarelink.com
 - *Login id: MNPS - Password: eap*

- **Legal Consultation Services**— This most frequently-utilized non-clinical service offers guidance to members seeking legal advice for issues such as will preparation, divorce, automobile accidents, elderly parent care, and other legal-related concerns.
- **Financial Consultation Services**—Members are able to receive assistance in managing inheritance or estate taxes, retirement fund rollovers or transfers, debt consolidation, and general tax or investment questions.
- **Telephonic Follow Up**—Horizon provides personal follow-up contact with each member to ensure the services provided are appropriate to the member’s counseling needs and are satisfactory.
- **Telephonic WorkLife Services**—Our WorkLife services target the life event issues most people experience at some point. We offer expert resources to assist your employees in finding appropriate resources for childcare, elder care, adoption, and other personal matters requiring careful research and detailed information. **1-866-563-8762**
- **HorizonCare™ Online Plus**—Easily accessible online EAP and WorkLife resources in one web-based application, giving members the power to access the information they need at the time and place most convenient.
 - www.horizoncarelink.com
 - *Login id: MNPS - Password: eap*
- **Worklife Services** - The WorkLife programs provide employees with convenient, confidential access to qualified specialists who can help address a variety of work-life issues, including but not limited to:
 - Child Care
 - Elder Care
 - Pet Care
 - Adoption
 - Education
 - Daily Support Services

Management Consultation and Referral

The management consultation and referral process offers managers and supervisors around-the-clock, year-round access to a team of master’s-level clinicians to help address employee disciplinary matters or work performance issues.

How Do I Access Services?

All services are strictly confidential and can be accessed by calling the contracted vendor who is available 24 hours a day, 365 days a year. The counselor who takes your call will ask you some questions and refer you to a provider based on the information you provide.

How Much Does It Cost?

There is no cost to you. You and your eligible dependents may receive unlimited counseling sessions at no cost to you. If it is determined that you need greater assistance than what the EAP can provide, you will be referred to your health insurance provider's mental health and substance abuse benefits.

FLEXIBLE BENEFITS

What are Flexible Benefits?	61
Pre-Tax Premium Payments	61
Medical Flexible Reimbursement Accounts	62
Dependent Care Reimbursement Accounts	63
Reimbursement Account Rules	63
How Does The Reimbursement Account Work?	64
How Do I Get Reimbursed?	65

What are Flexible Benefits?

A Flexible Reimbursement Account or Section 125 plan is a benefit plan that allows participants to re-direct some of their earnings into a customized spending account. The beauty of this plan is it is set up in accordance with Section 125 of the Internal Revenue Service code so benefits can be paid with tax free money. A Section 125 plan is completely income tax free; no Federal Income Tax, no Social Security tax, and no Medicare Tax.

MNPS offers 3 types of Flexible Reimbursement Accounts: Pre-Tax Premium Payments; Medical Reimbursement Accounts; and Dependent Care Accounts

Pre-Tax Premium Payments

The Pre-tax Premium Payment Program allows full-time MNPS Certificated employees to pay insurance premiums before income or social security tax is deducted. Pre-tax premiums reduce an employee's taxable income because they are deducted before taxes are withheld.

How Do I Enroll in This Program?

Enrollment in the Pre-tax Premium Payment Program is automatic. However, if you don't want to participate, you may complete a waiver form. This form must be signed and submitted before the end of each year. Detailed information can be obtained through the Insurance Department.

Are There Any Limitations to This Program?

Once enrolled in the Pre-tax Premium Program, Internal Revenue Service (IRS) rules do not allow your election to be changed for one year. This means you cannot cancel your coverage during the year, unless you experience a family status change like death, divorce, birth or adoption of a child, or a job change by you or your spouse. You must first have any such event approved through Employee Benefit Services. Any change you make must be relative to your family status change and reported within 60 days of the event.

Medical Flexible Reimbursement Accounts

A Medical Flexible Reimbursement Account allows you to set aside part of your salary each pay period on a pre-tax basis to pay for the out-of-pocket medical, dental, and vision care expenses not covered by your health benefits plan. There is a \$240 minimum to the amount you set aside, and the maximum is \$5,000 annually.

Eligible Expenses

The following is a partial list of expenses that are reimbursable tax-free with a Medical Flexible Reimbursement Account:

- Deductibles, co-pays, and other expenses not paid by insurance
- Prescription drugs and medical supplies
- Over-the-counter drugs like allergy medications, aspirin, or antacids
- Dental services, orthodontics, and dentures
- Eye surgery, glasses, contacts and contact lens solutions
- Weight-loss programs if prescribed by a physician for a medical condition
- Chiropractic services
- Psychiatric care and psychologist's fees
- Smoking-cessation programs

Medical Flexible Reimbursement vs. Claiming Expenses on a 1040

Unless your itemized medical expenses exceed 7.5% of your adjusted gross income, you cannot claim them on your IRS Form 1040. But you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Flexible Reimbursement Account.

Dependent Care Reimbursement Accounts

The Dependent Care Reimbursement Account allows you to set aside a maximum of \$5,000 in pre-tax dollars per calendar year to pay for eligible dependent care expenses.

Eligible Expenses

Dependent care expenses are eligible for reimbursement if they meet the following criteria:

- The annual amount submitted for reimbursement does not exceed the lesser of your income or your spouse's income.
- The expenses are necessary to enable you to work.
- Your dependent is under age 13 or physically or mentally incapable of caring for himself or herself.
- Your dependent is eligible to be claimed as a dependent on your Federal Income Tax Return.
- Your payments are not made to a person you claim as a dependent.
- If the services are provided by a dependent care center that provides care for more than six individuals (other than a resident of the facility), the center must comply with all state and local laws.

Note: When filing your Federal Income Tax Return you will be required to supply the name, address and taxpayer identification number of the dependent care provider.

Reimbursement Account Rules

Because reimbursement accounts offer tax advantages, the IRS places certain restrictions on these accounts.

- You cannot transfer money between accounts.
- You cannot change the annual amounts without an approved qualifying mid-year event.
- **You must use the full amount in the account each plan year, or lose it. The "Use it or lose it" rule means if you don't use all of the money in your account, you cannot get a refund or roll it over into the next plan year. For this reason, it's important that you set up your annual**

Flexible Reimbursement Accounts only for predictable expenses to be incurred during the plan year.

Who is Eligible to Participate?

All employees who are eligible for the MNPS Certificated Employee Health Benefits Program may participate. Enrollment in the MNPS Certificated Employees Health Benefits Program is not required.

How Does the Reimbursement Account Work?

- First, estimate how much money you'll spend from during the plan year for expenses which qualify for reimbursement. Your contribution to the account must be less than the maximum amounts allowed for each account.
- Once you've enrolled in an account, each pay period the amount you allocate to your Reimbursement Account is taken out of your pay before taxes are calculated and withheld. The money you set aside for your account is tax-free.
- During the plan year, when you pay for eligible expenses, you will be reimbursed for them with the tax-free money you have set aside in your Reimbursement Account by simply filing a Reimbursement Request Form with the supporting documentation.

Enrollment Period

Each year you must re-enroll in the account, even if you wish your total annual contribution for the new plan year to remain the same. You will be given opportunity to enroll during the fall open enrollment period.

Coverage Period

If you enroll in a Reimbursement Account during Open Enrollment, your period of coverage is the same as the plan year. The plan year is the calendar year plus 2.5 months (ex: January 1st, 2009 through March 15th, 2010). If you enroll after the plan year begins, your period of coverage begins on the effective date of your coverage (which will always be the first of the month) and ends on the last day of the plan year.

If you terminate employment or become ineligible to participate in the program, your Medical FRA will end the last day of the month unless you elect to extend participation in the Medical Reimbursement Account through the end of the plan year.

If you stop your participation in a Medical FRA due to a qualifying mid-year event, the account will end the last day of the month following receipt of a completed election form.

How Do I Get Reimbursed?

When you enroll, you will have the option of either using a debit card or filing claims for reimbursement.

Debit cards eliminate the "lag time" in claims reimbursement. Rather than paying the provider for eligible expenses with a personal check and then faxing the receipts to have your reimbursement check mailed to you, just swipe your Debit Card and you're done.

If filing a claim for reimbursement, you can go to <http://www.mnps.org/Page3424.aspx#flex> and download a copy of the claim form and directions. Forms are also available in Employee Benefit Services. You may submit a form anytime you incur reimbursable expenses during the plan year and up to three months after the end of the plan year. Forms may be faxed to the vendor for reimbursement at 1-850-425-4608.

For Medical Reimbursement Accounts, you will be reimbursed from your account for the total amount of the qualifying expenses claimed, up to your plan year election (as long as the expenses were incurred during your period of coverage).

For Dependent Care Reimbursement Accounts, you will be reimbursed from your account up to your existing balance.

LIFE INSURANCE

What Life Insurance Coverage is Available? 67

What Does Accidental Death & Dismemberment Coverage Provide? 68

When Can I Purchase Additional Life Insurance? 68

What Happens if I Become Disabled? 69

If I Become Terminally Ill Can I Access my Life Insurance? 69

What if I Die While Traveling? 70

Who Can Help My Beneficiaries? 70

What Life Insurance Coverage is Available?

To be eligible for the various life and special accident insurance programs, you must meet the eligibility guidelines listed on pages 13 (employees) and 16 (dependents). In addition, children are not covered until 15 days of age.

Basic Term Life and Accidental Death & Dismemberment Insurance

EMPLOYEE BASIC LIFE AND ACCIDENTAL DEATH

MNPS provides, at no cost to the active full-time employees, \$50,000 of basic term life and \$50,000 of basic special accidental death and dismemberment (“AD&D”).

The face amount of coverage is reduced to 65% at age 65, 50% at age 70.

Additional Life Coverage

These programs are available on a contributory basis for employees and dependents (spouse and children) whether or not they participate in health coverage. For guaranteed-issue coverage, the employee must enroll during the first full month of employment with MNPS. If optional life coverage is not elected at that time, the employee may only apply at a later date by furnishing satisfactory evidence of insurability.

EMPLOYEE OPTIONAL TERM LIFE & ACCIDENTAL DEATH COVERAGE

Employees may elect up to \$300,000 in optional life and accidental death insurance. Coverage is purchased in \$10,000 increments and premiums are based on the employee’s age. This is 5-year level term coverage. It increases when the employee reaches age 25, 30, 35, etc....

SPOUSE BASIC LIFE

If enrolled in the medical plan, spouses are automatically enrolled in life coverage as well. If not enrolled in the medical plan, employees may purchase \$25,000 of life insurance on their spouse. The premiums are constant and do not increase with employee age.

The face amount of coverage is reduced to 65% at age 65, 50% at age 70.

CHILD BASIC LIFE

If enrolled in the medical plan, children are automatically enrolled in life coverage as well. If not enrolled in the medical plan, you can also purchase life insurance on your eligible dependents (see dependent eligibility rules on page 16) for a face value of \$10,000. Premiums are collected on a per family basis, meaning that your premium amounts do not increase with the number of children you have. One premium covers all children in the family. Children are not covered until 15 days of age. Children age 15 days to 6 months have \$5,000 of coverage.

What Does Accidental Death & Dismemberment Coverage Provide?

The basic employee life coverage and the optional employee life policy have an Accidental Death and Dismemberment rider (“AD&D”). This additional benefit doubles the value of your life insurance coverage if you die in an accident. In addition, the dismemberment coverage provides benefits if you survive an injury, but lose the use of a body part.

SEAT BELT AND AIRBAG BENEFIT

If you suffer a loss while in an automobile and wearing a seatbelt, an additional benefit of \$10,000 will be provided. If you were also positioned behind an airbag an additional \$5,000 will be paid.

ADDITIONAL BENEFITS

Our life policies also provides: child care benefits for surviving children under 12; a coma benefit that provides a benefit for individuals who have been in a coma for a minimum of 31 days; dependent child education benefit that provides an education benefit to help current students complete post-secondary education; and spouse education benefit that can assist surviving spouses pay for higher education.

When Can I Purchase Additional Life Insurance?

NEW HIRES

New hires have 60 days from the date they are first eligible for coverage (see eligibility on page 11) to purchase guaranteed issue life insurance.

NEWLY ACQUIRED DEPENDENTS

Employees can purchase guaranteed issue Spouse basic life and optional life within 60 days of their marriage. They can also add dependent coverage within 60 days of acquiring their first dependent child.

LATE APPLICANTS WITH EVIDENCE OF GOOD HEALTH

During the fall annual enrollment period time, you can apply to purchase additional life insurance coverage, but you will have to submit evidence of good health. The insurer will review your application and make final determination regarding your eligibility.

DEPENDENT CHILDREN

Dependent Child coverage can be added during the annual enrollment period without need for evidence of good health.

What Happens if I Become Disabled?

If you become totally disabled before age 60 and your disability lasts for at least 6 months, you can qualify for a waiver of premium. You must provide proof of your disability within one year of your last day worked. Once approved, your coverage will continue without payment of premiums up to age 65 as long as you remain totally disabled.

Premium for your dependents' coverage will also be waived. Coverage for your dependents will terminate when your policy terminates.

All premiums must be paid and kept current until the disability waiver is approved. Contact the Insurance Department for assistance with waiver of premium applications.

If I Become Terminally Ill Can I Access my Life Insurance?

If you or your dependent is less than 60 years of age and have more than \$10,000 in coverage you can request up to 100% of your life insurance proceed prior to your death. You must present documentation of being diagnosed with a terminal illness with a life expectancy of less than 12 months.

What if I Die While Traveling?

If death occurs while traveling at least 75 miles away you're your primary residence, a repatriation benefit will be provided for the transportation of the body or its preparation for cremation. The benefit will be no greater than actual cost or \$5,000.

Who Can Help My Beneficiaries?

Grief, legal and financial counseling is available for beneficiaries at no charge through our carrier.

Call **1-866-293-6047**, to be directed to the beneficiary financial counselors provided by our life carrier.

In addition, the beneficiaries may be able to receive additional help through our **Employee Assistance Program**. Call **1-866-563-8762**.

RETIREMENT

What Retirement Plans Are Available?	73
What Are My Retirement Benefits?	73
When Can I Retire?	74
Can I Contribute to a Retirement Account?	75

What Retirement Plans Are Available?

Typically, there are two types of retirement plans: Defined Benefit Plans and Defined Contribution Plans.

These plan types are summarized below:

Defined Benefit Plan

- Benefit at retirement is based on a set formula which describes the benefit. e.g. (percent of pay) times (years of service) equals benefit.
- The employer bears the risk of investment loss.
- Contributions are not available for loans or withdrawal until termination of employment.
- Benefit payments are for an employee's lifetime.
- MNPS/TCRS Provides a Defined Benefit Plan

Defined Contribution Plan

- The benefit available at retirement is the retiree's account balance. Contributions based on a dollar amount or a percent of pay are put in each year. What it becomes over time is a result of the amount put in and the investment return.
- The employee chooses the investments and bears the risk of investment losses.
- Contributions may be available for withdrawals or loans; and subject to early withdrawal penalties.
- Examples of defined contribution plans: 403(b), 457, 401(k) plans.

What Are My Retirement Benefits?

MNPS is a member of the Tennessee Consolidated Retirement System ("TCRS"). TCRS is a trust fund established by the Tennessee General Assembly for the purpose of administering a retirement program for public employees.

All teachers in public school systems are Group 1 members. Teachers contribute five (5%) percent of salary to the Plan. MNPS pays an additional amount determined by an actuarial valuation.

Members attain vesting rights with five (5) years of service in TCRS. Vesting mean you have accrued enough service to guarantee a retirement benefit once the age requirements are met.

Visit <http://www.treasury.state.tn.us/tcrs/> for more information about the Tennessee Consolidated Retirement System.

When Can I Retire?

MNPS employees who are vested in the retirement plan are eligible for the various retirement options:

Service Retirement

An unreduced benefit payable to an employee who has met the requirements for employees who have attained age 60 with vesting rights or completion of 30 years of creditable service at any age.

Early Retirement

A reduced benefit is payable to an employee who retires prior to attaining the requirements for a full service benefit.

To be eligible for early retirement the employee must be age 55 and have 10 years of creditable service.

Disability Retirement

TCRS also provides disability benefits for those members who become disabled prior to meeting the service retirement requirements. There are two types of disability: ordinary and accidental.

Ordinary Disability Benefits

To qualify for Ordinary Disability benefits (a disability because of medical reasons), you must have at least five years of service, be unable to engage in any gainful employment and you must be approved by the TCRS medical panel. After approval, you are subject to periodic re-evaluations until you attain age 60.

Accidental Disability Benefits

To qualify for Accidental Disability benefits, your disability must be the direct result of an on-the-job injury that renders you unable to engage in any gainful employment. There are no minimum service requirements to apply for accidental disability. The disability must be documented to your last paid day of service; however, you must apply within one year of last paid date or within two years of the injury. You must be approved by the TCRS medical panel. After approval, you are subject to periodic evaluations until you attain age 60.

Can I Contribute to a Retirement Account?

In addition to our defined contribution plan, MNPS offers a deferred compensation plan, a 403(b) that allows employees to contribute additional funds towards their retirement. These contributions are employee funded and not matched by MNPS. MetLife administers the 403(b) plan. For more information regarding the plan and how you can participate please contact:

- Mike Shrieve, 615-874-0087, mshrieve@metlife.com, for Antioch, Cane Ridge, McGavock, Administrative Complex, Martin Luther King, East Literature, Hume Fogg, Hunters Lane, Maplewood, Stratford
- Linda Pearson, 615-371-3817, lpearson@metlife.com, for Glenclyff, Hillsboro, Overton, Hillwood, Pearl-Cohn, Whites Creek, Big Picture

The plan allows an employee to defer up to \$16,500 in compensation per calendar year. Additionally, if you are over age 50 you may be entitled to a \$5,500 catch-up provision, and if you have over 15 years service with MNPS you may be eligible for an additional \$3,000 catch-up provision.

The 403(b) is an individual contract with multiple investment options and loans and withdrawal provisions.

The key features of the MetLife Plan are:

- Mutual Funds – Best of Class
 - 22 Best of Class Mutual Funds by type. Large Cap, Small Cap, Income, Growth, Target Date.
- Fixed Account – MetLife Strategic Value Annuity
 - Current rate 3.7%
 - Guarantee minimum interest rate 3%
 - Principal protection
- Self-directed Brokerage Account
 - Ability to invest in more than 7,000 mutual funds, over 250 fund families.
 - Online trading
 - Account access via web, voice response or broker representative
- Plan pricing
 - No surrender charges, very low administrative cost

NOTES
