

RETIREMENT PACKET (Check List)

1). You must meet one of the retirement qualifications to be eligible to retire:

- Full retirement – 30 years of service or 60 years old with 5 years of service (vested)
- Early retirement – 55 years old with 5 years of service (vested) or 25 – 29 years
- Disability retirement – 5 years of service (vested) or approved accident on the job
 - You must be on an approved Leave of Absence – pending the approval of your Disability Retirement application
 - You must continue making payments for your health benefits pending the approval of the Disability Retirement application

2). Eligibility to continue benefits are based on Bartlett City Schools' approved board policy, excerpt listed below.

For Bartlett City Board of Education employees hired directly from Shelby County Schools prior to August 4, 2014 and employees hired by Bartlett City Board of Education between January 1, 2014 and June 30, 2014. Payment of individual hospitalization insurance coverage shall be available for any retiring employee at the same cost as for other employees until the employee reaches age sixty-five (65) provided that the employee is eligible for retirement under the eligibility standards as set by Tennessee Consolidated Retirement System; and the employee has been enrolled in the Bartlett City Board of Education sponsored insurance plan for one (1) full year immediately prior to retirement; and the employee has completed fifteen (15) years' service with Bartlett City Schools. For employees in this category hired directly from Shelby County Schools, prior service credited by Shelby County Schools will be applied to the 15-year service requirement.

(Please note, the district does provide and share in the cost of a Medicare Advantage Plan to post-65 retirees)

PLEASE COMPLETE THE ONLINE FORMS LISTED BELOW.

- Resignation/Retirement notice (*found on the Employee portal*)
- Application for Service of Early Retirement Benefits: <https://mytcrs.tn.gov>

IF YOU MEET THE ABOVE LISTED ELIGIBILITY REQUIREMENTS, please complete, and return the documents included in this packet, to the Employee Benefits office.

- **Application to "Continue Benefits at Retirement" form.** The purpose of this form is to re-enroll in Medical, Dental and Vision. The district continues to share in the cost of the medical plan. Coverage is extended to dependents already covered on the plan. Retirees must be enrolled in the medical plan to continue the dental and vision benefits. The benefits for the medical, dental and vision plans are the same benefits enjoyed by active employees.

- ***Aetna Medicare Advantage Plan** - This is the post-65 medical benefit offered to eligible retirees. The district contributes toward the cost of the post-65 benefits. In addition, for retirees who were teachers, TCRS also contributes an amount toward the cost too. The amount of the contribution is based on the retiree's years of service. Please make sure to enroll in Medicare Part A & Part B when first eligible, or at retirement.
 - o This plan provides the following benefits:
 - Large network of providers
 - Low copays at doctor and pharmacy
 - No deductibles
 - Annual Preventative and Wellness screenings included with no copay
 - COVID-19, Pneumonia, Flu and Hepatitis B immunizations covered with no copay
 - Silver Sneakers – Fitness benefits
- **Change of Beneficiary for Basic Life Benefits** - The district provides 1-time annual earnings up to \$50,000, to those eligible to continue the Basic Life benefits. Please return this form to make sure the district has the most current beneficiary designation.
- **Cancel form** – *Please complete form only if you are 'waiving' coverage for medical. (Canceling the medical, does not impact the Basic Life benefits continued at retirement, if eligible).*

Please Note: *The Care4US clinic is not available for use for retirees eligible for the Aetna Medicare Advantage Plan.*

BENEFITS CANCELED AT RETIREMENT

- Disability and Cancer policies (*American Fidelity will send information to continue through American Fidelity*)
- Voluntary Employee, Spouse and Child life (*may convert these benefits with Standard*)
- Contributions to Valic
- FSA/Dependent Childcare polices – (*You have 70 days past the termination of the benefit to claim funds*)
- Retirees not eligible to continue medical, dental and/or vision, and who are not eligible for Medicare, will be offered COBRA.

Open Enrollment for retirees will be offered each summer. It's at that time, information regarding possible premium and benefit changes will be communicated. This is also when retirees will have the opportunity to drop or make changes to their benefits. ***If you decline the medical benefits at retirement, or during Open Enrollment, you will not be allowed to enroll later, even if you lose benefits.***

** If you or your insured dependent are eligible for Medicare at the time of retirement, please notify the benefits office. There is a form BCS can provide to allow you and/or your spouse enrollment in Medicare's "Special Enrollment" provision.*

RETIREE MEDICAL PREMIUMS
as of 09-01-2022

PLAN	DESCRIPTION/TIER	EMPLOYEE COST
Medical COPAY Through MedBen	Medical COPAY Single Cov.	\$ 154.91
	Medical COPAY Employee + 1	\$ 457.37
	Medical COPAY Family	\$ 638.03
Dental Through Delta Dental	DESCRIPTION/TIER	EMPLOYEE COST
	DPP0 - \$2000 - Single Cov.	\$ 42.34
	DPP0 - \$2000 - Employee + 1	\$ 88.92
	DPP0 - \$2000 - Family	\$ 127.03
	DPP0 - \$1500 - Single Cov.	\$ 29.34
	DPP0 - \$1500 - Employee + 1	\$ 61.61
	DPP0 - \$1500 - Family	\$ 88.03
Vision Through Davis Vision	DESCRIPTION/TIER	EMPLOYEE COST
	Vision - Single Cov.	\$ 6.79
	Vision - Employee + 1	\$ 13.00
	Vision - Family	\$ 21.11
POST 65 MEDICAL BENEFITS AETNA MEDICARE ADVANTAGE PLAN	DESCRIPTION/TIER	*EMPLOYEE COST
	Single coverage	\$ 109.63
	Employee +1	\$ 219.26
	*Family	\$ 328.89
	Single coverage (\$25)	\$ 84.63
	Employee +1 (\$25)	\$ 194.26
	*Family (\$25)	\$ 303.89
	Single coverage (\$37.50)	\$ 72.13
	Employee +1 (\$37.50)	\$ 181.76
	*Family (\$37.50)	\$ 291.39
	Single coverage (\$50)	\$ 59.63
	Employee +1 (\$50)	\$ 169.26
	*Family (\$50)	\$ 278.89
Rates for 1 person on Medicare and 1 not, are based on individual coverage for each benefit plan. *Family coverage for the Medicare Advantage Plan is for 3 people		
** The state, for certified teachers, supplements the Medicare Advantage Plan based on the retiree's years of service		

Application to Continue Benefits at Retirement

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME		FIRST NAME		MI	EFFECTIVE DATE: (MM/DD/YYYY)
SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed		RETIREMENT DATE: (MM/DD/YYYY)
MAILING ADDRESS			School District 		
CITY					
STATE	ZIP	EMAIL			
HOME PHONE NUMBER		CELL PHONE NUMBER			
ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? ☐ YES ☐ NO (i.e. Medicare, Tricare, Spouse's plan)					
IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____					
TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (☐ Self, ☐ Spouse):					
IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____					
ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)					

How healthcare reform affects your plan:

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as health care reform includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing

Important note: Dependent coverage is now available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee's biological, step, foster or adopted child (including a child placed for adoption) until such child reaches age 26

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (If applicable)	COVERAGE LEVEL
MEDICAL/RX	COPAY PLAY (Pre-65 Benefit)	☐ SINGLE ☐ EMPLOYEE + ONE ☐ FAMILY ☐ DECLINE
	☐ *Medicare Advantage Plan (Post 65 benefit)	Check below if the Medicare Advantage Plan is for: ☐ Employee ☐ For Spouse ☐ Both
DENTAL (Must have Medical)	☐ DPPO \$1,500 ☐ DPPO \$2,000	☐ SINGLE ☐ EMPLOYEE + ONE ☐ FAMILY ☐ DECLINE
VISION (Must have Medical)		☐ SINGLE ☐ EMPLOYEE + ONE ☐ FAMILY ☐ DECLINE

DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE	DISABLED DEPENDENT*
					☐ MEDICAL/ RX ☐ DENTAL ☐ VISION	☐ YES ☐ NO
					☐ MEDICAL/R X ☐ DENTAL ☐ VISION	☐ YES ☐ NO
					☐ MEDICAL/RX ☐ DENTAL ☐ VISION	☐ YES ☐ NO
					☐ MEDICAL/RX ☐ DENTAL ☐ VISION	☐ YES ☐ NO
					☐ MEDICAL/RX ☐ DENTAL ☐ VISION	☐ YES ☐ NO

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, ☐ FULL TIME ☐ PART TIME						SPOUSE EMPLOYER NAME:		SPOUSE DATE OF BIRTH:	
INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS ENROLLED IN WITH HIS/HER EMPLOYER									
TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE(MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN				
MEDICAL									
PRESCRIPTION									
DENTAL									
VISION									

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐ YES ☐ NO						
EMPLOYER PROVIDING COVERAGE: IF YES, COMPLETE THE QUESTIONS BELOW						
TYPE OF OTHER COV.	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COV. (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
MEDICAL						
PRESCRIPTION						
DENTAL						
VISION						

*COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW					
LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	HICN	IS MEDICARE COV. DUE TO:
					☐ AGE ☐ DISABILITY ☐ ESRD
					☐ AGE ☐ DISABILITY ☐ ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my premium deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the premium deductions, if any, I am required to make per month to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the monthly deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above. I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you will not be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you *may be able to enroll new your dependent(s) provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you are declining to enroll yourself or an eligible dependent for health coverage because you have (or your dependent has) existing health coverage, your employer will require that you provide a written statement indicating that you are declining coverage because of the existing health coverage.

To request special enrollment, contact your Employee Benefits representative at 901-202-0855, ext. 2242 or email bclark@bartlettschools.org.

*Special Enrollment privileges are applicable to the Retiree only and do not apply to the surviving spouse.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE



My Name is: _____

Effective date of change/cancel: _____

***MEDICAL**

☐

I would like to cancel my Medical plan (*cancelling the medical insurance also terminates the dental and vision insurance if applicable*)

Signature

Date

* Please know that cancelation of these continued benefits is permanent and cannot be added at a later date, even if you lose coverage.

This change does NOT affect your continued life insurance with the district.

Return notice to Employee Benefits Department, 5705 Stage Road, Bartlett, TN 38134 or email the form to benefits@bartlettschools.org.

**STANDARD INSURANCE COMPANY****Beneficiary Designation/Change**

This designation will apply to the following Standard Insurance Company coverage (s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance and, unless specified otherwise on a separate sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to the Employer during your lifetime.

Sign and date the completed form and return it to your Human Resources Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle)	Social Security No.		
Your Address:	City	State	Zip
Group Name: Bartlett City Schools	Group No. 00-752189-0002		

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box (es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary – John Q Doe, 60%; Jane Q Does, 40%."

Primary – Full Name	Address	Soc. Sec. No.	Relationship	Phone	% of Benefit
Contingent – Full Name	Address	Soc. Sec. No.	Relationship	Phone	% of Benefit

Signature of Member/Employee

A digital signature will not be accepted as a legal signature

Date



Employer Group Enrollment Form Instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. The instructions for each section of this enrollment form are below. You can use this form to enroll or to submit a plan change if you're already enrolled.

- Effective date:** Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**
- Former employer information:** Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)
- Personal information:** This is your name, address, phone number, etc. **Please print clearly.**
- Health plan selection:** Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
- Select a provider:** **For Aetna Medicare Plan (HMO):** You're required to have a primary care physician (PCP) on file with us. This means you need to tell us who your doctor is. Write in the name of your PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
For Aetna Medicare Plan (PPO): You have the option to choose an Aetna network PCP. But when we know your doctor we can better coordinate your care. Write in the name of your Aetna Network PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
- Medicare information:** This is your Medicare insurance information, found on your red, white and blue Medicare card. Complete all the fields to avoid a delay in your coverage.
- Disclosures:** Read this information carefully.
- Signature required:** Sign and date the application in the space provided.
Authorized representatives: Sign the form and write in your information.
- Make a copy for yourself and return the original:** Make a copy of this entire application for your records. Then return your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may be included for your convenience.

Please call your former employer/union/trust or Aetna Medicare with any questions.

Phone number: 1-800-307-4830 (TTY: 711)
Hours: Monday - Friday, 8 AM to 9 PM ET
Mail to: Aetna Employer Group PO Box 7082 London, KY 40742
Website: AetnaRetireePlans.com
Fax Number: 1-833-806-0689

Make a copy for yourself and return the original

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Effective date: / 01 / 2022

Former employer/union/trust information: Write the name of the former employer/union/trust offering your retiree health plan unless this information is pre-filled.

Name of former employer/union/trust
IHBC - Bartlett City Schools

Group number
AE466538

Class code
803

Your information

Last name

First name

Middle initial

Birth date
(_ _ / _ _ / _ _ _ _)
(M M / D D / Y Y Y Y)

Sex
☐ M ☐ F

Primary phone number (_ _ _ _) _ _ _ - _ _ _ _

Secondary phone number (_ _ _ _) _ _ _ - _ _ _ _

Email address

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit (please specify)

City	County	State	ZIP Code
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Mailing address (only if different from your permanent residence street address)

City	State	ZIP Code
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Health plan selection

Check the box next to the plan you want to enroll in. Then write the name of the specific plan on the line provided (this information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on the last page of this form.**

☐ Aetna Medicare HMO (write plan name below)

☐ Aetna Medicare PPO (write plan name below)

☐ Aetna Medicare HMO with Rx
(write plan name below)

☒ Aetna Medicare PPO with Rx
(write plan name below)

Are you enrolled in another Medicare Advantage plan? If yes, fill in the following:

I'm currently enrolled in a Medicare Advantage plan issued by:

Name of insurance company _____

I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Applicant name:

Effective date: / 01 /2022

Tell us your provider

A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. To select a PCP visit our online provider directory at **AetnaMedicare.com/findprovider** or call the phone number on the instructions page of this enrollment form.

Write the full name of your PCP

Are you a current patient?

☐ Yes ☐ No

Provider ID (if applicable) (located in the provider directory):

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Primary Care ID (located in the provider directory):

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Provide your Medicare insurance information

Medicare Number _ _ _ _ - _ _ _ - _ _ _ _

Is Entitled To:

Effective Date:

HOSPITAL (Part A)

_ _ / _ _ / _ _ _ _

MEDICAL (Part B)

_ _ / _ _ / _ _ _ _

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions

☐ Yes ☐ No

1. **Are you an Aetna member?**

If "Yes," provide your member ID number _____

☐ Yes ☐ No

2. **Are you the retiree?** If "Yes," provide retirement date: _ _ / _ _ / _ _ _ _

If No, name of retiree: _____

☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer, trust or union plan?**

If "Yes," name of spouse: _____

Name(s) of dependent(s): _____

☐ Yes ☐ No

4. **Was your previous policy terminated?**

If "Yes," provide termination date: _ _ / _ _ / _ _ _ _

☐ Yes ☐ No

5. **Are you a resident in a long-term care facility, such as a nursing home?**

If "Yes," provide the following information:

Name of facility: _____ Phone number: (_ _ _) _ _ _ - _ _ _ _

Address: _____ State: _____ ZIP: _____

☐ Yes ☐ No

6. **Are you enrolled in your state's Medicaid program?**

If "Yes," write in your Medicaid number: _____

☐ Yes ☐ No

7. **Will you have other prescription drug coverage in addition to the Aetna Medicare plan?** Some individuals may have other drug coverage, including other private

insurance, worker's compensation, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

If "Yes," please list your other coverage and identification number(s) for this coverage.

Name of other coverage: _____

ID #: _____ Group #: _____

☐ Yes ☐ No

8. **Have you had creditable coverage since you became eligible for Medicare**

prescription drug coverage? Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.

If "Yes," my coverage started on _ _ / _ _ / _ _ _ _ (date) and ended on

_ _ / _ _ / _ _ _ _ (date).

Name of other coverage: _____

NOTE: If you've not had creditable coverage, you may have to pay a late enrollment

penalty. Aetna may ask you to provide evidence of creditable coverage. If you have

questions about the late enrollment penalty, call Aetna at the number provided on this form.

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Applicant name: _____ **Effective date:** / 01 / 2022

Indicate your preferred spoken language (if not English): ☐ Spanish ☐ Other _____

Indicate your preferred written language (if not English): ☐ Spanish ☐ Other _____

If you need information in another language or accessible format (e.g. large print or braille), contact us at **1-888-267-2637 (TTY: 711)** 8 AM to 6 PM, local time, Monday through Friday.

DISCLOSURES – Read this section carefully and sign below

By completing this enrollment application, I agree to the following: Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

The Aetna Medicare plan serves a specific service area. If I move out of the area that Aetna Medicare plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I'm a member of the Aetna Medicare plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage with this Medicare plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

HMO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

PPO plans: I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

I understand if I'm getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the Aetna Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

Signature _____ **Today's date** ____/____/____

If you're the authorized representative helping someone fill out this form, you must sign above and provide the following information.

Representative's name	Address
Phone number (____) _____ - _____	Relationship to enrollee



Benefits and Premiums are effective January 1, 2022 through December 31, 2022

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.

Annual Deductible	\$0
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This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.

Annual Maximum Out-of-Pocket Amount

Annual maximum out-of-pocket limit amount \$2,500
includes any deductible, copayment or coinsurance that you pay.

It will apply to all medical expenses except Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	\$0 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Observation Care	Your cost share for Observation Care is based upon the services you receive.
Outpatient Services & Surgery	\$0
Ambulatory Surgery Center	\$0



PHYSICIAN SERVICES		☐ This is what you pay for network & out-of-network providers.
Primary Care Physician Visits	\$20	
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	\$35	
PREVENTIVE CARE		☐ This is what you pay for network & out-of-network providers.
Medicare-covered Preventive Services	\$0	
<ul style="list-style-type: none">• Abdominal aortic aneurysm screenings• Alcohol misuse screenings and counseling• Annual Well Visit - One exam every 12 months.• Breast exams• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.• Cardiovascular behavior therapy• Cardiovascular disease screenings• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.• Depression screenings• Diabetes screenings• HBV infection screening• Hepatitis C screening tests• HIV screenings - annually for patients younger than 15 and adults older than 65 at increased risk for HIV infection• Lung cancer screenings and counseling - Aged 55-77• Nutrition therapy services• Obesity behavior therapy• Pelvic Exams - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.• Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service		



MUNICIPAL SCHOOL DISTRICTS OF SHELBY COUNTY

Aetna MedicareSM Plan (PPO)

Medicare (C04) ESA PPO Plan

Rx 1211

☐ ☐
• Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)

• Sexually transmitted infections screenings and counseling

☐ • Tobacco use cessation counseling

• Welcome to Medicare preventive visit

☐ • Bone mass measurements \$0

• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)

- For all members aged 50 to 85 years

• Medicare Diabetes Prevention Program - 12 \$0

☐ month of core session for program eligible members with an indication of pre-diabetes.

☐ **Immunizations** \$0

• Flu

• Hepatitis B

• Pneumococcal

Additional Medicare Preventive Services \$0

• Barium enema - one exam every 12 months.

• Diabetes self-management training (DSMT)

☐ • Digital rectal exam (DRE)

• EKG following welcome exam

• Glaucoma screening

EMERGENCY AND URGENT MEDICAL CARE This is what you pay for network & out-of-network providers.

Emergency Care; Worldwide \$0
(waived if admitted)

Urgently Needed Care; Worldwide \$0



MUNICIPAL SCHOOL DISTRICTS OF SHELBY COUNTY

Aetna MedicareSM Plan (PPO)

Medicare (C04) ESA PPO Plan

Rx 1211

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology MRI and CT scans	\$0
Lab Services	\$0
Diagnostic testing & procedures	\$0
Outpatient X-rays	\$0
HEARING SERVICES	This is what you pay for network & out-of-network providers.
Routine Hearing Screening One exam every 12 months.	\$0
Medicare Covered Hearing Examination	\$35
DENTAL SERVICES	This is what you pay for network & out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	\$35
VISION SERVICES	This is what you pay for network & out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	\$0
Diabetic Eye Exams	\$0
MENTAL HEALTH SERVICES*	This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$0 per stay
Outpatient Mental Health Care Individual visit	\$35
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$0 per stay
Outpatient Substance Abuse Individual visit	\$35

**SKILLED NURSING SERVICES*****This is what you pay for network & out-of-network providers.****Skilled Nursing Facility (SNF) Care**

\$0 copay per day, day(s) 1-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES***This is what you pay for network & out-of-network providers.****Outpatient Rehabilitation Services**

\$0

(Speech, physical, and occupational therapy)

AMBULANCE SERVICES**This is what you pay for network & out-of-network providers.****Ambulance Services**

\$0

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES**This is what you pay for network & out-of-network providers.****Transportation (non-emergency)**

Not Covered

MEDICARE PART B PRESCRIPTION DRUGS***This is what you pay for network & out-of-network providers.****Medicare Part B Prescription Drugs**

\$0

MEDICARE PART D PRESCRIPTION DRUGS**This is what you pay for network & out-of-network providers.**

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.



MUNICIPAL SCHOOL DISTRICTS OF SHELBY COUNTY

Aetna MedicareSM Plan (PPO)

Medicare (C04) ESA PPO Plan

Rx 1211

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Blood	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	\$0
Chiropractic Services*	\$0
Medicare covered benefits only.	
Diabetic Supplies*	\$0
Includes supplies to monitor your blood glucose from LifeScan.	
Durable Medical Equipment/ Prosthetic Devices*	\$0
Home Health Agency Care*	\$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Outpatient Dialysis Treatments*	\$0
Podiatry Services	\$35
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	\$0
Radiation Therapy*	\$0



MUNICIPAL SCHOOL DISTRICTS OF SHELBY COUNTY

Aetna MedicareSM Plan (PPO)

Medicare (C04) ESA PPO Plan

Rx 1211

ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers
Resources For Living[®]	Covered
For help locating resources for every day needs.	
Teladoc[™]	\$20
Telemedicine services with a Teladoc [™] provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	\$20
Telehealth Specialist	\$35
Telehealth Other Health care Providers	\$35
Telehealth Individual Mental Health	\$35
Telehealth Group Mental Health	\$35
Telehealth Individual Psychiatric Services	\$35
Telehealth Group Psychiatric Services	\$35
Telehealth Urgent care	\$0
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Routine Physical Exams	\$0
One exam per calendar year	

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

**PHARMACY - PRESCRIPTION DRUG BENEFITS****Calendar-Year deductible for Prescription drugs** \$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (<http://www.aetnaretireeplans.com>.)

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Initial Coverage Limit (ICL) \$4,430

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

3 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	Preferred Mail	Standard Retail or Mail
Tier 1 - Generic Generic Drugs	\$5	\$10	\$10
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$30	\$60	\$60
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$60	\$120	\$120

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail



pharmacy and you may receive up to a 31 day supply.

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach \$7,050 in prescription drug expenses is indicated below.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage:

Greater of 5% of the cost of the drug - or -
\$3.95 for a generic drug or a drug that is
treated like a generic and \$9.85 for all other
drugs.

Catastrophic Coverage benefits start once \$7,050 in true out-of-pocket costs is incurred.

Requirements:

Precertification

Applies

Step-Therapy

Applies

Enhanced Drug Benefit

- Not Covered

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member



Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers



Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated



on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

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Delta Dental of Tennessee

Municipal Schools of Shelby County – Option 2

Your Delta Dental Benefit Highlights

Group #6733 coverage

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

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

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

Finding a Delta Dental provider

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

When do benefits start?

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

View your benefit details online

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

Questions?

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

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

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

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

Delta Dental of Tennessee

Municipal Schools of Shelby County – Option 1

Your Delta Dental Benefit Highlights

Group #6733

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

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

View your benefit details online

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

Questions?

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

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

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

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

Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 3148 to locate providers or for additional information.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Interlocal Health Benefits Committee. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Your Davis Vision Designer Plan Benefits

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	September 1	\$10	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	September 1	\$20	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	Every other September 1	\$0	<p>Covered in Full Frames: Any Fashion or Designer level frame from Davis Vision's Collection² (retail value, up to \$160).</p> <p>OR, Frame Allowance: \$130 toward any frame from provider plus 20% off any balance.¹ No copay required.</p> <p>OR, Visionworks Frame Allowance: \$180 allowance plus 20% off any balance toward any frame from a Visionworks family of store locations.⁶ No copay required.</p>
Contact Lens Evaluation, Fitting & Follow Up Care	September 1	\$0	<p>Davis Vision Collection Contacts: Covered in full.</p> <p>Non Collection Standard Contacts: 15% discount¹</p> <p>Non Collection Specialty Contacts³: 15% discount¹</p>
Contact Lenses (in lieu of eyeglasses)	September 1	\$20	<p>Covered in Full Contacts: From Davis Vision's Collection², after copay, up to: Planned Replacement Two boxes/multi-packs* Disposable Four boxes/multi-packs*</p> <p>OR, Contact Lens Allowance: \$150 allowance toward any contacts from provider's supply plus 15% off balance.¹</p> <p>OR, Visually Required Contacts: Covered in full with prior approval.</p> <p><small>*Number of contact lens boxes may vary based on manufacturer's packaging.</small></p>

Significant savings on optional frames, lens types and coatings!

Member Price

Davis Vision Collection Frames: Fashion Designer Premier	\$0 \$0 \$25
Tinting of Plastic Lenses	\$0
Oversize Lenses	\$0
Scratch-Resistant Coating	\$0
Premium Scratch-Resistant Coating	\$30
Ultraviolet Coating	\$12
Anti-Reflective Coating: Standard Premium Ultra Ultimate	\$0 \$13 \$25 \$85
Polycarbonate Lenses	\$0 ⁴ - \$30
High-Index Lenses 1.67 1.74	\$55 \$120
Progressive Lenses: Standard Premium Ultra Ultimate	\$0 \$40 \$140 \$175
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ⁵	\$65
Digital Single Vision Lenses	\$30
Scratch Protection Plan: Single Vision Multifocal Lenses	\$20 \$40
Trivex Lenses	\$50
Blue Light Filtering	\$15

¹ Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

² The Davis Vision Collection is available at most participating independent provider locations. The Davis Vision Contact Lens Collection includes select torics and multifocals.

³ Including, but not limited to toric, multifocal and gas permeable contact lenses.

⁴ For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

⁵ Transitions® is a registered trademark of Transitions Optical Inc.

⁶ Enhanced frame allowance available at all Visionworks Locations nationwide.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?

Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?

Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?

Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?

Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?

You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?

Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - \$30 | single vision lenses - \$25 | bifocal - \$35 | trifocal - \$45 | lenticular - \$60 | frame - \$30 | elective contacts - \$75 | Visually Required contacts - \$225.

Are there any exclusions to the vision benefits?

Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.⁷¹

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities, or more information about Davis Vision, please log on to our member Web site or contact us at 1.800.999.5431.

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

⁷¹Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.