

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.

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

**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

Date

*A digital will not be accepted
as a legal signature*



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		

The COPAY Plan	
Descriptions	Plan Benefits
***WELLNESS (Routine Care)	
Physical Exams (per ACA)	100%
Well Child Care (Including Immunizations)	
Mammogram (Test and Reading, including 3D and diagnostic mammograms)	
Pap Smears (Test and Reading)	
Prostate Blood Test/Colonoscopy (Test and Reading)	
Fecal Occult Screening (Test and Reading)	
MAJOR MEDICAL	
Deductible	N/A
Plan Payment (Coinsurance)	100%
Out-of-Pocket Max. (medical copays only)	\$2,000/Indv. \$3,750/Indv. + 1 \$5,500/Fam.
**Out-of-Pocket Max. (Including medical and prescription copays per ACA)	\$8,550 (Single)/\$17,100 (Non-Single) <i>(Out of Pocket accumulators for prescription benefits are based on the member's actual cost)</i>
Lifetime Maximum per Family Member	Unlimited
**Out of Pocket expenses accumulate on a calendar year basis.	
*HOSPITAL BENEFITS	
In-Patient	\$500 copay per admission
Out-Patient	\$250 copay per visit
Emergency Room	\$250 copay per visit
Emergency Room copay waived if admitted due to Medical Emergency	
Maternity	100% after \$500 copay <i>(does not include services performed in the physician's office)</i>
SURGICAL / PHYSICIAN BENEFITS	
In-Patient/Out-Patient	100%
PHYSICIAN OFFICE VISIT	
Primary Care	100% after \$30 copay
CARE4US Onsite Clinics	100%, \$0 copay (Prescriptions dispensed at time of service also have a \$0 copay)
Specialist	100% after \$45 copay
*DIAGNOSTIC SERVICES	
Routine X-Ray & LAB Services (outpatient)	100%
*CAT Scan	100% after \$150 copay
*MRI/MRA/PET Scans	100% after \$250 copay
Diagnostic Imaging Facility, 6401 Poplar Ave, Ste 100, Memphis, TN · (901) 387-2340	\$0 copay
PRESCRIPTIONS BENEFITS FILLED AT PHARMACIES	
Tier 1 -Generic	\$10
Tier 2 - Preferred	20% up to \$200
Tier 3 - Non-Preferred	20% + \$50 up to \$200

Discretionary/Elective Drugs	100% of discounted claim charge
Mail Order (90 day supply)	3 times retail pharmacy
Descriptions	Plan Benefits
<i>The copays and out of pocket costs, listed above are based on a 30-day supply. Prescriptions filled for 60 days are doubled; 90 days are tripled.</i>	
MENTAL/NERVOUS & SUBSTANCE ABUSE	
In-Patient	\$500 per admission
Physician's Office Visit	100% after \$30 copay
Intensive Outpatient Therapy	100% after \$30 copay
*ADDITIONAL MEDICAL BENEFITS	
Therapies (cognitive therapy, physical therapy, occupational therapy, speech therapy, pulmonary therapy)	100% after \$30 copay (60 visits maximum)
Diabetic self-management and Cardiac rehab	100% after \$45 copay each visit (60 visits maximum)
Chiropractic	100% after \$45 copay (60 visits maximum)
Home Health Care	100% (60 visits maximum)(precertification required)
Extended Care Facility	\$100 copay (60 visits maximum)
Hospice	100% (precertification required)
Urgent Care	100% after \$50 copay
Ambulance Services	100% after \$50 copay
Medical Supplies & DME	100% after \$50 copay per device - (rental or purchase)
Chemotherapy Treatment	100% after \$50 copay
Chemotherapy and Radiation Treatment at Baptist Facilities	\$0 copay
<p><i>*The Plan requires precertification by the Utilization Review Service prior to the commencement of the following services: all in-patient surgeries and procedures, any non-office based out-patient procedures, the purchase of durable medical equipment exceeding \$1500, home health services, MRI, CAT and PET scans, just to name a few. Precertification confirms "Medical Necessity"; therefore, services found not medically necessary, will not be approved for payment and are not be covered under the Plan. It is the member's responsibility to make sure precertification is obtained. Please refer to Article VI in the Plan Document for a complete list of services or supplies and an explanation of all precertification requirements. Precertification is not required for any imaging services performed at Diagnostic Imaging Facility and for outpatient services rendered at Baptist Health Service Group of Mid-South, Inc. or St. Francis/Tenet.</i></p>	
<p>Plan Document: The plan document is the governing document; therefore, any discrepancies which may be found in this summary are not binding. The Plan Document may be found by going to the Employee Benefits Webpage or by contacting the Benefits office for a copy.</p>	
<p>***Wellness: For a detailed listing of preventive services, please refer to Section 3.1 under RECOMMENDED WELLNESS SERVICE in the plan document.</p>	
<p>The COPAY Plan uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated. Please contact MedBen at (800) 686-8425 (M-F 7:00 am - 5:30 pm), if you receive a bill for an amount above what your explanation of benefits (EOB) from MedBen says you owe. You may also email medben@medben.com.</p>	
<div>  <div> <p>The Care4Us clinics (Bartlett and Collierville) are open to all insured employees and their covered dependents for acute and primary care services. There is no copay for services, and for prescriptions received at the clinic. Please call (901) 979-3151 or login to www.mypremisehealth.com to schedule your visit today.</p> <p>More information regarding the Care4Us Onsite Clinics is in the Brochure</p> </div> </div>	

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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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.