PARTNERS FOR HEALTH

State Group
Insurance Program

2013 Eligibility and Enrollment Guide

Local Education Employees

If you need help...

Contact your agency benefits coordinator. Your agency benefits coordinator has received special training in our insurance programs. If he or she cannot answer your question, you'll be directed to someone who can.

For additional information about a specific benefit or program, refer to the chart below.

	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	1.800.253.9981	www.tn.gov/finance/ins www.partnersforhealthtn.gov Email: benefits.administration@tn.gov
Health Insurance	BlueCross BlueShield of Tennessee Cigna	1.800.558.6213 1.800.997.1617	www.bcbst.com/members/tn_state www.cigna.com/stateoftn
Pharmacy Benefits	CVS Caremark	1.877.522.TNRX (1.877.522.8679)	www.caremark.com
Mental Health, Substance Abuse and Employee Assistance Program	Magellan	1.855.HERE.4.TN (1.855.437.3486)	www.Here4TN.com
Wellness and Nurse Advice Line	Healthways	1.888.741.3390	www.partnersforhealthtn.gov
Dental Insurance	Assurant Employee Benefits Delta Dental	1.800.443.2995 1.800.223.3104	www.assurantemployeebenefits.com/stoftn www.deltadentaltn.com/statetn
Vision Insurance	EyeMed Vision Care	1.855.779.5046	www.eyemedvisioncare.com/stoftn
Long-Term Care Insurance	MedAmerica	1.866.615.5824	www.ltc-tn.com
Edison	TN Department of Finance & Administration	password reset 615.741.3590 or 1.800.253.9981 option 3	https://www.edison.tn.gov

Enrollment forms and handbooks...

All enrollment forms and handbooks referenced in this guide are located on our website at **www.tn.gov/finance/ins** or you can get a copy from your agency benefits coordinator.

Online resources...

Visit the ParTNers for Health website at www.partnersforhealthtn.gov. Our ParTNers for Health website has information about all the benefits described in this guide—plus definitions of insurance terms that may be unfamiliar and answers to common questions from members. The website is updated often with new information and frequently asked questions.

TABLE OF CONTENTS

INTRODUCTION 1
Overview 1
For More Information 1
Authority 1

ELIGIBILITY AND ENROLLMENT 2
Employee Eligibility 2
Dependent Eligibility 2
Enrollment and Effective Date of Coverage 3
Choosing a Premium Level (Tier) 3
Premium Payment 4
Adding New Dependents 4
Updating Personal Information 4
Annual Enrollment Transfer Period / Open Enrollment 5
Canceling Coverage 5
Transferring Between Plans 6
If You Don't Apply When First Eligible 6

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION 8
Extended Periods of Leave 8
Termination of Employment 9
Continuing Coverage through COBRA 9
Continuing Coverage at Retirement 9
Coverage for Dependents in the Event of Your Death 10

AVAILABLE BENEFITS 11
Health Insurance 11
Dental Insurance 15
Vision Insurance 17
Employee Assistance Program 19
ParTNers for Health Wellness Program 19
Long-Term Care Insurance 20

OTHER INFORMATION 21
Coordination of Benefits 21
Subrogation 21
On the Job Illness or Injury 21
Fraud, Waste and Abuse 22
To File an Appeal 22

LEGAL NOTICES 24
Information in this Guide 24
Member Privacy 24
Medicare Part D 24

TERMS AND DEFINITIONS 25

TN Department of Finance and Administration,
Authorization No. 317376, November 2012.
This public document was promulgated at a cost of $0.71 per copy.

INTRODUCTION

Overview

This guide is to help you understand your insurance options. Read the information in this guide and make sure you know the rules.

Benefits Administration within the Department of Finance and Administration manages the group insurance program. Three separate groups receive benefits. The State Plan includes employees of state government and higher education. The Local Education Plan is available to local K-12 school systems. The Local Government Plan is available to local government agencies that choose to participate.

If you are eligible, you may enroll in health coverage. Dental and long-term care coverages are also available, if offered by your agency.

There are other handbooks that explain the health and dental benefits. You may obtain a copy of those books from your agency benefits coordinator or from the Benefits Administration website.

For More Information

Your agency benefits coordinator is your primary contact. This person is usually located in your human resource office. He or she is available to answer benefit questions and can provide you with forms and insurance booklets.

Authority

The Local Education Insurance Committee sets benefits and premiums. The Committee is authorized to (1) add, change or end any coverage offered through the state group insurance program, (2) change or discontinue benefits, (3) set premiums and (4) change the rules for eligibility at any time, for any reason.

Local Education Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Education as designated by the Governor
- Three teachers selected by the Tennessee Education Association
- One member selected by the Tennessee School Board Association

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

The following employees are eligible to enroll in coverage:

- A teacher as defined in Tennessee Code Annotated, Section 8-34-101-(46)
- An interim teacher whose salary is based on the local school system's schedule
- Full-time employees not defined above who are regularly scheduled to work at least 30 hours per week
- Full-time non-certified employees who have completed 24 months of employment with a local education agency that participates in the plan and works a minimum of 25 hours per week — a resolution passed by the school system's governing body authorizing the expanded 25 hour rule for the local education agency must be sent to Benefits Administration before enrollment
- School board members
- All other individuals cited in state statute or approved as an exception by the Local Education Insurance Committee

Employees NOT Eligible to Participate in the Plan

- Substitute teachers
- Individuals performing services on a contract basis
- Individuals in positions that are temporary appointments
- Individuals who do not meet the eligibility rules

Dependent Eligibility

If you are enrolling dependents, you must provide proof of eligibility when you fill out your enrollment application. The following dependents are eligible for coverage:

- Your spouse (legally married) — Article XI, Section 18 of the Tennessee Constitution provides that a marriage from another state that does not constitute the marriage of one man and one woman is "void and unenforceable in this state"
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian
- Children for whom the plan has qualified medical child support orders

All dependents must be listed by name on the enrollment application. Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart included on the enrollment application for the types of proof you must provide. A dependent can only be covered once within the same plan, but can be covered under two separate plans (State, Local Education or Local Government). Dependent children are eligible for coverage through the last day of the month of their 26th birthday.

Children who are mentally or physically disabled and not able to earn a living may continue coverage beyond age 26 if they were disabled before their 26th birthday and they were already insured under the state group insurance program. The child must meet the requirements for dependent eligibility listed above. A request for extended coverage must be provided to Benefits Administration within 90 days before the dependent's 26th birthday. The insurance carrier will decide if a dependent is eligible based on disability. Coverage will end and will not be restored once the child is no longer disabled.

A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who declined coverage when first eligible. The employee spouse will always have dependent status unless he or she later qualifies under the special enrollment provisions.

Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse (with the exception of long-term care)
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

Enrollment and Effective Date of Coverage

As a new employee, your eligibility date is your hire date or no later than the end of the subsequent month. You must complete enrollment prior to your eligibility date unless you become eligible on your hire date. In that case, you must complete enrollment within 31 days after your hire date. Coverage starts on the first day of the month after your eligibility date.

If you are a part-time employee and gain full-time status, your coverage will start the first day of the month after gaining full-time status or you may choose the next month for coverage to start. You must complete one full calendar month of employment. Application must be made within one full calendar month after becoming eligible

You must be in a positive pay status on the day your coverage begins. If you do not enroll in health coverage by the end of your enrollment period, you will only be eligible if you have a qualifying event under the special enrollment provisions. Refer to the special enrollment provisions section of this guide for more information.

Positive Pay Status – Being paid even if you are not actually performing the normal duties of your job. This is related to any type of approved leave with pay.

A dependent's coverage starts on the same date as yours unless newly acquired. Newly acquired dependents will start coverage on the date they were acquired if you are in family coverage. You may also choose to have coverage start the first day of the following month. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption.

An insurance card will be mailed to you three to four weeks after your application is processed. You may call the insurance carrier to ask for extra cards or print a temporary card from the carrier's website.

Choosing a Premium Level (Tier)

There are four premium levels for health, dental and vision coverage to choose from depending on the size of your family.

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Employee + Spouse + Child(ren)

Family Coverage – Coverage other than Employee Only is considered family coverage.

If you enroll as a family in the second, third or fourth premium level, all of you must enroll in the same health, dental and vision options. However, if you are married to an employee who is also a member of the State, Local Education or Local Government Plan, you can each enroll in employee only coverage if you are not covering dependent children. If you have children, one of you can choose employee only and the other can choose employee + child(ren). Then you can each choose your own benefit option and carrier.

Premium Payment

The state pays about 45 percent of the cost of health coverage for certified teaching staff in the Local Education Plan. Some agencies may give more premium support. Your agency benefit coordinator can explain when your premium will be taken from your paycheck. Optional coverages gets no state support and you must pay the total premium.

The plan permits a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled back to the date you last paid a premium. There is no provision for restoring your coverage.

Premiums are not prorated. You must pay the premium for the entire month in which the effective date occurs.

Adding New Dependents

An enrollment application must be completed within 60 days of the date a dependent is acquired. The "acquire date" is the date of birth, marriage, or, in case of adoption, when a child is adopted or placed for adoption. Premium changes start on the first day of the month in which the dependent was acquired or, the first of the next month, depending on the coverage start date.

An employee's child named under a qualified medical support order must be added within 40 days of the court order.

If adding dependents while on single coverage, you must request the correct family coverage tier for the month the dependent was acquired so claims are paid for that month. This change is retroactive and you must pay the premium for the entire month the dependent is insured.

To add a dependent more than 60 days after the acquire date, the following rules apply based on the type of coverage you currently have.

If you have single coverage

- The new dependent can only enroll if they have a qualifying event under the special enrollment provisions

If you have family coverage

- The new dependent can only enroll if they have a qualifying event under the special enrollment provisions, unless;
- The level of family coverage you had on the date the dependent was acquired was sufficient to include that dependent without requiring a premium increase. You must have maintained that same level of family coverage without a break. The dependent's coverage start date may go back to the acquire date in this case.

More information is provided under the special enrollment provisions section of this guide.

Updating Personal Information

Local education members should update personal information, such as home address, by contacting your agency benefits coordinator. You can also call the Benefits Administration service center to request an address change. You will be required to provide the last four digits of your social security number, Edison ID, date of birth, previous address and confirm authorization of the change before our office can update your information. **It is the member's responsibility to keep address and phone number current with your employer.**

Annual Enrollment Transfer Period / Open Enrollment

During the fall of each year, benefit information is mailed to you. Review this information carefully to make the best decisions for you and your family members. The enrollment transfer period gives you another chance to enroll in optional dental or vision coverage, if offered by your agency. You can also make changes to your existing coverage, like transferring between health, dental and vision options and canceling coverage. Changes you request start the following January 1.

Benefit enrollments remain in effect for a full plan year (January 1 through December 31). You may not cancel coverage outside of the transfer period unless eligibility is lost or there is a qualifying change or event. For more information, see the section on canceling coverage in this guide.

Canceling Coverage

Outside of the annual enrollment transfer period, you can only cancel health, dental and/or vision coverage for yourself and/or your covered dependents, IF:

- You lose eligibility for the state group insurance program (e.g., changing from full-time to part-time)
- You experience a special qualifying event, family status change or other qualifying event as approved by Benefits Administration

You must notify your agency benefits coordinator of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for adopted children ends when the legal obligation ends. Insurance continued for a disabled dependent child ends when he/she is no longer disabled or at the end of the 31-day period after any requested proof is not given. For a divorce or legal separation, you cannot remove your spouse until a final decree is entered, unless your spouse or the court gives permission.

You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you become newly eligible for coverage under another plan. There are no exceptions. You have 60 days from the date that you and/or your dependents become newly eligible for coverage to turn in an application and proof to your agency benefits coordinator. The required proof is shown on the application. Approved reasons to cancel are:

- Marriage
- Adoption/placement for adoption
- New employment (self or dependents)
- Return from unpaid leave
- Entitlement to Medicare, Medicaid or TRICARE
- Birth
- Divorce or legal separation
- Court decree or order
- Open enrollment
- Change in place of residence or work out of the national service area (i.e., move out of the U.S.)
- Change from part-time to full-time employment (spouse or dependents)

Once your application and required proof are received, the coverage end date will be either:

- The last day of the month before the eligibility date of other coverage
- The last day of the month that the event occurred
- The last day of the month that documentation is submitted (to cancel prepaid dental)

Transferring Between Plans

Members eligible for coverage under more than one state-sponsored plan may transfer between the State, Local Education and Local Government Plans. You may apply for a transfer during the plan's designated enrollment transfer period with an effective date of January 1 of the following year. In no case may you transfer to another state-sponsored plan and remain on your current plan as the head of contract.

If You Don't Apply When First Eligible

If you do not enroll in health coverage when you are first eligible, you can only apply later through special enrollment due to certain life events. You should apply for health insurance when you are first employed. You may not be able to get coverage at a later date.

Special Enrollment Provisions

The Health Insurance Portability Accountability Act (HIPAA) is a federal law. It allows you to enroll in a group health plan due to certain life events. The state group insurance program will only consider special enrollment requests for health, dental and/or vision coverage.

If adding a newly acquired dependent for any of the reasons below, you may also add previously eligible dependents at the same time. Approved reasons are:

- A new dependent spouse is acquired through marriage
- A new dependent newborn is acquired through birth
- A new dependent is acquired through adoption or legal custody

You must make the request within 60 days of acquiring the new dependent. You must also submit proof, as listed on the enrollment application, to show:

- The date of the birth
- The date of placement for adoption
- The date of marriage

The above events are ONLY subject to special enrollment IF you want to add other previously eligible dependents at the same time as the new dependents. If you only want to add a newly acquired dependent, this is treated as a regular enrollment.

Options for coverage start dates due to the events above are:

- Day on which the event occurred if enrollment is due to birth, adoption or placement for adoption
- Day on which the event occurred or the first day of the next month if enrollment is due to marriage

Other events allow enrollment based on a loss of coverage under another plan:

- Death of a spouse or ex-spouse
- Divorce
- Legal separation
- Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause)
- Termination of spouse or ex-spouse's employment
- Employer ends total premium support to the spouse's, ex-spouse's or dependent's insurance coverage (not partial)
- Spouse's or ex-spouse's work hours reduced
- Spouse maintaining coverage where lifetime maximum has been met
- Loss of TennCare (does not include loss due to non-payment of premiums)

Applications for the above events must be made within 60 days of the loss of the insurance coverage.

You must submit proof as listed on the enrollment application to show ALL of the following:

- A qualifying event has occurred
- You and/or your dependents were covered under another group health plan at the time of the event
- You and/or your dependents may not continue coverage under the other plan

If enrolling due to loss of coverage under another plan, options for coverage start dates are:

- The day after the loss of other coverage, or
- The first day of the month following loss of other coverage

Important Reminders

- If enrolling dependents who qualify under the special enrollment provisions, you may choose to change to another carrier or health option, if eligible
- If you or your dependents had COBRA continuation coverage under another plan and coverage has been exhausted, enrollment requirements will be waived if application is received within 60 days of the loss of coverage
- Loss of eligibility 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

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION OF EMPLOYMENT

Extended Periods of Leave

Family and Medical Leave Act (FMLA)

FMLA allows you to take up to 12 weeks of leave during a 12-month period for a serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to get the portion of your health insurance premium that your employer would pay if you were in a positive pay status. Initial approval for family and medical leave is up to each agency head. You must have completed a minimum of 12 months of employment immediately before the onset of leave. Cancelation due to failure to pay premiums does not apply to FMLA.

Leave Without Pay — Health Insurance Continued

If continuing coverage while on an approved leave of absence you must pay the total monthly health insurance premium once you have been without pay for one full calendar month. You will be billed at home each month for your share and the employer's share. The maximum period for a leave of absence is two continuous years. At the end of the two years, you must immediately report back to work for no less than one full calendar month before you can continue coverage during another leave of absence. If you do not immediately return to work at the end of two years of leave, coverage is canceled and COBRA eligibility will not apply.

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any optional coverages. You may reinstate coverage when you return to work. If canceled for nonpayment, coverage cannot be restored unless you have a qualifying event under the special enrollment provisions.

To Reinstate Coverage After You Return

You must submit an application to your agency benefits coordinator within 31 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 31 days of your return to work, you can only re-enroll if you have a qualifying event under the special enrollment provisions. The following rules apply:

If returning within six months

- No waiting period, coverage goes into effect the first of the next month after you return to work
- Preexisting condition does not apply

If returning after six months

- Must wait one full calendar month before coverage starts
- Must satisfy the twelve-month preexisting condition clause (waived if you provide a certificate of coverage letter showing other coverage while on leave without a 63-day lapse)

If you and your spouse are both insured with the state group insurance program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract. To transfer coverage, submit an enrollment application to suspend your coverage. Your spouse should submit an enrollment application to add you as a dependent. Benefits Administration must be contacted to assist with this change and to transfer deductibles and out-of-pocket expenses.

Reinstatement for Military Personnel Returning from Active Service

An employee who returns to work after active military duty may reinstate coverage on the earliest of the following:

- The first day of the month, which includes the date discharged from active duty
- The first of the month following the date of discharge from active duty
- The date returning to active payroll
- The first of the month following return to the employer's active payroll

If restored before returning to the employer's active payroll, you must pay 100 percent of the total premium. In all instances, you must pay the entire premium for the month.

Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave. No preexisting conditions or waiting period will apply.

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration. A COBRA notice to continue health, dental and/or vision coverage will be mailed to you.

Continuing Coverage through COBRA

You may be able to continue health, dental and/or vision coverage under the Consolidated Omnibus Budget Reconciliation Act. This is a federal law known as COBRA. This law allows employees and dependents whose insurance would end to continue the same benefits for specific periods of time. Persons may continue health, dental or vision insurance if:

1. Coverage is lost due to a qualifying event (refer to the COBRA brochure on our website for a list of events)
2. You are not insured under another group health plan as an employee or dependent (waived if you or your dependents enroll in another group health plan that has a preexisting condition clause, and a condition exists that is not covered by the other plan). In this case, you must provide the following to Benefits Administration:
    - 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 doctor stating your preexisting condition

Benefits Administration will send a COBRA packet to you. It will be sent to the address on file within 7-10 days after your coverage ends. Make sure your correct home address is on file with your agency benefits coordinator. You have 60 days from the date coverage ends or the date of the COBRA notice, whichever is later, to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. If you do not receive a letter within 30 days after your insurance ends, you should contact Benefits Administration.

Continuing Coverage at Retirement

Members who meet the eligibility rules may continue health insurance at retirement for themselves and covered dependents until eligible for Medicare. For service retirement, a minimum of ten years employment is required. To continue coverage as a retiree, you must submit an application within one full calendar month of the date active coverage ends. A member cannot have retiree coverage and keep active coverage as an employee in the same plan. Information on eligibility requirements can be found in the guide to continuing insurance at retirement available on our website.

Coverage for Dependents in the Event of Your Death

If You Are an Active Employee

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage under COBRA for a maximum of 36 months as long as they remain eligible. If your spouse will be receiving your TCRS retirement benefit, he or she may be eligible to continue insurance as a retiree in lieu of COBRA. The surviving spouse should contact the agency benefits coordinator or Benefits Administration to confirm eligibility. Dental and vision insurance will terminate at the end of the month of the death of the employee. However, continuation of coverage through COBRA will be available.

If You Are a Covered Retiree

Your covered dependents will get up to six months of health coverage at no cost. Dependents may apply to continue to be covered as long as they continue to meet eligibility rules.

If You Are Covered Under COBRA

Your covered dependents will get up to six months of health coverage at no cost. After that, they may continue health coverage under COBRA if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

AVAILABLE BENEFITS

Health Insurance

You have a choice of two health insurance options:

- Partnership PPO
- Standard PPO

PPO stands for preferred provider organization. With a PPO, you can see any doctor you want. However, the PPO has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. These providers make up a network. You can visit any doctor or facility in the network. These providers have agreed to take lower fees for their services. The cost is higher when using out-of-network providers.

The PPOs cover the same services, treatments and products, including the following:

- In-network preventive care, x-ray, lab and diagnostics at no cost
- Primary and specialist doctor office visits for a fixed copay without having to meet a deductible
- Prescription drugs for a fixed copay without having to meet a deductible
- Both have deductibles and coinsurance for certain services such as hospitalization, therapy, durable medical equipment, advanced imaging and ambulance
- Both have out-of-pocket maximums to limit your coinsurance costs and physician office visit copays

Partnership Promise

There is one important difference between the Partnership PPO and the Standard PPO. If you choose the Partnership PPO, you must agree to a Partnership Promise. The Partnership Promise requires you to take certain steps to get or stay as healthy as you can. In return, you will pay less than you would with the Standard PPO. In general, the Partnership Promise is a commitment to:

- Know your health history
- Know your health risks
- Take actions to get and stay as healthy as you can

The Partnership Promise is an annual commitment. In order to remain in the Partnership PPO, you must meet your commitment each year. When you sign the enrollment application or enroll through employee self service (ESS) you are agreeing to fulfill the Partnership Promise requirements each year you are enrolled in the Partnership PPO. You will not be required to sign a new promise each year. You and all eligible family members must enroll in the same PPO. If you choose the Partnership PPO, your dependent spouse must also agree to the Partnership Promise. Children are not required to take action.

By signing your enrollment form and agreeing to the Partnership Promise in 2013, you are making a specific commitment to do the following within 120 days of your coverage effective date:

- **Complete the on-line Well-Being Assessment**
- **Get a biometric screening from your healthcare provider (you can use screening results from a doctor's visit within the last 12 months)**

Note: to access the Well-Being Assessment and the physician screening form, visit partnersforhealthtn.gov and click on the partnership promise link for more information.

In return for committing to the Partnership Promise, you will have lower premiums, copays, coinsurance, deductibles and out-of-pocket maximums than under the Standard PPO. If you sign up for the Partnership PPO, but do not satisfy the Partnership Promise, you will only be eligible for the Standard PPO in the next plan year.

Preexisting Conditions

A preexisting condition is a condition for which you had treatment or advice during the 6-month period immediately prior to coverage with the state group insurance program.

Preexisting conditions do not apply to pregnancy, newborns or dependent children up to age 26. If you are enrolling as a new hire and have had health coverage without a 63-day lapse in coverage, the preexisting condition clause will be waived.

If you or your dependent spouse do not have prior health coverage, or if the prior coverage canceled for more than 63 days, you must meet the preexisting condition requirement. Treatments for conditions determined to be preexisting will not be covered until insurance has been in force for 12 months.

You or your dependent spouse must furnish a certificate of coverage letter (letter on former employer or insurance carrier letterhead) stating that you had prior coverage. The letter must include the names of the persons who were enrolled and the date the coverage ended. You must provide this letter to your benefits coordinator in order to be exempt from the preexisting condition rule. There cannot be a lapse of coverage longer than 63 days. If you do not have the letter when you enroll, you may provide it later and Benefits Administration will change the coverage to show that the preexisting conditions clause does not apply.

Monthly Premiums for Local Education Plan Active Employees

	EAST AND MIDDLE TENNESSEE		WEST TENNESSEE	
	BCBST	CIGNA	BCBST	CIGNA
PARTNERSHIP PPO				
Employee Only	$512.04	$532.04	$532.04	$512.04
Employee + Child(ren)	$844.87	$884.87	$884.87	$844.87
Employee + Spouse	$998.48	$1,038.48	$1,038.48	$998.48
Employee + Spouse + Child(ren)	$1,331.30	$1,371.30	$1,371.30	$1,331.30
STANDARD PPO				
Employee Only	$537.04	$557.04	$557.04	$537.04
Employee + Child(ren)	$869.87	$909.87	$909.87	$869.87
Employee + Spouse	$1,048.48	$1,088.48	$1,088.48	$1,048.48
Employee + Spouse + Child(ren)	$1,381.30	$1,421.30	$1,421.30	$1,381.30

The premium amounts shown reflect the total monthly premium. Please see your agency benefits coordinator for your monthly deduction, the state's contribution and your employer's contribution, if applicable.

Services that Require Copays

Services in this table ARE NOT subject to a deductible and costs DO NOT APPLY to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Preventive Care				
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, prostate, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No charge	$45 copay	No charge	$50 copay
Outpatient Services				
Primary Care Office Visit * • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25 copay	$45 copay	$30 copay	$50 copay
Specialist Office Visit * • Including surgery in office setting	$45 copay	$70 copay	$50 copay	$75 copay
Mental Health and Substance Abuse * [2]	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation and results (not including advanced x-rays, scans and imaging)	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Allergy Injection with Office Visit *	$25 copay primary; $45 copay specialist	$45 copay primary; $70 copay specialist	$30 copay primary; $50 copay specialist	$50 copay primary; $75 copay specialist
Chiropractors	Visits 1-20: $25 copay Visits 21 and up: $45 copay	Visits 1-20: $45 copay Visits 21 and up: $70 copay	Visits 1-20: $30 copay Visits 21 and up: $50 copay	Visits 1-20: $50 copay Visits 21 and up: $75 copay
Pharmacy				
30-Day Supply	$5 copay generic; $35 copay preferred brand; $85 copay non-preferred brand	Copay plus amount exceeding MAC	$10 copay generic; $45 copay preferred brand; $95 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic; $65 copay preferred brand; $165 copay non-preferred brand	Copay plus amount exceeding MAC	$20 copay generic; $85 copay preferred brand; $185 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [4]	$5 copay generic; $30 copay preferred brand; $160 copay non-preferred	Copay plus amount exceeding MAC	$10 copay generic; $40 copay preferred brand; $180 copay non-preferred	Copay plus amount exceeding MAC
Urgent Care				
Convenience Clinic or Urgent Care Facility	$30 copay		$35 copay	
Emergency Room				
Emergency Room Visit (waived if admitted) **	$125 copay		$145 copay	

*** Out-of-Pocket Copay Maximum — per individual** (applies to **in-network** office visits for primary care, specialist care and mental health and substance abuse treatment); **$900 Partnership PPO; $1,100 Standard PPO**

** Services subject to coinsurance may be extra

Services that Require Coinsurance — Deductibles and Out-of-Pocket Coinsurance Maximums

Services in this table ARE subject to a deductible and eligible expenses CAN BE APPLIED to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services • Inpatient care [3] • Outpatient surgery [3] • Inpatient mental health and substance abuse [2] [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care [3] • Home health • Home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [3]; outpatient • Skilled nursing facility [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [3] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies [3] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance	40% coinsurance
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
Deductible				
Employee Only	$450	$800	$800	$1,500
Employee + Child(ren)	$700	$1,250	$1,250	$2,350
Employee + Spouse	$900	$1,600	$1,600	$3,000
Employee + Spouse + Child(ren)	$1,150	$2,050	$2,050	$3,850
Out-of-Pocket Coinsurance Maximum				
Employee Only	$1,550	$2,900	$1,900	$3,600
Employee + Child(ren)	$2,450	$4,600	$3,100	$5,900
Employee + Spouse	$3,100	$5,800	$3,800	$7,200
Employee + Spouse + Child(ren)	$4,000	$7,500	$5,000	$9,500

No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS difference between MAC and actual charge.
[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization, and intensive outpatient therapy. Prior authorization (PA) is required for psychological testing and electroconvulsive therapy.
[3] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)
[4] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies; statins (see page 2).

Dental Insurance

Local Education participants are eligible for dental if offered by the employing agency. You must pay 100 percent of the premium if you elect this coverage. Two options are available — a prepaid plan (Assurant) and a preferred dental organization (PDO) plan (Delta Dental).

In the prepaid plan, you must select from a specific group of dentists. Under the PDO plan, you may visit the dentist of your choice; however, members get maximum savings when visiting a PDO network provider. Both dental options have specific rules for benefits such as exams and major procedures, and have a four-tier premium structure just like health insurance.

You can enroll in dental coverage as a new employee or during the annual enrollment transfer period. You may also enroll if you have a special qualifying event. You do not have to be enrolled in health coverage to be eligible for dental insurance.

Prepaid Plan (Assurant)

- Must select a network provider for each covered family member
- Major services at predetermined copayments
- No claim forms
- Preexisting conditions are covered
- No maximum benefit levels
- No deductibles
- No charge for oral exams, routine semiannual cleanings, most x-rays and fluoride treatments; however, an office visit copay will apply

PDO Plan (Delta)

- Select any dentist
- $1,500 calendar year benefit maximum per person
- $0 calendar year deductible per individual in-network, $100 per individual out-of-network
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of $1,250 for orthodontia

Monthly Premiums for Active Members

	PREPAID PLAN	PDO PLAN
Employee Only	$9.63	$20.46
Employee + Child(ren)	$20.00	$47.03
Employee + Spouse	$17.07	$38.69
Employee + Spouse + Child(ren)	$23.47	$75.71

Dental Insurance Benefits at a Glance

The benefits listed below are a summary of some common benefit categories. Please refer to insurance carrier member handbooks for complete information on coverage, limitations and exclusions.

	ASSURANT PREPAID OPTION		DELTA PDO OPTION	
COVERED SERVICES	**GENERAL DENTIST**	**SPECIALIST DENTIST**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	None		None	$100 single; $300 family, per policy year [5]
Annual Maximum Benefit	None		$1,500 per person, per policy year	
Pre-existing Conditions	Covered		Some exclusions	
Office Visit	$10 copay [3]		No charge	20% of MAC
Periodic Oral Evaluation	No charge		No charge	20% of MAC
Routine Cleaning	No charge		No charge	20% of MAC
X-ray — Intraoral, Complete Series	No charge	$5 copay	20% of MAC	40% of MAC
Amalgam (silver) Filling — 2 Surfaces Permanent	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$250 copay	$600 copay	50% of MAC	
Major Restorations — Crowns (porcelain fused to high noble metal)	$275 copay, plus lab fees [1]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	$100 copay	$120 copay	50% of MAC	
Dentures — Complete Upper	$310 copay, plus lab fees [1]		50% of MAC [4]	
Orthodontics	25% off participating orthodontist's usual fees		50% of MAC [4]	
• Annual Deductible	None		None	
• Lifetime Maximum	None		$1,250 (including any benefits received under a prior dental plan) [2]	
• Waiting Period	None		12 months	
• Age Limit	None		Up to age 19	

MAC—Maximum Allowable Charge

The benefits listed are a sample of the most frequently utilized dental treatments. Refer to vendor materials for complete information on coverage, limitations and exclusions.

[1] Members are responsible for additional lab fees for these services.

[2] If an individual had coverage through another dental plan, they may also have had a lifetime maximum for orthodontia. The orthodontia maximum is a lifetime benefit, which means, if an individual enrolls under the PDO, the benefit amount will not start over again. The benefits for orthodontia under the PDO would be adjusted based on the benefits a member may have received previously through another dental plan.

[3] A charge of $20 may apply for a missed appointment when the member does not cancel at least 24 hours prior to the scheduled appointment.

[4] A 12-month waiting period applies.

[5] Does not apply to diagnostic and preventive benefits such as periodic oral evaluation, cleaning and x-ray.

Vision Insurance

Optional vision coverage is available to local education employees and dependents, if offered by your agency. Check with your agency benefits coordinator to see if this option is available to you. You can choose from two plans: a basic plan and an expanded plan. Both plans offer the same services, including:

- Annual routine eye exam
- Frames
- Eyeglass lenses
- Contact lenses
- Discount on Lasik/Refractive surgery

What you pay for services depends on the plan you choose. With the basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials. The expanded plan provides services with a combination of copays, allowances and discounted rates. See the benefit chart on the following page to compare benefits in both plans.

As with other optional products, the state's vision insurance is an employee pay-all option. This means the state does not pay any part of the premium. Members are responsible for the full premium.

The basic and expanded plans are both administered by EyeMed Vision Care. You will receive the maximum benefit when visiting a provider in their **Select network.** However, out-of-network benefits are also available.

General Limitations and Exclusions

The following services are not covered under the vision plan:

- Treatment of injury or illness covered by workers' compensation or employer's liability laws
- Cosmetic surgery and procedures
- Services received without cost from any federal, state or local agency
- Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility
- Services by a vision provider beyond the scope of his or her license
- Vision services for which the patient incurs no charge
- Vision services where charges exceed the amount that would be collected if no vision coverage existed

Note: If you receive vision services and materials that exceed the covered benefit, you will be responsible for paying the difference for the actual services and materials you receive.

Monthly Premiums for Active Members

	BASIC	EXPANDED
Employee Only	$3.27	$5.73
Employee + Child(ren)	$6.54	$11.46
Employee + Spouse	$6.21	$10.89
Employee + Spouse + Child(ren)	$9.61	$16.84

Vision Insurance Benefits at a Glance

Here is a comparison of discounts, copays and allowed amounts under the vision options. Copays represent what the member pays. Allowance and percentage discount represent the cost the carrier will cover..

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	$0 copay	$10 copay
Retinal Imaging Benefit	none	up to $39 copay
Frames	$50 allowance; 20% discount off balance above the allowance	$115 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass)	$50 allowance; 20% off balance over $50	
• Single, Bifocal, Trifocal, Lenticular		$15 copay
• Standard Progressive Lens		$55 copay
• Premium Progressive Lens		$81–$93
Eyeglass Lens Options (upgrades)	20% discount off all options	maximum copayments:
• Anti-reflective		$45 copay
• Polycarbonate		$30 copay; $0 for children 18 and under
• Photochromic		$70 copay
• Scratch resistance coating		$15 copay
• UV coating		$10 copay
• Tints		$25 copay
• Polarized		20% off retail price
• Premium Anit-Reflective		$57–$68
• All other eyeglass lens options		20% discount
Exam for Contact Lenses (fitting and evaluation)	15% discount off retail price	up to $60 copay
Contact Lenses [1]		
• Elective		
• Conventional	$50 allowance; 15% off balance over $50	$130 allowance; 15% off balance over $130
• Disposable	$50 allowance	$130 allowance
• Medically Necessary [2]	$150 allowance	covered at 100%
Lasik/Refractive Surgery (for select providers)	15% discount off usual and customary fees	15% discount off usual and customary fees
Out-of-Network Benefits		
• All Eye Exams	up to $30 allowance	up to $45 allowance
• Frames	up to $50 allowance (frames and lenses combined)	up to $70 allowance
• Eyeglass Lenses		
• Single Vision		up to $30 allowance
• Lined Bifocal		up to $50 allowance
• Lined Trifocal		up to $65 allowance
• Elective Contacts (conventional or disposable)	$25 allowance	up to $50 allowance
• Medically Necessary Contacts [2]	$75 allowance	up to $100 allowance
Frequency		
• Eye Exam	Once every calendar year per person	Once every calendar year per person
• Eyeglass Lenses and Contacts	Once every calendar year per person	Once every calendar year per person
• Frames	Once every two calendar years per person	Once every two calendar years per person

[1] In lieu of eyeglass lenses
[2] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

EyeMed offers some additional discounts which include:

- 40% off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- 15% off conventional contact lenses after the benefit has been used
- $60 off one pair of Ray-Ban polarized sunglasses per member, with coupon provided by EyeMed
- 20% off non-covered items such as lens cleaner, accessories and non-prescription sunglasses
- Expanded Plan Only: 25% to 50% savings on premium progressive lenses and anti-reflective lenses

Employee Assistance Program

The Employee Assistance Program (EAP) is a no cost, confidential support tool that helps you, and those around you, deal with personal issues and situations. Seeking help is not a weakness. The goal is that after you make the decision to ask for help, you will find the program both easy to access and helpful. Sooner or later, all of us will encounter a personal problem of some kind. The EAP can help with issues including:

- Financial strain or planning
- Everyday stress
- Behavioral health
- Family/marital
- Workplace
- Addiction
- Chronic illness
- Grief and loss
- Legal
- Elder care
- Parenting

The EAP offers seminars on various issues of interest at locations across the state. Call 615.741.1925 or visit our website for more information.

All services are confidential, and available at no cost to members. Prior authorization is required. Services can be easily accessed by calling Magellan — available 24 hours a day, 365 days a year. You may participate in EAP services on work time with your supervisor's approval.

You and your eligible dependents may get up to five counseling sessions per problem episode at no cost to you. If you need assistance beyond the EAP, you will be referred to your insurance carrier's mental health and substance abuse benefits. The program is available to all local education employees enrolled in a state sponsored health plan. Dependents of local education members may get EAP services even if the dependents are not enrolled in health coverage.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is free to all state group insurance program members and eligible spouses and dependents. This program is an optional benefit for Standard PPO members.

24/7 Nurse Advice Line

The ParTNers for Health Nurse Advice Line gives you information and support, 24 hours a day, 7 days a week, at no cost to you. Health professionals are available to help you make more informed healthcare decisions and live well. Call day or night to talk to a nurse about:

- The closest hospital or after-hours clinic
- Understanding what your doctor told you
- Your symptoms or questions about medications

Working with a Health Coach

Health coaches can help you reach your personal health goals, and will schedule calls when it is convenient for you. All calls are confidential. For more information about working with a health coach, see the frequently asked questions section of the ParTNers for Health website.

ParTNers for Health Web Portal

The ParTNers for Health Web Portal, Well-Being Connect™, provides you with powerful online tools and health information at your fingertips. Choose from a variety of online health improvement focus areas and keep track of your progress to reach your personal goals. Registration is easy. Simply go to www.partnersforhealthtn.gov, click on the "My Wellness Login" button and follow the registration instructions.

Health Screening

Free health screenings are held in locations all around the state. Screenings will not be held during 2013 but will resume in 2014. Screenings are available to employees who participate in both the Standard and Partnership PPOs.

Healthways Well-Being Assessment™ (WBA)

An online Well-Being Assessment (health questionnaire) is available to help you learn more about your health and any health risks you may have. The WBA asks a series of questions about your health and lifestyle habits. Once you complete the Well-Being Assessment, you will view your results and create your personal Well-Being Plan, which will help you set goals and focus on areas where you can make improvements. Visit the wellness page on the ParTNers for Health website for more information.

Weekly Health Tips by E-mail

Don't forget to sign up for free weekly health tips by e-mail. Visit our website and click the "Weekly Health Tips" link to sign up. You will get a short e-mail with each week's healthy living tip.

Fitness Center Discounts

Available to all insurance plan members, discounts have been secured from fitness centers throughout the state. Refer to the wellness page on the ParTNers for Health website to view a list of participating fitness centers.

Long-Term Care Insurance

Long-term care insurance is available to local education participants, if your agency chooses to participate. Qualified employees, their eligible dependents (spouse and children ages 18 through 25), retirees, parents and parents-in-law are eligible to enroll in long-term care coverage. This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness or an accident may bring on this need.

Services covered include nursing home care, assisted living, home health care, home care and adult day care. Benefits are available through different options based on a daily benefit amount ($100, $150 or $200) for either a three-year or five-year coverage period. The benefits are also available with or without inflation protection.

When your agency first chooses to offer this benefit, active employees can enroll in coverage on a guaranteed issue basis (no medical underwriting) during the initial offering period. If your agency already offers this benefit, as a new employee, you have 90 days to enroll and have guaranteed issue of coverage. You may sign-up for coverage by completing the enrollment form enclosed in the enrollment kit, over the phone by speaking with customer service or on-line via the insurance carrier's website. Your spouse, eligible dependent children, parents and parents-in-law may also apply for coverage; however, they must provide information about their health status and will be subject to medical underwriting review for approval to enroll. After the initial guaranteed issue period, you may still apply for coverage, but will also be subject to the same medical underwriting review for approval to enroll.

You must pay 100 percent of the premium if you choose this coverage. Premiums are based on age at the time of enrollment. So the younger you are when you apply, the lower your monthly premium will be. You may choose to have the premium taken from your payroll check, or may opt for a direct bill arrangement with the carrier. Direct billing or payment by bank draft or credit card can be set up on a quarterly, semi-annual or annual basis.

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together and pay up to 100 percent of the eligible charges. At no time should payments exceed 100 percent of the eligible 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, the oldest plan is 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 would be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.

From time to time, carriers will send letters to members asking for other coverage information. This is necessary because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. In addition to sending a letter, the carriers may also attempt to gather this information when members call in. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

If you do not respond to requests for other coverage information, your claims may be pended or held for payment. When claims are pended, it does not mean that coverage has been terminated or that the claims have been denied. However, claims will be denied if the requested information is not received by the deadline. Once the carrier gets the requested information, they will update the information regarding other coverage, and claims that were pended or denied will be released or adjusted for payment.

Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover the following:

- Any payments made as a result of injury or illness caused by the action or fault of another person
- A lawsuit settlement that results in payments from a third party or insurer of a third party
- Any payments made due to a workplace injury or illness

These payments would include payments made by worker's compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation section. Failure to respond to the plan's requests for information, and to pay the plan back for any money received for medical expenses, will result in disenrollment from the plan for you and your dependents.. If disenrolled from the plan due to failure to cooperate and pay outstanding medical expenses you and your dependents cannot rejoin the plan for three years and are not eligible for COBRA.

On the Job Illness or Injury

Work-related illnesses or injuries are not covered under the plan. The plan will not cover claims related to a work-related accident or illness regardless of the status of a worker's compensation claim or other circumstances.

Fraud, Waste and Abuse

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 guide.

If your covered dependent becomes ineligible, you must inform your benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he or she cannot be covered 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, you must notify your benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your healthcare. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or member fraud. You can help prevent fraud and abuse by working with your employer and plan administrator 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 carrier to question any charge that you do not understand
- Report anyone who permits a relative or friend to "borrow" his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who makes false claims or alters amounts charged on claim forms

Please contact Benefits Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

To File an Appeal

If you experience a problem relating to the plan policies or the services provided, there are established internal and external procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

You should direct any specific questions regarding initial levels of appeal (the internal appeal process) to the insurance carrier. Other appeal questions may be directed to the Benefits Administration appeals coordinator at 615.741.4517 or 1.866.576.0029.

Administrative Appeals

To file an appeal about an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues or timely filing issues) contact your agency benefits coordinator and explain your request. The benefits coordinator will forward your request to Benefits Administration for review and response.

Benefit Appeals

Before starting an appeal related to benefits (e.g., a prior-authorization denial or an unpaid claim), you should first contact the insurance company to discuss the issue. You may ask for an appeal if the issue is not resolved as you would like.

Different insurance companies manage approvals and payments related to your medical, mental health, substance abuse and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you direct your request to the correct company. You have insurance cards for medical and pharmacy. You can find member service numbers for medical and mental health and substance abuse on your medical card. Your pharmacy card will have the member service number for pharmacy.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), call the toll-free member service number on your insurance card. You may file a formal request for an appeal or member grievance by completing a form or as otherwise instructed.

The insurance company will process internal levels of appeal — Level I and Level II appeals. Decision letters will be mailed to you at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

Pursuing Further Action

In cases where internal and external appeal procedures have been completed, decision letters will notify you of the option to pursue further action through litigation.

LEGAL NOTICES

Information in this Guide

This guide does not give every detail of the state-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. If information in this guide conflicts with the Plan Document, the Plan Document will control. Your department or facility (benefits section) has a copy or you can obtain a copy from the Benefits Administration website.

The information contained in this guide is accurate at the time of printing. The Insurance Committees may change the plans at their discretion. Changes to federal and/or state laws may also impact the plans. You will be given written notice of changes. The benefits described in this guide cannot be changed by any oral statements.

All health, dental and life coverages have member handbooks to explain benefits in detail. Those are available from your agency benefits coordinator or you may obtain a copy from the Benefits Administration website.

Member Privacy

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

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

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

To obtain a copy of the privacy notice describing, in greater detail, the practices concerning use and disclosure of your health information, visit our website or you may obtain a copy from your agency benefits coordinator.

Medicare Part D

Medicare eligible retirees have access to a Medicare supplement plan. The supplemental plan does not include pharmacy benefits and retirees should enroll in a Medicare Part D plan for prescription drug benefits.

TERMS AND DEFINITIONS

Acquire Date
The acquire date is the date that establishes a relationship between you and your dependents, such as date of marriage for a spouse, date of birth for a natural child, or date of legal obligation if you are appointed as a guardian.

Balance Billing
If you get treated by out-of-network providers, you can be subject to balance billing by the out-of-network provider. This is the process of billing a patient for the difference between the provider's charges and the amount that the provider will be reimbursed from the patient's insurance plan. For example, let's say that a doctor typically charges $100 for a certain service. An in-network doctor has agreed to provide the same service for a reduced rate of $75 and he or she writes off the rest of the charge. An out-of-network provider has not agreed to any reduced rates as he or she does not have a contract with the carrier and will bill the entire charge of $100. However, the insurance carrier will not reimburse more than $75 for the service which means that you may owe the out-of-network provider the additional $25.

Claims
Claims are the bills received by the plan after a member obtains medical services.

Coinsurance
Coinsurance is the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service. The amount you pay in coinsurance (for eligible services) will count towards your out-of-pocket maximum.

Copay
A copay is a flat dollar amount that you pay for certain services like office visits and prescriptions.

Deductible
A fixed dollar amount you must pay each year for services that require coinsurance before the plan pays certain benefits. See the benefit grid for details.

Drug List
The drug list is a list of covered drugs. The listing includes generic and preferred brand drugs covered by the plan. This list is often called a formulary.

Drug Tiers
The drugs covered by the state's pharmacy benefit are grouped into three tiers — generic, preferred brand and non-preferred brand. Each tier has a different copay amount.

Fully-Insured Plan
Under a fully insured plan, an insurance company, rather than a group sponsor (like the state) pays all claims. The sponsor pays a premium to the insurance company. The state's dental plans are fully insured.

Generic Drug (Tier One)
A generic drug (also called tier one) is a Food and Drug Administration (FDA) approved copy of a brand name drug. A generic medicine is equal to the brand name product in safety, effectiveness, quality and performance. You pay the least when you fill a prescription with a generic drug.

Guarantee Issue
Guarantee issue means that you cannot be denied coverage and do not have to answer questions about your health history and long as you enroll within a certain amount of time.

Head of Contract
The head of contract is an employee who works for a participating employer group and enrolls in coverage during the initial eligibility timeframe. Two married employees who both work for participating employer groups could each be the head of their own contract or one could be the head of contract and the other a covered dependent spouse.

Health Insurance Portability and Accountability Act (HIPAA)
The Health Insurance Portability and Accountability Act (HIPAA) is legislation that protects health insurance coverage for persons who lose or change jobs and establishes a privacy rule and national standards for protecting personal health information. HIPAA means your personal health information can't be shared without your consent and protects your privacy.

In-Network Care
In-network care is provided by a network provider. Costs for in-network care are usually less expensive than out-of-network care as a result of special agreements between insurance carriers and providers.

Maximum Allowable Charge (MAC)
The maximum allowable charge (MAC) is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay the difference between the MAC and the actual charge.

Meeting Your Medical Deductible
Meeting your medical deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays benefits. It applies to hospital charges and other services that require coinsurance. It does not apply to services with a copay such as a visit to your primary care doctor or to prescription drugs.

Network
A network is a group of doctors, hospitals and other health care providers contracted with a health insurance carrier to provide services to plan members for set fees.

Non-Preferred Brand Drug (Tier Three)
A non-preferred brand drug (also called tier three) belongs to the most expensive group of drugs. You will pay the most if your prescription is filled with a non-preferred brand.

Out-of-Network Care
Out-of-network care refers to health care services from a provider who is not contracted with your insurance carrier. Costs for out-of-network care are usually more than for in-network care. The benefits paid are usually based on the maximum allowed by the plan. When out-of-network charges are higher than the maximum allowed, the member pays the difference.

Out-of-Pocket Coinsurance Maximum
An out-of-pocket coinsurance maximum is the most you will pay for your deductible and coinsurance each year. The out-of-pocket maximum does not include premiums or copays. Once you reach your out-of-pocket coinsurance maximum, the plan pays 100 percent of coinsurance for covered medical expenses for the rest of the year.

Out-of-Pocket Copay Maximum
An out-of-pocket copay maximum is the most you will pay for certain in-network office visits for primary care, specialist care and outpatient mental health and substance abuse treatment. It does not apply to chiropractic care or rehabilitation and therapy services.

Preferred Brand Drug (Tier Two)
A preferred brand drug (also called tier two) belongs to a group of drugs that cost more than generics but less than non-preferred brands.

Preferred Provider Organization (PPO)
A PPO gives plan participants direct access to a network of doctors and facilities that charge pre-negotiated (and typically discounted) fees for the services they provide to members. Plan participants may self-refer to any doctor or specialist in the network. The benefit level covered through the plan typically depends on whether the member visits an in-network or out-of-network provider when seeking care.

Premium
The amount you pay each month for your coverage, regardless of whether or not you receive health services. What you pay depends on where you work (state, higher education, local education or local government) and the PPO you select.

Prescription Drug Copay
Typically, members must pay a prescription drug copay when filling a prescription. This is the fixed dollar amount you pay, such as $25 per prescription. The copay is lowest for a generic, higher for a preferred brand and highest for a non-preferred brand.

Preventive Care
Preventive care refers to services or tests that help identify health risks. For example, preventive care includes mammograms and colonoscopies as well as regular blood pressure checks. In many cases, preventive care helps a patient avoid a serious or even life-threatening disease.

Primary Care Physician
Primary care physician (also known as PCP) refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, an OB/GYN or a pediatrician, a nurse practitioner, physician's assistant or nurse midwife (licensed healthcare facility only) working under the supervision of a primary care provider.

Self-Insured Plan
Under a self-insured plan, a group sponsor (like the State) or employer, rather than an insurance company, is financially responsible for paying the plan's expenses, including claims and plan administration costs. The state's health insurance plans are self-insured.

Special Enrollment Provision
A rule that allows persons to request enrollment beyond the initial eligibility period due to certain life events.

Special Qualifying Event
A personal change in status, such as divorce or termination of spouse or ex-spouse's employment, which may allow persons to change benefit elections.

The Plan
In the broadest sense of the word, Plan is the applicable State of Tennessee Preferred Provider Organization (PPO) Comprehensive Medical and Hospitalization Program. Plan may also refer to specific group plans within the larger comprehensive plan, such as the State Plan, the Local Education Plan or the Local Government Plan.

STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
26TH FLOOR, 312 ROSA L. PARKS AVENUE • WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102