2022 Certificated Employee

Benefits Handbook

METRO NASHVILLE PUBLIC SCHOOLS

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How to Enroll for Benefits/Log onto Benefit Express

For details on when to enroll for MNPS benefits, see page 7. Then follow the steps below to complete online enrollment. You will enroll through our online enrollment vendor, **Benefit Express**. You will also use this site to keep your benefits information (dependents, beneficiaries, etc.) up to date. To log on and enroll, follow these steps:

1. Log on.

- Go to **www.MNPSBenefits.org**.
- At the homepage, click Benefit Express enrollment login
- At the login page, enter the following:
  – User name in ALL CAPS: MNPS + first letter of your first name + your full last name + your month and day of birth
  – Password in ALL CAPS: your full last name + last four digits of your Social Security number
  For example, David Public, born February 7, SSN 123-45-6789:
  User name: MNPSDPUBLIC0207 (case-sensitive)
  Password: PUBLIC6789 (case-sensitive)
  Note: Your password will change once you've been prompted to change it.
- At the Welcome page, click Enroll (right side of page) and answer a few questions.

2. Add/update dependent and beneficiary information.

- Follow the prompts to:
  - Add/update dependent information.
  - Designate/update beneficiary(ies).

3. Choose your benefits.

- Follow the prompts to select your coverage.
- Choose the guided walk-through if you need help.

4. Confirm your elections.

- View your Confirmation Statement. If you are satisfied with your elections, click Submit. **You must confirm your elections, or your changes will not be made.**
- Print your Confirmation Statement for your records.
- Log out.

If you have questions about your online enrollment, contact Employee Benefit Services at 615-259-8607 or the Benefit Express help line at 1-844-593-0331, or email help@mybenefitexpress.com.

How to take the Health Assessment

1. Go to **www.myCigna.com**. Register or log in.
2. Once signed in, click My Health Assessment under the Wellness tab.

Note: If you complete the Cigna health assessment each year by the close of annual enrollment (November 30), you will qualify for the lowest coverage premiums for the upcoming calendar year. Only the employee is required to do this, and you must have medical coverage in place before you can take the health assessment. Although biometrics are not required this year, it's helpful to know your numbers when completing the health assessment. You can use your own physician, or you can have your biometrics measured at no cost to you at the MNPS Health Care Centers. If you had blood work done earlier this year, you can use those results to complete the health assessment.

This handbook does not include every limitation or exclusion of the MNPS-sponsored plans. The plan documents are the legal publications that define eligibility, enrollment, benefits and administrative rules. Copies of the plan documents can be obtained from Employee Benefit Services or by visiting ***www.MNPSBenefits.org*** *and logging onto Benefit Express. The information contained in this handbook is accurate at the time of printing; however, the Board of Education may change the plans at their discretion. The benefits described in this handbook cannot be modified by any oral statements.*

What Is This Information and Why Do I Need It?

The Benefits Handbook is provided to help you understand the benefits for MNPS certificated employees. Familiarize yourself with topics in this book. Know your responsibilities regarding eligibility and enrollment requirements.

Full-time certificated employees working a minimum of 18 hours a week have the following benefits available to them:

- $50,000 Basic Life and AD&D Insurance (100% paid by MNPS)
- Basic Benefits Package (75% paid by MNPS, 25% paid through employee contributions)
    - Medical Insurance
    - Dental Insurance
    - Vision Insurance
    - Hearing Benefit
    - Dependent Life Insurance (included with Dependent Medical Insurance)
- Retirement (TCRS) (paid by MNPS and employee contributions)

Optional benefits (paid 100% by employee):

- Flexible Spending Accounts (Health Care FSA and Dependent Care FSA)
- Supplemental Term Life Insurance
- Dependent Life (if you do not have Dependent Medical)
- Short-term Disability
- Long-term Disability
- Leave Time/Sick Leave Bank
- State of Tennessee 401(k) Deferred Compensation Program

In addition, all full-time and part-time employees have:

- Employee Assistance Program (EAP)
- Injury On Duty Program (IOD)
- Access to Vanderbilt Health at MNPS Employee & Family Health Care Centers

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

Employee Benefit Services is responsible for administering and/or overseeing all benefits.

We hope you find this information helpful, useful and easy to understand. Please contact Employee Benefit Services if you have comments or suggestions related to this publication or if you require this publication in an alternative format.

Who Governs the Group Insurance Program?

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

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

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

Important Contacts

General benefits questions
Employee Benefit Services
615-259-8607, Monday-Friday, 8 a.m.-4:30 p.m.
Website: MNPSBenefits.org
Online enrollment: Benefit Express (log on through MNPSBenefits.org)

MNPS Health Care Centers
Vanderbilt Health at MNPS Employee & Family Health Care Centers
MNPSHealth.org
615-259-8755

Employee Assistance Program (EAP)
ComPsych
1-888-297-9028
www.guidanceresources.com (Username: MNPS; Password: EAP)

Medical
Cigna
If currently enrolled, log onto myCigna.com (claims, eligibility, enrollment, provider directories)
If not yet enrolled, visit MNPSBenefits.org/medical
1-800-Cigna24 (1-800-244-6224); TTY: 1-800-987-8816
24-Hour Health Information Line: 1-800-244-6224

Other health programs associated with Cigna medical plan
Fertility coverage: Progyny; 855.507.6311
Behavioral telehealth: Synchronous Health, www.sync.health/mnps
Diabetes/heart disease/hypertension program: Omada, omada.com/mnps

Dental
Cigna (effective January 1, 2022)
If currently enrolled, log onto myCigna.com
If not yet enrolled, visit MNPSBenefits.org/dental
1-800-Cigna24 (1-800-244-6224); TTY/TDD: 1-800-987-8816

Vision
EyeMed
eyemed.com (eligibility, enrollment, provider directories, discounts)
1-866-800-5457

Hearing
Cigna/Amplifon
amplifonusa.com/cigna (participating providers, claims assistance and more)
1-888-901-0811

Flexible spending accounts (FSAs)
Health care FSA/Dependent care FSA
Cigna
If currently enrolled, log onto myCigna.com
If not yet enrolled, visit MNPSBenefits.org/fsas
1-800-Cigna24 (1-800-244-6224); TTY/TDD: 1-800-987-8816

Life, AD&D and Disability
Dearborn Group
Claims: 1-800-348-4512

Retirement benefits
Tennessee Consolidated Retirement System (TCRS) &
Tennessee 401(k) Deferred Compensation Plan
Empower Retirement
retirereadytn.gov
1-800-922-7772

Member Privacy

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

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

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

To obtain a copy of the health plan's privacy notice describing in greater detail the practices concerning use and disclosure of your health information, visit **www.MNPSBenefits.org** and log onto Benefit Express or request a copy from Employee Benefit Services.

Benefit Basics

Who is Eligible?

To be eligible for certificated employee benefits, you must be an active full-time certificated employee regularly scheduled to work at least 18 hours per week (50% schedule).

What Dependents are Eligible?

The following dependents are eligible:

- Your opposite-sex or same-sex spouse or domestic partner, provided your spouse or domestic partner is not an active certificated MNPS employee.
- Natural or adopted children under 26 years of age (regardless of where they live) for whom the employee has legal custody or is legal guardian, and stepchildren are eligible provided the employee or spouse has legal custody or joint parenting.
- Adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption — the obligation may be determined by court records, federal income tax records or other appropriate documentation.

All covered dependents must be listed in the online enrollment system at Benefit Express (see inside front cover of this handbook) and you must provide documents certifying that each enrolled dependent is eligible (e.g., marriage certificate, birth certificate, Declaration of Domestic Partnership form, etc.) by uploading copies of those documents to Benefit Express. Benefits are not provided for dependents not listed. A dependent can only be covered once within the same plan. Domestic partners who wish to enroll must complete and electronically sign a Declaration of Domestic Partnership when you go online to enroll. The declaration states you and your partner are in a committed, long-term relationship and have shared the same residence for the last six months, while not legally married to or separated from another individual during that same six-month period. You must provide three sources of documentation supporting your financial interdependence on one another. You can find the Declaration of Domestic Partnership form as well as details about eligibility requirements, possible tax implications and instructions for uploading required documentation on My Benefit Express. **Important note**: You may only add your domestic partner and his/her dependent child(ren) during annual enrollment or within 60 days of a qualifying life event.

Dependent children are eligible for coverage through the last day of the month of their 26th birthday. Proof of a dependent's eligibility may be required.

Incapacitated children (mentally or physically disabled and incapable of earning a living) may continue health or dental coverage, if applicable, beyond age 26 as long as the incapacity existed before their 26th birthday and they were already insured under the MNPS Certificated Employees Group Insurance Program. The child must meet the requirements for dependent eligibility previously listed. A request for extended coverage must be provided to Employee Benefit Services within 31 days of the dependent's 26th birthday. Additional proof may be required periodically. Approval of the incapacitation request is determined by the claims administrator for your health insurance company. Coverage will not continue and will not be reinstated once the child is no longer incapacitated.

If a change in your dependent's eligibility status occurs, visit **www.MNPSBenefits.org** and log onto Benefit Express to update your coverage.

What Dependents are Not Eligible?

The following dependents are NOT eligible:

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children over age 26 (unless they meet qualifications for incapacitation)
- Live-in companions who are not legally married to the employee or don't meet the requirements of domestic partner

When Can I Enroll?

Generally, there are two times when you can enroll for benefits: when you first become eligible, and during annual enrollment. See "How to Enroll for Benefits" at the beginning of this handbook.

Once you enroll, your elections remain in effect throughout the calendar year. You generally cannot change your benefits during the year, unless you experience a "qualifying event," as described below under special enrollment provisions.

You have 30 days from the first day of employment to elect benefits coverage. If you fail to enroll in health coverage by the end of your enrollment period, you will only be eligible by satisfying one of the special enrollment provisions listed below or by applying for coverage during the next annual enrollment period.

What is the Annual Enrollment Period?

During November of each year, you have the opportunity to continue or change your existing benefits coverage for the next calendar year if you are currently enrolled, or to enroll for coverage if you or your eligible dependents are not currently covered. Benefits information is mailed to your home address, and you should review this information carefully to make the correct decision for you and your family. If you decide to make changes to your coverage during annual enrollment, those changes will be effective the following January 1, and you must remain enrolled until the next year, unless otherwise indicated.

If you enroll for life or disability benefits, you may have to submit evidence of insurability and be approved by the carriers prior to receiving coverage.

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

If you do not elect health coverage for yourself and/or your dependents when first eligible, (see above) and you later decide to enroll, you and/or your dependents will not be allowed to enroll until the annual enrollment period, or due to a qualifying event under the special enrollment provisions below. Annual enrollment is conducted in November with requested changes in coverage effective January 1.

Anyone who does not enroll when first eligible is considered a "late enrollee" and will be subject to a summer pre-pay amount.

Summer Premium Pre-Pay Plan

Those on a 10-month work schedule are subject to summer pre-pay. If your benefits begin after the first pay period of the new school year, you are required to make up the missed contribution amount associated with the pre-pay. At the end of the school year, your health plan benefits will be fully paid for the summer months. The total amount due will be prorated over the remaining pay periods.

What are Special Enrollment Provisions?

The Health Insurance Portability and Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made for eligible

employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse. The following required documentation must be submitted to Employee Benefit Services and coverage applied for within 60 days of loss of health coverage.

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

- Copy of the birth certificate, marriage certificate or adoption documents

Death

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

Divorce

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

Legal separation

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

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

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

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

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

Termination of employment (voluntary and non-voluntary)

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

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

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

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

- Written documentation from the employer on company letterhead providing names of covered participants and verifying the employer's discontinuation of total contribution toward health insurance coverage. The effective date of coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month or subsequent month following approval by Employee Benefit Services; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period.

What Types of Health Coverage Are Available?

- Single: Covers employee only
- Employee and Spouse: Covers employee and eligible spouse only; does not include coverage for dependent child(ren)
- Employee and Child(ren): Covers employee and dependent child(ren) only; does not include coverage for a spouse
- Family: Covers employee, spouse and all eligible dependent child(ren)

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

When Does Coverage Begin?

All coverage begins on the first day of the month following one month of active employment, provided you enroll during your first 30 days of employment.

A dependent's coverage is effective on the same date as yours unless newly acquired. Newly acquired dependents' coverage will become effective on the date they were acquired if you have family coverage. You may also choose to have coverage effective the first day of the month following the month you change from single to family coverage.

Coverage for an adopted child begins when appropriate documentation reflecting legal obligation of support of such child is submitted to Employee Benefit Services. See the complete definition of dependents on pages 6-7.

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

How Do I Pay For Coverage?

Contributions are deducted from your paycheck for medical, dental, vision, hearing and voluntary insurance coverage. Employee Benefit Services can provide you with information regarding your current deductions, or log onto Benefit Express.

Most certificated employees pay their annual contributions over 10 months. Benefit deductions are not collected over the summer months. Employees who do not return the following school year will have their benefits terminated at the end of July.

NOTE: Employees on an approved leave without pay must arrange to make payments for your contributions. Contact Employee Benefit Services for payment information.

The plans permit a 30-day grace period for remittance of premiums. If the premium is not paid at the end of this deferral period, coverage will be canceled retroactive to the date you last paid a premium with no provision for reinstatement of coverage. To obtain medical, dental vision and hearing coverage again, you will have to wait for the annual enrollment period.

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

What If I Need to Change My Coverage?

To make a change in your coverage (add or terminate a dependent, etc.), visit **www.MNPSBenefits.org** and log onto Benefit Express. Eligibility requirements for dependents apply.

How Do I Add Dependents to My Coverage?

Log onto Benefit Express within 60 days of the date a dependent is acquired to add that dependent to your coverage. The "acquire date" is the date of birth, marriage, change of student status or, in the case of adoption, the legal obligation and support of such child. Changes in type of coverage (e.g., single to family) are effective on the acquire date. If you maintained family coverage on the date the dependent was acquired, the effective date may be retroactive to the dependent's acquire date even if beyond the 60-day enrollment period.

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

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

How Do I Terminate a Dependent's Coverage?

To remove a dependent from your coverage, log onto Benefit Express and make the change. When you request cancellation, a dependent's coverage will terminate on the date you indicated online. In the case of ineligibility, the dependent is covered until midnight on the last day of the month that the ineligibility occurs. For adopted children, coverage terminates upon the termination of legal obligation. In the event of a divorce for any reason other than irreconcilable differences, your spouse cannot be removed from coverage until the divorce is final. All claims paid for ineligible dependents will be recovered. As the head of contract, you are responsible for reimbursing the plan for incorrect claims payments.

You can change your type of coverage by logging onto Benefit Express. Keep in mind that deleting a dependent may change your type of coverage.

Employee Benefit Services reserves the right to request documentation certifying that your enrolled dependents are eligible. You must upload copies of those certifying documents to Benefit Express. Failure to provide requested proof will result in suspension of the dependent's coverage.

If the dependent becomes ineligible, it is your responsibility to remove that dependent from coverage.

How Do I Terminate Health Coverage?

If you wish to terminate insurance coverage, you must log onto Benefit Express and make the change. Employee Benefit Services reserves the right to request documentation.

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

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

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

What If I Have Other Insurance?

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

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

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

The health insurance providers have the right to subrogate claims. This means they can recover any payments made as a result of injury or illness caused by the action or fault of another person, or lawsuit settlement from payments made by a third party insurance company. This would include automobile or homeowners insurance, whether yours or someone else's. You are required to assist in this process.

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

On-the-Job Injuries

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

What If I Terminate Employment?

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

How Do I Continue Coverage?

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

1. Coverage is lost due to one of the "qualifying events" outlined starting on page 12
2. Covered individuals are not insured under another group medical plan as an employee or dependent. (This restriction is waived if you or your dependent enrolls in another group medical plan that has a preexisting conditions clause, and a condition exists that is not covered by the other plan.) In this situation, you must provide the following to Employee Benefit Services:

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

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

You or one of your family members must notify Employee Benefit Services if a dependent wants to continue coverage under COBRA because:
- Of a divorce
- A dependent child is no longer eligible for medical or dental coverage because of a loss of dependent status

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

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

The COBRA Administrator will then send your dependent the COBRA enrollment packet to your address. Restrictions for returning the enrollment form (when premiums must be paid and other provisions) are outlined in the COBRA packet. Failure to report a dependent becoming ineligible to continue coverage within 60 days of the loss of eligibility will result in the dependent not being offered the opportunity to continue coverage under COBRA, as their 60-day eligibility period will have lapsed.

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

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

Qualifying Events for Employees
You may continue your single or family medical coverage for a maximum of 18 months if coverage is lost due to one of the following qualifying events:
- Employment is terminated for any reason other than gross misconduct
- Work hours are reduced below 30 hours
- Changes in your job appointment make you ineligible for coverage (example: changing to a part-time position)

Qualifying Events for Dependents
Dependents may also continue their medical or dental coverage under COBRA for 18 months based on the events listed for employees. Furthermore, dependents may continue medical or dental

coverage for an additional 18 months — maximum of 36 months — if coverage is lost due to one of the qualifying events listed below:

- Your death
- Your divorce from your spouse
- You become entitled to Medicare prior to enrolling in COBRA (the 36-month period is retroactive to the date of Medicare entitlement)
- Your dependent child is no longer eligible as a dependent (married, in the Armed Forces on a full-time basis, over age 26 unless meeting qualifications for incapacitation, etc.)
- A child born to or placed for adoption with you during a period of COBRA continuation coverage is also eligible for continuation of coverage, provided coverage is requested within the 60-day time period.

How Much Are COBRA Premiums?

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

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

When Does COBRA Coverage End?

Any COBRA coverage ends on the earliest of the following:

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

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

Medical Plan

What is the Medical Plan?

The medical plan, administered by Cigna, covers a wide range of services, including preventive care, office visits, surgery, hospitalization and prescription drugs. See the charts on pages 17-18 for details.

What does medical coverage cost?

Medical, dental, vision and hearing coverage are bundled together. You pay 25% of the cost; MNPS pays the rest. You pay your share by pre-tax payroll deduction. Deductions are based on whether you work a 10-month or 12-month schedule. Additionally, if you cover dependents, you automatically receive spouse/child life insurance at the below rates. Following are deductions for the 2021-22 school year.

	Medical/Dental/Vision/ Hearing		**Life and AD&D***	
	Your share** (10-month)	Your share** (12-month)	Your share (10-month)	Your share (12-month)
Employee only	$129.86	$99.89	$0.00	$0.00
Employee + spouse	$259.71	$199.78	$3.00	$2.31
Employee + child(ren)	$185.12	$142.40	$0.60	$0.46
Family	$312.71	$240.55	$3.60	$2.77

* Includes basic employee life/AD&D coverage of $50,000, spouse life of $25,000 and up to $10,000 of child life coverage per child; see pages 34-36 for more details.

** Rates are based on employee taking the Cigna health assessment. If not taken by the deadline, a premium surcharge will apply. See below.

What is the Health Assessment?

The health assessment is an online questionnaire that asks questions about your life, job, stress level and overall health. It also asks some biometric information such as your cholesterol and blood pressure levels. The health assessment gives you a picture of your current health that can serve as a foundation on which to build a healthy lifestyle. It takes 15-30 minutes to complete. Your answers will generate a personal health report with an explanation of any health risk factors you may have. You can print the report and share it with your doctor.

Taking the health assessment is optional. However, you must take it to qualify for the lowest health coverage premiums. Here's how it works: You (the employee only) must take (or re-take) the health assessment once a year by the deadline, which is generally by the close of annual enrollment on November 30. If you do not complete the assessment by the specified deadline, you will pay an $800/year surcharge, prorated equally by the number of paychecks (20 or 26) you receive in a year. You will receive more information and reminders prior to the specified deadline.

Your spouse is welcome to participate in the health assessment, but it is not a requirement to qualify for lower premiums.

How to Take the Health Assessment

Follow the steps listed at the front of this handbook to log in and complete the health assessment.

Who Sees My Health Assessment Results?
Your individual answers are completely confidential and will not be shared with anyone at MNPS. The MNPS Employee & Family Health Care Centers will receive a summary of participants' health assessment results in accordance with federal laws protecting your private health information.

If your health assessment reveals areas needing improvement because of a chronic health condition, you may be invited to work with a health coach or Cigna health advocate.

What Will the Medical Plan Cover?

The medical plan covers medical treatments and services provided by recognized medical providers as outlined in the Plan Document. This handbook provides a summary of those benefits but does not outline every limitation or exclusion of the Certificated Employee Health Plan. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. A copy of the Plan Document can be found at **www.MNPSBenefits.org**.

Summary of Benefits and Coverage
In accordance with the Patient Protection and Affordable Care Act, MNPS and Cigna have created a Summary of Benefits and Coverage (SBC), which provides additional information about your MNPS medical plan. You can find the SBC by logging onto Benefit Express. Or you may request a free, printed copy by contacting Employee Benefit Services at 615-259-8607 or benefits@mnps.org.

How Much Will I Have to Pay for Medical Care?

In-Network and Out-of-Network Services
The medical plan centers around Cigna's Open Access Plus (OAP) network of health care providers. When you use OAP network providers and facilities, you will receive in-network benefits and generally pay less out of your own pocket. You can use providers outside the OAP network and still receive benefits; however, you will receive lower out-of-network benefits and likely pay more out of your pocket. Out-of-network benefits are also subject to maximum allowable limits. Additionally, out-of-network providers can charge you for services not covered by the health plan, and you will be responsible for the cost of those non-covered services.

Copays
A copay is a set dollar amount you pay for a service or product provided. If a copay is charged, the deductible does not apply; the plan provides benefits for services even if your deductible is not satisfied. See the charts on pages 17-18 for copay amounts.

Medical copays do not count toward your deductible, but they do count toward your annual out-of-pocket maximum. Pharmacy copays apply to your annual pharmacy out-of-pocket maximum (see Pharmacy Benefits below).

Deductible and Coinsurance
Many services are subject to an annual deductible that has to be satisfied before benefits are paid. Only the cost of covered services can be applied toward satisfying the deductible.
The plan has an individual and family deductible. A family deductible is three times the amount of the individual deductible. The family deductible serves as a cap, which limits the employee deductible cost if he/she covers more than one dependent on the health plan.

Additionally, the plans have different and lower deductibles for network providers than for non-network providers. ***Care provided by the MNPS Employee & Family Health Care Centers under the MNPS Certificated Employee Health Plan is not subject to a copay.***

See the charts on pages 17-18 for deductible and coinsurance amounts.

Out-of-Pocket Maximums
Once you reach the out-of-pocket maximum in a calendar year, the plan will provide 100% reimbursement for covered expenses for the remainder of that calendar year.

Copays, coinsurance and deductibles apply toward the out-of-pocket maximum.

The plans have different and lower out-of-pocket maximums for network providers than for non-network providers. See pages 17-18.

Pharmacy Benefits
Our plan covers medically necessary prescription medications that:
- Have been approved by the Food and Drug Administration
- Have been prescribed by a licensed physician
- Have been dispensed by a licensed pharmacist
- Require a prescription (not including over-the-counter)

Prescription drugs are not subject to a deductible; rather, you pay a copay based on the drug's classification and whether you purchase it at a network retail pharmacy or through the mail order or 90-day at retail program. See the charts on pages 17-18 for your prescription drug copay amounts.

To get a list of brand drugs that are considered Preferred, log onto to **myCigna.com**. You may also contact Cigna Customer Service at 1-800-244-6224.

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

Lifetime Maximum Benefit
Our medical plan has an unlimited lifetime benefit.

Cigna One Guide®
Understanding and using your health insurance is not always easy. Often, it can be downright confusing.

Meet Cigna One Guide. It's a Cigna service that just makes health care simpler. Cigna One guide combines the ease of a powerful app with the personal touch of a live person. Specifically, your One Guide team can help you:
- Better understand your coverage
- Answer your health plan questions
- Find the best provider for your needs
- Get estimates and avoid surprise expenses
- Make sure you're getting the most from your benefits and earning all available incentives

Start using the Cigna One Guide today — by app, chat or phone. Download the **myCigna.com** app or call 1-888-806-5042.

Schedule of Benefits

	In-network	Out-of-network
Lifetime maximum medical benefits	Unlimited	Unlimited
You pay…		
Annual deductible[1]	$300/person; $900/family	$800/person; $2,050/family
Annual medical out-of-pocket maximum[1]	$2,500/person $7,500/family	$5,000/person
Wellness		
Preventive care/immunizations	$0	40% after deductible
Office/routine care		
MNPS Employee & Family Healthcare Center visits (in-person and telehealth)	$0	
Primary care visits (in-person and telehealth)	$30	40% after deductible
Convenient care clinics	$30	40% after deductible
Mental health/substance abuse office visit	$0	40% after deductible
Specialist visits	$40	40% after deductible
Lab and x-ray in physician's office	$0	40% after deductible
Urgent care facility	$30	$30
Chiropractic (up to 24 visits/year)	$40	Not covered
Physical, occupational and speech therapy	10% after deductible	40% after deductible
Durable medical equipment	10% after deductible	40% after deductible
Maternity/fertility		
Prenatal care	You pay $30 copay for initial visit	40% after deductible
Delivery	10% after deductible	40% after deductible
Fertility	Call 1-855-507-6311	Not covered
Hospital care/outpatient facility		
Inpatient hospitalization	10% after deductible	40% after deductible
Outpatient surgery	10% after deductible	40% after deductible
Outpatient/diagnostic facility	10% after deductible	40% after deductible
Emergency (copay waived if admitted)	$150, then 10% after deductible	
Ambulance	10% after deductible	
Skilled nursing facility	10% after deductible	40% after deductible
Home health care	10% after deductible	40% after deductible
Mental health and substance abuse		
Inpatient	$0	40% after deductible
Outpatient (individual and group)	$0	40% after deductible

[1] Copays do not count toward the deductible, but copays and amounts paid toward the deductible do count toward your out-of-pocket maximum. Office visits are covered with a copay and not subject to the deductible.

Schedule of Benefits continued

Prescription drugs[2]	**In-network**	**Out-of-network**
Annual pharmacy out-of-pocket maximum	$1,500/person $3,000/family	$1,500/person $3,000/family
Certain preventive drugs		
Generic	$5	$5
Preferred brand	$25	$25
Non-preferred brand	$80	$80
Network retail (30-day supply)		
Generic	Not covered	Not covered
Preferred brand	Not covered	Not covered
Non-preferred brand	Not covered	Not covered
Mail order (90-day supply)	**Cigna Home Delivery**	**Other pharmacies**
Generic	$10	Not covered
Preferred brand	$50	Not covered
Non-preferred brand	$160	Not covered

[2] If you choose a brand name drug when a generic is available, you will pay the brand name copay, plus the cost difference between the brand name and the generic. There is one exception: If your doctor specifies that the brand name drug is medically necessary and gets required authorization from Cigna, you will pay only the brand name copay.

How Does the Plan Control Costs?

In order to control costs, our health plan employs various strategies.

Preferred Provider Network

All providers in our network agree to discounted fees and to abide by certain quality standards. These arrangements ensure better quality of care at better rates.

Preadmission Certification/Authorization

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

If you go out-of-network, it is your responsibility to get care authorized. If you fail to get an inpatient admission authorized, benefits for the non-preferred admitting physician will be reduced to 60% of eligible charges after any applicable deductible is satisfied. Balances of charges after the benefit reduction will not apply toward any out-of-pocket limits in the covered person's coverage.

Medical Necessity Review

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

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

Our Claims Administrator routinely reviews care to make sure we cover only medically necessary treatments. If you use a network provider, it is his/her responsibility to provide only medically necessary care or to advise you if the treatment would not be covered by the health plan. You will be held harmless if he/she fails to do so.

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

Wellness Initiatives
MNPS works to reduce costs by helping employees live healthier lifestyles. We are gradually introducing wellness initiatives that help you tackle your health challenges and build on your successes. Each year, you will be asked to take a health assessment (with biometrics in certain years) in order to pay the lowest health coverage premiums. A biometric screening is a simple blood test that measures your risk for certain conditions and diseases. Additionally, you may be invited to partner with an onsite health coach or a Cigna health advocate if your health assessment results show areas needing improvement. You are encouraged to actively work with your health coach or health advocate to address any identified health risks. Visit **MNPSBenefits.org** for more about our wellness initiatives and incentives.

Are There Any Special Benefits?

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

Chiropractic Care
Chiropractic care is covered up to a maximum of 24 visits per year. Only in-network chiropractic services are covered. No benefits are provided for out-of-network chiropractors. *Chiropractic care provided by the MNPS Employee & Family Health Care Centers has a $0 copay.*

Home Health Care
Skilled services provided by a home healthcare agency are covered by the plan. These services include nursing care, therapy, oxygen and its administration and diagnostic services.

Hospice
Benefits for hospice providers will be provided for services related to the care of a terminally ill patient (where life expectancy is six months or less). Prior authorization is required for in-patient services.

Preventive Care
To encourage early detection and prevention, the health plan provides for routine physicals, well-child visits, and other routine preventive care tests and immunizations for a $0 copay through an in-network provider. Preventive care provided by non-network providers is covered at 60% and subject to the deductible. *Preventive care provided by the MNPS Employee & Family Health Care Centers has a $0 copay.*

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

As an alternative to the traditional maternity benefits provided with your Certificated Employee Health Plan coverage, you and your covered dependents are eligible to participate in a Vanderbilt-based maternity care bundle program called, MyMaternityHealth, that provides an enhanced clinical and service experience for expectant mothers. The program is an innovative approach that coordinates and "bundles" all of the services an expectant mother and baby need to receive the

best care, all with zero out-of-pocket costs. Learn more at **MNPSBenefits.org/my-maternity-health**.

Under federal law, our health plan cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, our plan does not require that a provider obtain authorization for lengths of stay not in excess of 48 hours or 96 hours.

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

As a participant, you will have opportunities for education and support through your entire pregnancy and after.

Special features of Healthy Babies include:
- Support from a registered nurse case manager for moms and babies with special health care needs. These nurses are just a toll-free call away and can provide you with education on risk factors as well as offer access to services that can help you have a healthy delivery and baby.
- Pregnancy newsletter, parenting magazine and calendar.
- Around-the-clock access to a health advocate to assist you in making sure you receive the care you need.
- Enrollment in Healthy Babies is as easy as calling toll-free **1-800-615-2906**
- If you participate, you will receive $500 if you enroll in your first trimester (or $250 in your second trimester) once the program is completed.

Fertility benefits
MNPS has partnered with Progyny, the leading fertility benefits provider, to provide an all-inclusive family-building benefit for every unique path to parenthood. This comprehensive, new benefit includes:
- Coverage for IUI, IVF and more
- Access to the largest national network of premier fertility specialists
- Unlimited guidance and personalized support from a Patient Care Advocate throughout your fertility journey

The Progyny benefit is available to certificated employees and their spouses/partners covered by the MNPS Cigna medical plan. To learn more and get started, call **1-855-507-6311**.

Medical Emergencies
Emergency services are medical, psychiatric, surgical, hospital and related healthcare services and testing, including ambulance services, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result

in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

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

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

A copay does apply to emergency room use, in addition to the deductible and coinsurance. If you are admitted to the hospital as an inpatient, the copay will be waived.

Skilled Nursing Facilities/Rehabilitation Facilities
Confinements to skilled nursing or rehabilitation facilities are covered at network levels after receiving prior authorization.

What Are the Behavioral Health Benefits?

Under the Cigna plan, office visits for behavioral health concerns (mental health and/or substance abuse) are covered at 100%, no copay required when you use a Cigna in-network provider.

Inpatient (hospitalization) and outpatient (individual or group therapy, intensive outpatient and partial hospitalization) care is covered at 100% when you use a Cigna network provider. Out-of-network treatment, both inpatient and outpatient, is limited to 60% reimbursement after your deductible is satisfied.

In addition to the behavioral health benefits provided under the Cigna medical plan, MNPS provides the following additional programs:

- Counseling through the Employee Assistance Program (EAP) at no charge to employees and members of their household (see page 30)
- Onsite behavioral health visits through the MNPS Employee & Family Health Care Centers at $0 copay per visit
- A behavioral telehealth program through Synchronous Health called Connect with Karla®, provided at no cost to you (visit **www.sync.health/mnps**)

How is Incorrect Information Handled?

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

If your covered dependent(s) becomes ineligible, it is your responsibility to inform Employee Benefit Services and remove that dependent from coverage within one full calendar month of that dependent losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, it is your responsibility to notify your insurance preparer. Any refunds of premiums are limited to three months from the date a notice is received by Employee Benefit Services. Claims paid in error for any reason will be recovered from the employee.

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

How You Can Help
- Pay close attention to the Explanation of Benefits (EOB) forms sent to you when a claim is filed under your contract and always call the toll-free number on the reverse side of your identification card to question any charge that you do not understand — this will prevent providers from billing for services not provided to you or your dependents, or misrepresenting the date of service, the amount charged or the type of service provided.
- Report anyone who permits a relative or friend to "borrow" an insurance identification card.
- Report anyone who makes false statements on their insurance enrollment applications.
- Report anyone who fabricates claims or alters amounts charged on claim forms.
- Please contact Employee Benefit Services to report fraud, waste or abuse of the plan. All calls are strictly confidential.

What if a Mistake Was Made in Paying My Claim?
First call Cigna at 1-800-244-6224 if you believe an error was made in processing your claim, have a question about your health coverage, are unsure if a claim has been filed, or have a question regarding a dependent's eligibility. If Cigna is unable to answer your questions, contact Employee Benefit Services at 615-259-8607.

Is There an Appeal Process?

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

Appealing to the Insurance Company
Our insurance company has their own internal appeals process that must be followed prior to appealing to the Insurance Trust. Your first step is to contact Cigna at 1-800-244-6224.

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

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

The appeal should be in the form of a letter (from the employee) detailing the events leading to the denial of the insurance claim. Copies of all correspondence and explanation of benefits relating to the claim should accompany the letter. Also include any other documented information, such as names of personnel you have talked with, dates of the communications, physicians' statements, etc. It is very important that you provide a phone number or email address where you can be

reached during business hours so that you can be contacted with questions or information about your appeal. The deadline for filing an appeal is two years after claim rejection.

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

Some cases may also require review by an independent medical consultant. The determination to request such a review will be made by the appeals coordinator. Many appeals are resolved during this review phase of the process. If, however, your appeal is not resolved, it may be scheduled for presentation to the Review Committee.

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

Dental Plan

What is the Dental Plan?

The MNPS Certificated Employee Health Plan includes a dental plan for all active employees enrolled in the medical plan. It is included automatically and provided by Cigna.

You may use the dentist of your choice, but dental benefits may be higher when you choose a provider in the Cigna Total DPPO Network. That's because these providers have agreed to a lower contracted fee for services, so the percentage of the charge you pay is based on this lower contracted fee.

What Will I Have to Pay for Dental Care?

Cigna Total DPPO Network dentists have agreed to a lower contracted fee for services. When you use a Cigna participating provider, the percentage of the charge you pay is based on this lower contracted fee. However, if you use a non-Cigna provider and the provider's charges exceed the contracted amount (called the Maximum Allowable Charge, or MAC), you must pay your coinsurance plus the amount exceeding the MAC.

Schedule of Benefits

	In-network (Cigna Total DPPO Network dentists)	**Out-of-network**[1] (Non-participating dentists)
Annual deductible	$50/person $150/family	$50/person $150/family
Plan pays…		
Preventive/diagnostic[2] (exams/cleanings up to 2 per year, x-rays, fluoride treatments)	100%; no deductible	100%; no deductible
Basic restorative (fillings, extractions, oral surgery, root canals, periodontics)	80% after deductible	80% after deductible
Major restorative (crowns, bridges, dentures, implants)	50% after deductible	50% after deductible
Orthodontia (for adults and children)	50%; no deductible	50%; no deductible
Annual benefit maximum (not including preventive/diagnostic care or orthodontia)	$1,000/person	$1,000/person
Lifetime orthodontia maximum	$1,000/person	$1,000/person

[1] Cigna Total DPPO Network dentists have agreed to a lower contracted fee for services; if you use a non-participating provider, you'll be responsible for charges exceeding the Maximum Allowable Charge (MAC).
[2] Costs for preventive/diagnostic services do not count toward your annual benefit maximum.

This is not a full listing of benefits or exclusions. Visit **MNPSBenefits.org/dental** for more details.

How Do I Get Questions Answered?

If you have questions regarding the dental plan, call Cigna Customer Service at 1-800-Cigna24 (1-800-244-6224). Once enrolled, visit **www.myCigna.com** or download the myCigna app.

Vision Plan

What is the Vision Plan?

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

You may use the eye care professional of your choice. However, to receive the highest level of benefits, you and your dependents must select an eye care provider from EyeMed's list of participating providers. When you see a participating provider, your out-of-pocket costs for covered services are limited to the copay amounts shown on your Schedule of Benefits (see page 25).

What Services Are Available?

Vision Examinations
Each member is eligible for a comprehensive eye examination. This well-vision exam is fully covered after a $10 copay once every calendar year.

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

Lenses
Single vision, lined bifocals and standard progressives are fully covered after a copay every calendar year.

Frames
Frames are covered after a copay every other calendar year.

Contacts Through an EyeMed Doctor
The plan covers medically necessary and elective contacts (in lieu of frames/lenses). See page 25 for coverage amounts.

How Much Will I Have to Pay for Vision Care?

Schedule of Benefits

	In-network (EyeMed provider)	**Out-of-network** (Non-EyeMed provider)
Annual deductible	$0	$0
Eye exams (every 12 months)	You pay $10 copay	Plan pays up to $45
Frames (every 24 months)	You pay $0 copay (up to $120 retail allowance, then 20% off)	Plan pays up to $50
Lenses (every 12 months) - Single vision - Bifocals - Trifocals - Standard progressive	 You pay $10 copay You pay $10 copay You pay $10 copay You pay $65 copay	 Plan pays up to $40 Plan pays up to $55 Plan pays up to $70 Plan pays up to $55
Contact lenses (materials only) - Conventional - Disposable - Medically necessary	 Plan pays up to $120 (15% off balance over $120) Plan pays up to $120 Play pays 100%	 Plan pays up to $120 Plan pays up to $120 Play pays up to $210
Additional pairs	Once above benefits used, receive 40% off eyeglasses and 15% off conventional contacts	N/A

How Do I Use My Vision Insurance?

To use your vision insurance, go to **www.eyemed.com** (select Find a Provider, then select the INSIGHT network from the dropdown menu).

If you do not receive services from an EyeMed provider, your benefits will be based on the out-of-network allowances shown above. You must pay the provider in full at the time of service, and submit a claim for reimbursement.

How Do I Get Questions Answered?

If you have questions prior to enrolling, call 1-866-800-5457. Once enrolled, call the number listed on your ID card. Or visit **www.eyemed.com** anytime.

Hearing Benefit

What is the Hearing Benefit?

A hearing benefit, offered through Cigna/Amplifon, is provided with your medical/dental/vision coverage at no additional cost to you.

How Does the Plan Work?

The plan pays a hearing aid benefit of up to $1,400 per person every five years when you use Amplifon's network of providers. There are no benefits if you go out-of-network. Plan features include:

- Brand name hearing aids with a low price guarantee
- Large network of audiologists and ENTs
- Extended product warranty
- Money-back guarantee trial period

Visit **amplifonusa.com/cigna** or call 1-888-901-0811 to get started.

Vanderbilt Health at MNPS Employee & Family Health Care Centers

What Are the MNPS Employee & Family Health Care Centers?

One of the benefits of being enrolled in the MNPS Health Plan is the ability to receive services from the MNPS Employee & Family Health Care Centers. The clinics are managed by Vanderbilt Health and offer MNPS employees, retirees and their family members quality care plus the opportunity to participate in many Vanderbilt programs. The Centers are located around Metro Nashville and provide primary care exclusively to Metro retirees, employees and their dependents. For more information, visit our website at **MNPSHealth.org**.

The Centers are staffed by highly qualified family nurse practitioners with experience in the areas of primary care, family practice and women's health. These practitioners work under the supervision of the clinic's physician medical director.

What Are the Locations and Hours?

The centers are conveniently located, with five facilities in Davidson County close to your home or work. Check **MNPSHealth.org/covid19** for any hours changes due to COVID-19.

Central
Employee Wellness Center at Berry Hill
2694 Fessey Court, Nashville
Clinic: Monday-Friday 7 a.m.-7 p.m. and Saturday, 8 a.m.-2 p.m.
Pharmacy: Monday-Friday 7:30 a.m.-7 p.m. and Saturday, 8:30 a.m.-2 p.m.
Fitness center: Monday-Friday 5:30 a.m.-6 p.m.
The Daily Grind café: Monday-Friday 6 a.m.-2:30 p.m.

North
Taylor Stratton Elementary
306 West Old Hickory Blvd., Madison
Monday-Friday 7 a.m.-6 p.m.

Northeast
Two Rivers Middle
2995 McGavock Pike, Nashville
Monday-Friday 8 a.m.-6 p.m.

Southeast
Mt. View Elementary
3812 Murfreesboro Rd., Antioch
Monday-Friday 7 a.m.-5 p.m.

West
Bellevue Middle
651 Colice Jeanne Rd., Nashville
Monday-Friday 8 a.m.-6 p.m.

What Services Are Available?

Below are core services provided by the MNPS Health Care Centers. A variety of additional health improvement programs are available to help you pursue your best life. Visit **MNPSBenefits.org/hip** for details.

Primary Care

The Centers provide care for acute illness and minor injuries with little to no wait. Center providers can treat you for conditions such as:

- Colds, flu, cough, sinus infections, strep throat, headache, stomach upset and more
- Strains, sprains and cuts
- Allergy shots
- Lab tests
- Chronic condition management
- Behavioral health screenings

Preventive Care

Our family nurse practitioners are also a great resource for:

- Women's and men's health
- Adolescent care
- Annual and sports physicals
- Immunizations

Berry Hill Services

Additionally, our Employee Wellness Center at Berry Hill offers:

- Onsite physical therapy
- Onsite chiropractic, acupuncture care and dry needling
- Onsite behavioral health care
- Kroger pharmacy
- Full-service fitness center (Certificated employees, retirees and their spouses/partners can use the fitness facility. Their children and adult dependents can use clinic and pharmacy services, but are not eligible for the fitness center.)
- The Daily Grind healthy food café (proudly serving Starbucks®)

Personalized Coaching

Health Coaches

Cigna plan enrollees also have access health coaches, who are dedicated to helping you tackle your biggest health challenges, including:

- Losing, gaining or maintaining your weight
- Improving your eating habits
- Controlling chronic conditions like diabetes, high blood pressure or cholesterol, heart disease, asthma and COPD
- Designing a personal exercise plan and getting fit
- Making overall health improvements

Services are confidential and provided at no cost to those covered by the Cigna medical plan. Simply call 615-259-8755 to make an appointment.

Weight Management Program
The Weight Management Program, offered through the MNPS Health Care Centers, provides personalized help for people with a BMI of 25 or greater who want to lose weight.

Enrollees who meet certain requirements can receive 50% reimbursement for:
- Membership fees at an approved weight management program/organization (for example, The New Beginnings Center, WeightWatchers®, Jenny Craig®, YMCA, etc.)
- One-on-one nutrition counseling with a registered dietician/nutritionist

Call Laura Vanderpool at 615-875-1966. Or talk to your health coach.

How Much Will Care Cost Me?
If you are enrolled in the MNPS Certificated Employee Health Plan, care provided by the MNPS Employee & Family Health Care Centers is provided without a copay or deductible.

If you are not enrolled under the MNPS Certificated Employee Health Plan, you can still receive care at the Centers and be billed for the balance due after your health plan pays.

How Do I Schedule an Appointment?
Call 615-259-8755.

Why Should I Use the Centers?

Convenience
Same-day appointments are often available.

High-quality, patient-centered
Our Centers are staffed with highly qualified, Board-certified family nurse practitioners. We work as a team to provide care that respects your needs, culture, values and preferences. A physician is available for nurse consultation at all times. If you need more care than we offer, we can refer you to an appropriate specialist or expedite a referral to Vanderbilt Medical Group.

Confidential
Center staff respect your privacy and follow all laws to protect your personal health information.

Employee Assistance Program

What is the Employee Assistance Program?

MNPS provides employees and their household family members with an employee assistance program (EAP) through ComPsych, called GuidanceResources® EAP. Services are free and completely confidential, and you don't have to be enrolled in an MNPS medical plan to use the EAP.

What Services Are Available?

Through the program, you'll have access to:

- Confidential, licensed professional counseling by guidance consultants for personal, family or work-related issues
- Stress management support, including help for anxiety and depression, relationship/marital conflicts, grief and loss, job pressures and substance abuse
- Legal advice about divorce and family law, debt and bankruptcy, real estate transactions, civil and criminal actions, contracts and more
- Financial information and resources from a Certified Public Accountant or Certified Financial Planner on issues such as getting out of debt, retirement planning, tax questions, and credit card and loan problems
- Work-life solutions for child and elder care, moving and relocation, college planning, home repair and more
- GuidanceResources® Online, your one stop for expert information about relationships, work, school, children, wellness and more

Management Consultation and Referral

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

How Do I Access Services?

All services are strictly confidential and can be accessed by calling 1-888-297-9028, or by visiting **www.guidanceresources.com**. Enter Username: MNPS; Password: EAP. The counselor who takes your call will ask you some questions and refer you to a provider based on the information you provide.

How Much Does It Cost?

You and your eligible dependents may receive EAP counseling at no cost to you. The number of visits will be determined by your EAP provider based on your individual needs. If it is determined that you need greater assistance than the EAP can provide, you will be referred to your health insurance provider's mental health and substance abuse benefits.

Flexible Spending Accounts

What Are Flexible Spending Accounts?

A Flexible Spending Account (FSA) is a benefit that allows participants to re-direct some of their earnings into a customized spending account. The beauty of this is it is set up in accordance with Section 125 of the Internal Revenue Service (IRS) code so benefits are paid tax-free. A Section 125 plan is completely income tax free; no federal income tax, no Social Security tax and no Medicare tax.

MNPS offers three types of FSAs: Pre-tax Premium Payment, Health Care FSA and Dependent Care FSA.

What is the Pre-Tax Premium Payment Program?

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

How Do I Enroll in This Program?

Enrollment in the Pre-tax Premium Payment Program is automatic. However, if you don't want to participate, you may complete a waiver form. This form must be signed and submitted before the end of each year. Contact Employee Benefit Services for details.

Are There Any Limitations to This Program?

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

What is the Health Care FSA?

A Health Care FSA allows you to set aside part of your salary each pay period on a pre-tax basis to pay for the out-of-pocket medical, dental and vision care expenses not covered by your health benefits plan. You can contribute between $240 and $2,750 a year (Note: This contribution limit may increase after the printing of this handbook; see Benefit Express for the latest information).

Eligible Expenses

The following is a partial list of expenses that are reimbursable tax-free with a Health Care FSA:

- Deductibles, copays and other expenses not paid by insurance
- Prescription drugs and medical supplies
- Dental services, orthodontics and dentures
- Eye surgery, glasses, contacts and contact lens solutions
- Weight-loss programs if prescribed by a physician for a medical condition
- Chiropractic services
- Psychiatric care and psychologist's fees
- Smoking-cessation programs

Health Care FSA vs. Claiming Expenses on a 1040

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

What is the Dependent Care FSA?

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

Eligible Expenses

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

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

Note: When filing your federal income tax return, you will be required to supply the name, address and taxpayer identification number of the dependent care provider.

What Are FSA Rules?

Because FSAs offer tax advantages, the IRS places certain restrictions on these accounts:

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

Who is Eligible to Participate?

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

How Do the FSAs Work?

- First, estimate how much money you'll spend during the plan year for expenses that qualify for reimbursement. Don't exceed maximum contribution amounts.
- Once you've enrolled in an account, each pay period the amount you allocate to your FSA is taken out of your pay before taxes are calculated and withheld. The money you set aside for your account is tax-free.
- During the plan year, when you pay for eligible expenses, you will be reimbursed for them with the tax-free money you have set aside in your FSA by simply filing a Reimbursement Request Form with the supporting documentation.

Enrollment Period

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

Coverage Period

If you enroll in an FSA during annual enrollment, your period of coverage is the same as the plan year. The plan year is the calendar year plus 2.5 months (ex: January 1 through March 15). If you

enroll after the plan year begins, your period of coverage begins on the effective date of your coverage (which will always be the first of the month) and ends on the last day of the plan year. Expenses incurred in the 2.5 months after a calendar year will be applied to any unused balance from the prior calendar year. This is called a grace period.

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

If you stop your participation in a Health Care FSA due to a qualifying mid-year event, the account will end the last day of the month in which you drop participation.

How Do I Get Reimbursed?

You may use the FSA debit card you receive after enrollment to pay for eligible healthcare expense or file a claim for reimbursement.

Debit cards eliminate the "lag time" in claims reimbursement. Rather than paying the provider for eligible expenses with a personal check and then filing a claim, just swipe your debit card at any vendor that accepts FSA debit cards and you're done. Do save your receipts, however, in case you're later asked by Cigna to substantiate a claim.

For more details about the FSAs, call Cigna Customer Service at 1-800-Cigna24 (1-800-244-6224). Once enrolled in an FSA, visit **www.myCigna.com** to access account information, claim status, claim forms and answers to general questions.

For the Health Care FSA, you will be reimbursed for qualified expenses claimed up to your plan year election (as long as the expenses were incurred during your period of coverage).

For the Dependent Care FSA, you will be reimbursed for qualified expenses up to your current FSA balance.

Life Insurance

What Life Insurance Coverage is Available?

To be eligible for the various life and accident insurance programs, you must meet the eligibility guidelines for employees and dependents listed on page 6. In addition, children are not covered until 15 days of age.

Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Employee Basic Life and AD&D
MNPS provides, at no cost to active full-time employees working a schedule of 18 hours per week, $50,000 of basic term life and $50,000 of basic AD&D coverage.

The face amount of coverage is reduced to 65% at age 65 and 50% at age 70. All benefits terminate at retirement.

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

Employee Optional Term Life & Accidental Death Coverage
Employees may elect up to $500,000 in optional life and accidental death insurance. Coverage is purchased in $10,000 increments and premiums are based on the employee's age. This is five-year level term coverage. The guaranteed issue amount is up to $300,000 during initial eligibility.

The chart below shows the monthly cost per $10,000 of coverage elected. (For example, if you are age 40 and elect $80,000 in supplemental employee life, you would pay $8/month ($1.00 times 8). This monthly amount would be prorated based on how many paychecks you receive during the year.

Age	Monthly rate per $10,000 in coverage
Under 30	$0.70
30-34	$0.80
35-39	$0.90
40-45	$1.00
46-49	$1.30
50-54	$1.90
55-59	$3.50
60-64	$5.20
65-69	$9.80
70 or older	$15.80

Spouse Basic Life
If enrolled in the medical plan, spouses automatically receive $25,000 of spouse life insurance. If not enrolled in the medical plan, employees may purchase $25,000 of life insurance on their spouse; the cost is listed on page 14.

Child Basic Life
If enrolled in the medical plan, children are automatically covered for $10,000 life insurance ($5,000 from 14 days to 6 months and $2,500 0-13 days). If not enrolled in the medical plan, you can purchase life insurance for your eligible dependents (see dependent eligibility rules on page 6); the cost is listed on page 14.

What Does AD&D Coverage Provide?

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

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

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

When Can I Purchase Additional Life Insurance?

New Hires
New hires have 30 days from the date they are first eligible for coverage to purchase guaranteed issue life insurance.

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

Late Applicants With Evidence Of Good Health
During November annual enrollment, you can apply to purchase additional life insurance coverage, but you will have to submit evidence of good health. The insurer will review your application and make a final determination regarding your eligibility.

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

What Happens if I Become Disabled?

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

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

All premiums must be paid and kept current until the disability waiver is approved. Call 1-800-778-2281 for assistance with waiver of premium applications.

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

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

What if I Die While Traveling?

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

How Do I File a Claim?

Contact Dearborn Group at 1-800-348-4512. In the event of a life insurance claim, a certified copy of the death certificate is required. If you need help filing a claim, contact Employee Benefit Services at 615-259-8607.

Who Can Help My Beneficiaries?

Grief, legal and financial counseling is available for beneficiaries at no charge through our carrier. Call 1-800-778-2281 to be directed to a beneficiary financial counselor.

In addition, beneficiaries may also receive help through our Employee Assistance Program. Call 1-888-297-9028.

Disability Insurance

What Disability Coverage is Available?

Disability coverage continues a portion of your paycheck if a serious illness, injury or pregnancy keeps you from working. MNPS offers optional employee-paid short-term and long-term disability coverage through Dearborn Group.

Short-term Disability
Short-term disability coverage can help fill the gap between sick leave and long-term disability. Short-term disability benefits begin after a 14-day waiting period and after all salary continuation, sick leave and vacation pay have been exhausted. The plan pays 60% of your weekly earnings, up to $1,150/week. Benefits generally continue up to 13 weeks or until long-term disability begins, if earlier.

Long-term Disability
Long-term disability benefits generally begin after 90 days of total disability (waiting period). The plan replaces 60% of your earnings, up to $5,000 a month. This includes earnings at this employer, any other employer and any other work for pay or profit. Limits may apply.

Benefits generally continue until your disability ends or you reach normal Social Security retirement age, whichever comes first. If you are age 62 or older when your covered disability begins, your benefits duration may differ. See the official plan documents.

What if I Become Disabled?

If you become totally disabled, you may apply for benefits by contacting Dearborn Group at 1-800-348-4512. If you need help filing a claim, contact Employee Benefit Services at 615-259-8607.

Are There Any Limits to My Disability Benefits?

Pre-existing Condition and Other Benefit Limits
Disability benefits will not be paid for any disability resulting from a pre-existing condition. However, the length of the pre-existing condition waiting period may be reduced if you have previous "creditable coverage" under The Hartford (our prior plan administrator).

Pre-existing condition means a condition:

- Resulting from a sickness or injury for which you received medical treatment, advice or prescriptions (even if the condition was not officially diagnosed) within 12 months prior to your effective date
  AND
- Resulting in a disability that begins in the first 12 months after your effective date (for short-term disability) or 24 months after your effective date, unless you received no treatment of the condition for 12 consecutive months after your effective date (for long-term disability)

There are certain situations in which your disability benefits may be reduced or limited. For example, benefits may be reduced by any other disability benefits you are eligible to receive.

Retirement

What Retirement Plans Are Available?

Typically, there are two types of retirement plans: defined benefit plans and defined contribution plans. The TCRS Hybrid Plan is a combination of a defined benefit plan and a 401(k) defined contribution plan.

Defined Benefit Plan (TCRS Retirement plan)

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

Defined Contribution Plans (Tennessee 401(k) Deferred Compensation Plan)

- The benefit available at retirement is the retiree's account balance. Contributions, based on a dollar amount or percentage of pay, are put in each year. The account balance over time is a result of the amount put in and the investment return.
- The employee chooses the investments and bears the risk of investment losses.
- Contributions may be available for withdrawals or loans, and subject to early withdrawal penalties.
- Examples of defined contribution plans: 401(k), 457 and Roth 401(k) plans.
- Under the Hybrid Plan, MNPS contributes 5% of pay to a 401(k), and the employee contributes 2%, which can be increased or discontinued by the employee.

What Are My Retirement Benefits?

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

All teachers in public school systems are Group 1 members. Teachers contribute 5% of salary toward the cost of the TCRS Defined Benefit Pension Plan. MNPS pays any additional costs. Members are vested after five years of service in TCRS. Vesting means you have a right to a guaranteed retirement benefit when age requirements are met. Benefits are based on your years of service times a percentage of your pay (based on your highest five consecutive years of service). For those hired before July 1, 2014, that percentage is 1.565%; for those hired on or after July 1, 2014, the percentage is 1%.

In addition to the defined benefit portion of TCRS, teachers hired after July 1, 2014 are enrolled in the State of Tennessee 401(k) Deferred Compensation Program as part of the TCRS Hybrid Plan. MNPS contributes an amount equal to 5% of your pay to this plan, and employees are automatically enrolled with a 2% of pay contribution. Employees may increase or discontinue their contributions at any time. See the enrollment guide for 401(k) Deferred Compensation Program for details.

When Can I Retire?

Employees who are vested in the retirement plan are eligible for the various retirement options.

Service Retirement

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

Early Retirement

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

To be eligible for early retirement the employee must be at least age 55 and have 10 years of creditable service OR have at least 25 years of creditable service.

Disability Retirement

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

Ordinary Disability Benefits

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

Accidental Disability Benefits

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

Can I Contribute to a Retirement Account?

In addition to the defined benefit plan, the State of Tennessee offers a deferred compensation plan called a 401(k), which allows MNPS employees to contribute additional pre-tax or after-tax funds toward their retirement. Employees may also participate in a 457 plan.

This plan allows an employee to defer to each plan up to $19,500 in compensation per calendar year (indexed annually for inflation). Additionally, if you are over age 50, you may be entitled to a $6,500 catch-up provision, and if you have more than 15 years' service with MNPS, you may be eligible for an additional $3,000 catch-up provision.

The 401(k) has multiple investment options.