PARTNERS
FOR HEALTH

State Group
Insurance Program

2018 Eligibility and Enrollment Guide

State and Higher Education Employees

If you need help…

Contact your agency benefits coordinator. He or she has received special training in our insurance programs. For additional information about a specific benefit or program, refer to the chart below.

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 or 615.741.3590 — M-F, 8-4:30	tn.gov/finance/fa-benefits partnersforhealthtn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	TBD	888.741.3390 — M-F, 8-8	partnersforhealthtn.gov (wellness tab)
Disability Insurance	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Vision Insurance	Davis Vision	800.208.6404 — M-F, 7-10, Sat, 8-3 Sun, 11-3 Basic Client Code: 8155 Expanded Client Code: 8156	davisvision.com/stateofTN
Life Insurance	Securian (Minnesota Life)	866.881.0631 — M-F, 7-6	lifebenefits.com/stateoftn
Long-term Care Insurance	MedAmerica	866.615.5824 — M-F, 7:30-5	ltc-tn.com
OTHER PROGRAMS			
Edison	Tennessee Department of Finance & Administration	password reset for higher education 800.253.9981 — M-F, 8-4:30; state call Edison help desk at 866.376.0104 — M-F, 7-4:30	edison.tn.gov
Flexible Benefits medical & dependent care transportation & parking (state employees only)	 PayFlex Benefits Administration	 855.288.7936 — M-F, 7-7, Sat, 9-2 800.253.9981 — M-F, 8-4:30	 stateoftn.payflexdirect.com tn.gov/finance/fa-benefits

Enrollment forms and handbooks…

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

Online resources…

Visit the ParTNers for Health website at 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.

Zendesk…

You can search the help center, find articles or submit questions at **https://benefitssupport.tn.gov/hc/en-us**. Additionally, the ParTNers for Health website referenced above includes a "Help" button, or live-chat feature, that is operational during normal business hours.

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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 State 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, dental, vision, life and disability insurance. Flexible spending accounts (FSA) are also available.

For More Information

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

You can also find information that explains benefits details on the Benefits Administration website. This includes brochures and handbooks. Plan documents, summaries of benefits and coverage and sample life insurance certificates are also available.

Authority

The State 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 eligibility rules at any time, for any reason.

State Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Human Resources
- Two members elected by popular vote of general state employees
- One higher education member selected under procedure established by the Tennessee Higher Education Commission
- One member from the Tennessee State Employees Association selected by its Board of Directors
- Chairs of the House and Senate Finance, Ways and Means Committee

Certain state and federal laws and regulations, which may be amended or the subject of court rulings, apply to the group insurance program. These laws, regulations and court rulings shall control over any inconsistent language in this guide.

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

The following employees are eligible to enroll in coverage:

- Full-time employees regularly scheduled to work at least 30 hours per week
- All other individuals cited in state statute, approved as an exception by the State Insurance Committee or defined as full-time employees for health insurance purposes by federal law

Employees NOT Eligible to Participate in the Plan

Individuals who do not meet the employee eligibility rules outlined above, are ineligible UNLESS they otherwise meet the definition of an eligible employee under applicable state or federal laws or by approval of the State Insurance Committee. As an example, the following individuals are normally ineligible but might qualify for coverage if they meet the federal definition of a full-time employee under the Patient Protection and Affordable Care Act.

- Individuals performing services on a contract basis
- Individuals in positions that are temporary appointments

Dependent Eligibility

If you enroll in health, vision or dental coverage, you may also enroll your eligible dependents. You or your spouse must be enrolled in voluntary term life in order to add a child term rider to the coverage.

The following dependents are eligible for coverage:

- Your spouse (legally married)
- 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 during enrollment. Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart 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 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's spouse will have dependent status unless he or she requests to change during the annual enrollment period or 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
- 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. You must complete enrollment within 31 days after your hire date. Coverage starts on the first day of the month after you complete one full calendar month of employment.

If you are a part-time employee who has completed one full calendar month of employment and you gain full-time status, your coverage will start the first day of the month after gaining full-time status. Application must be made within 31 calendar days of the date of the status change, but you should submit your enrollment request as soon as possible to avoid the possibility of double premium deductions.

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 must wait for the annual enrollment period, unless you have a qualifying event during the year. 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. Application to add a newly acquired dependent must be submitted within 60 days of the acquire date. Family coverage based on enrolling newly acquired dependent children due to birth, adoption or legal custody must begin on the first day of the month in which the event occurred and the children shall be eligible for coverage on the date they were acquired. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption. If enrolled in single coverage and adding a newly-acquired spouse, you may choose to begin family coverage on the first day of the month in which your spouse was acquired or the first day of the following month. Depending on the date you choose, your newly acquired spouse will be covered beginning with the acquire date (date of marriage) or the first day of the following month.

Insurance cards 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.

- 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.

If you are in the state plan and your spouse is also in the state plan, you both may want to think about choosing coverage as the head of contract. State plan employees can get a higher level of life insurance coverage as the head of contract. Refer to the available benefits section of this guide for more information.

Premium Payment

For state and higher education employees, the state pays about 80 percent of the cost of your health insurance premium if you are in a positive pay status or on approved family medical leave. If you are approved for workers compensation and receiving lost-time pay, the state pays the entire health insurance premium. Insurance premiums are taken from the paycheck you get at the end of each month to pay for the next month's coverage. Voluntary coverages, such as dental, get no state support, and you must pay the total premium.

Pre-tax Premiums — State employee premiums for health, dental and vision are paid before income or Social Security tax is deducted. Pre-tax premiums reduce an employee's taxable income because they are taken out before taxes are withheld.

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 and for each covered month thereafter.

Adding New Dependents

Enrollment 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 each 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 enroll if they have a qualifying event under the special enrollment provisions or during the annual enrollment period.

If you have family coverage

- The new dependent can enroll if they have a qualifying event under the special enrollment provisions or during the annual enrollment period.
- The new dependent can also enroll if 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

State employees can update information, such as home address, in Edison or by contacting their agency human resource offices. Higher education employees can update information in Edison, contact their agency benefits coordinators or call the Benefits Administration service center to request an address change. All employees who contact Benefits Administration (BA) will be required to provide the last four digits of their Social Security number, Edison ID, date of birth, previous address and confirm authorization of the change before BA can update the information. **It is your responsibility to keep your address and phone number current with your employer.**

Annual Enrollment Period

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 period gives you another chance to enroll in health, dental, vision, voluntary accidental death coverage, voluntary term life and disability insurance coverage. You can also make changes to your existing coverage, like increasing or decreasing voluntary term life insurance, transferring between health, dental and vision options and canceling insurance.

Most changes you request start the following January 1. However, voluntary term life insurance may start January 1, February 1 or March 1.

Benefit enrollments remain in effect for a full plan year (January 1 through December 31), with the exception of disability and voluntary term life insurance coverage. You may cancel disability and voluntary term life coverage at any time. **You may not cancel other coverage outside of the enrollment 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 period, you can only cancel coverage (other than disability and voluntary term life insurance) 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 unless your spouse or the court gives permission, until occurrence of one of the following:

- The final divorce decree is entered
- The order of legal separation is entered
- The petition is dismissed
- The parties reach agreement
- The court modifies or dissolves the injunction against making changes to insurance

You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you lose eligibility or you experience an event that results in you/your dependents becoming 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 other coverage to turn in an application and proof to your agency benefits coordinator. The required proof is shown on the application. Events that might result in becoming newly eligible for coverage elsewhere 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 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 must wait for the annual enrollment period. You can also apply during the year through special enrollment due to certain life events.

Special Enrollment Provisions

The Health Insurance Portability and 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 vision insurance coverage.

An employee experiencing one of the events below may enroll in employee only or family coverage. Previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible) may also be enrolled.

- 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 use the event to enroll yourself or you already have coverage and want to add other previously eligible dependents at the same time as the new dependent. If you already have coverage and only want to add a newly acquired dependent, this is treated as a regular enrollment change.

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's 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 required 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 things like 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 and medical leave, you will continue to get state support of your health insurance premium. Initial approval for family and medical leave is up to each agency head. You must have completed a minimum of 12 months of employment and worked 1,250 hours in the 12 months 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 voluntary coverage. The $20,000 basic term life and the $40,000 basic accidental death coverages provided at no cost to all eligible employees will remain in effect. You may reinstate coverage when you return to work. If canceled for nonpayment, you must wait for the next annual enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year.

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 must wait for the next annual enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year. Coverage goes into effect the first of the next month after you return to work.

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.

Leave Due to a Work-related Injury

If you have a work-related injury or illness, contact your benefits coordinator about how this will affect your insurance. You must keep insurance premiums current until you receive a notice of lost-time pay from the Division of Claims Administration. You will receive a refund for any health insurance payments you make once you receive notice.

If approved for lost-time pay, only the premium for health insurance is paid by your agency. You must pay the premium for any voluntary coverage on a monthly basis. You are responsible for 100 percent of the premium when lost-time pay ends if you do not have any paid leave.

All benefits paid by the plan for work-related injury or illness claims will be recovered. This means that you are required to repay all claims paid related to a work-related injury.

Lost-time Pay — Payments received due to lost time (without pay) caused by an approved work-related injury. Lost-time pay is approved by the Department of Treasury, Division of Claims.

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration.

- State employees: If your last day worked is the last day of the month, your coverage will end on the last day of the following month. If your last day worked is any date other than the last day of the month, your coverage will end on the last day of the current month.
- Higher education employees: Coverage will end on the last day of the month following the month you terminate employment.

A COBRA notice to continue health, dental and vision coverage will be mailed to you. Life insurance conversion notices will also be mailed, if applicable.

In the event that your spouse is also insured as a head of contract under either the state, local education or local government plan, you have the option to transfer to your spouse's contract as a dependent. Application must be made within one full calendar month of your termination of employment.

Continuing Coverage through COBRA

You may be able to continue health, dental and/or vision insurance 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:

- Coverage is lost due to a qualifying event (refer to the COBRA brochure on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

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 whose first employment with the state began prior to July 1, 2015, who meet the eligibility rules may continue health insurance at retirement until age-eligible for Medicare. They may also continue coverage for their dependents until the dependents become age-eligible for Medicare or otherwise cease to meet eligibility requirements. 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 the eligibility requirements can be found in the guide to continuing insurance at retirement available on the Benefits Administration website. Employees whose first employment with the state began on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement.

One way to save money for healthcare expenses when you retire is to enroll in the CDHP, which includes a health savings account (HSA). Please see the available benefits section for details.

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 the surviving spouse of 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 dental and vision coverage through COBRA will be available. The dependents may be able to convert life insurance.

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 Die in the Line of Duty

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage only at an active employee rate until they become eligible for other insurance coverage or they no longer meet the dependent eligibility rules.

Line of Duty — An employee on the job in a positive pay status; as determined by the State Division of Claims Administration in the Department of Treasury.

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 three health insurance options:

- Premier Preferred Provider Organization (PPO)
- Standard PPO
- Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA)

You also have a choice of three insurance carrier networks:

- BlueCross BlueShield Network S
- Cigna LocalPlus Network
- Cigna Open Access Plus Network (monthly surcharge applies)

With each healthcare option, you can see any doctor you want. However, each carrier network has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. The providers in the network have agreed to take lower fees for their services. Your cost is higher if you use out-of-network providers.

Each healthcare option:

- Provides the **same comprehensive health insurance coverage** (although medical policies for specific services may vary between carriers)
- Includes in-person and Telehealth medical services
- Offers the **same provider networks**
- Covers **in-network preventive care** (like annual well visits and routine screenings) **at no cost to you**
- Covers **maintenance** prescription drugs without having to first meet a deductible
- Has a deductible
- Has out-of-pocket maximums to limit your costs

There are some differences between the PPOs and the CDHP.

With the PPOs

- You pay a higher monthly premium but have a lower deductible
- You pay fixed copays for doctor office visits and prescription drugs without first having to meet your deductible

With the CDHP/HSA

- You pay a lower monthly premium but have a higher deductible
- You pay the full discounted network cost for **ALL** healthcare expenses, except for in-network preventive care and certain maintenance drugs, until you meet your deductible
- You have a tax free health savings account (HSA) which can be used to cover your qualified medical expenses, including your deductible

CDHP/HSA

If you enroll in this option, the state will deposit $250 for employee only coverage or $500 for family coverage into your health savings account (HSA). If your coverage effective date is September 2 through the end of the year, you will not receive the state contribution towards your HSA in 2018.

Health Savings Account

If you enroll in the CDHP, a health savings account (HSA) will be set up for you. You can contribute pre-tax money to your HSA through payroll deduction to cover your qualified medical expenses, including your deductible, or save it. For example, you could take the money you save in premiums for this plan versus a PPO and put it in your HSA. The HSA is managed by PayFlex, a company selected and contracted by the state.

Benefits of a HSA

- The money you save in the HSA (both yours and any employer contributions) rolls over each year and collects interest. You don't lose it at the end of the year.
- You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses.
- The money is yours! You take your HSA with you if you leave or retire.
- The HSA offers a triple tax advantage on money in your account:
    1. Both employer and employee contributions are tax free
    2. Withdrawals for qualified medical expenses are tax free
    3. Interest accrued on HSA balance is tax free
- The HSA can be used to pay for qualified medical expenses that may not be covered by your health insurance plan (like vision and dental expenses, hearing aids, contact lens supplies, acupuncture and more) with a great tax advantage.
- It serves as another retirement savings account option. Money in your account can be used tax free for health expenses even after you retire. And, when you turn 65, it can be used for non-medical expenses. But non-medical expenses will be taxed.

Contribution Limits

- IRS guidelines allow total tax-free annual contributions up to $3,450 for individuals and $6,900 for families in 2018.
- At age 55 and older, you can make an additional $1,000/year contribution ($4,450 for individuals or $7,900 for families).

These limits include the $250 individual and $500 family state contributions.

Restrictions

You cannot enroll in the CDHP/HSA if you are enrolled in another plan, including a PPO, your spouse's plan or any government plan (e.g., Medicare A and/or B, Medicaid, TRICARE), or if you have received care from an Veterans Affairs (VA) facility or the Indian Health Services (IHS) within the past three months.

Generally, members eligible to receive care at any VA facility cannot enroll in the CDHP because a HSA is automatically opened for them. Individuals are not eligible to make HSA contributions for any month if they receive medical benefits from the VA at any time during the previous three months. However, members may be eligible if the following applies:

- Member did not receive any care from the VA facility for three months, or
- The member only receives care from a VA facility for a service-connected disability (and it must be a disability).

You cannot have a HSA if you or your spouse are enrolled in a flexible spending account (FSA) or a HRA. Instead, if you have one available, you can enroll in a limited purpose FSA for dental or vision costs.

Pharmacy

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. How much you pay for your drug depends on whether it is a generic, preferred brand, or non-preferred brand, or specialty drug and the day-supply. Specialty drugs must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price for these certain medications, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication. The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

Eligible members will be able to receive certain low-dose statins in-network at zero cost share. These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

Any and all compound medications (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound medications require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Basic Features of the Health Options

	PPOs (Premier & Standard)	CDHP/HSA
Covered Services	Each option covers the same set of services	
Preventive Care — routine screenings and preventive care	Covered at 100% (no deductible)	
Employee Contribution — premium	Higher than the CDHP	Lower than the PPOs
Deductible — the dollar amount of covered services you must pay each calendar year before the plan begins reimbursement	Lower than the CDHP	Higher than the PPOs
Physician Office Visits — includes specialists and behavioral health and substance use services	You pay fixed copays without having to first meet your deductible	You pay the discounted network cost until the deductible is met, then you pay coinsurance
Non Office Visit Medical Services — hospital, surgical, therapy, ambulance, advanced x-rays	You pay the discounted network cost until the deductible is met, then you pay coinsurance	
Prescription Drugs	You pay fixed copays without having to first meet your deductible	You pay for the medication at the discounted network cost until your deductible is met — then you pay coinsurance until you meet the out-of-pocket maximum
Out-of-Pocket Maximum — The most you pay for covered services; once you reach the out-of-pocket maximum, the plan pays 100%	Higher than the CDHP	Lower than the PPOs
Health Savings Account	None	The state will contribute $250 for single coverage and $500 for family coverage to help offset the deductible — your contributions are pre-tax

HEALTHCARE OPTION	PREMIER 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, 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
Behavioral Health and Substance Use [2] Including telemental health	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance	
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance	
Telehealth	$15 copay	N/A	$15 copay	N/A
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
Chiropractic Limit of 50 visits per year	Visits 1-20: $25 copay Visits 21-50: $45 copay	Visits 1-20: $45 copay Visits 21-50: $70 copay	Visits 1-20: $30 copay Visits 21-50: $50 copay	Visits 1-20: $50 copay Visits 21-50: $75 copay
PHARMACY				
30-Day Supply	$7 copay generic; $40 copay preferred brand; $90 copay non-preferred	copay plus amount exceeding MAC	$14 copay generic; $50 copay preferred brand; $100 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 copay generic; $80 copay preferred brand; $180 copay non-preferred	N/A - no network	$28 copay generic; $100 copay preferred brand; $200 copay non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 copay generic; $40 copay preferred brand; $160 copay non-preferred	N/A - no network	$14 copay generic; $50 copay preferred brand; $180 copay non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min $50; max $150	N/A - no network	10% coinsurance; min $50; max $150	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE				
Convenience Clinic	$25 copay	$45 copay	$30 copay	$50 copay
Urgent Care Facility	$45 copay	$70 copay	$50 copay	$75 copay
EMERGENCY ROOM				
Emergency Room Visit	$150 copay (services subject to coinsurance may be extra)		$175 copay (services subject to coinsurance may be extra)	

CDHP/HSA	
IN-NETWORK	OUT-OF-NETWORK [1]
No charge	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	
20% coinsurance	N/A
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance plus amount exceeding MAC
20% coinsurance	N/A - no network
10% coinsurance without first having to meet deductible	N/A - no network
20% coinsurance	N/A - no network
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	

2018 Benefit Comparison

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. For all plans, costs DO APPLY to the annual out-of-pocket maximum.

2018 Monthly Premiums — Active Employees

ALL REGIONS				
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS	EMPLOYER SHARE
PREMIER PPO				
Employee Only	$150	$150	$190	$599
Employee + Child(ren)	$225	$225	$265	$898
Employee + Spouse	$314	$314	$394	$1,258
Employee + Spouse + Child(ren)	$389	$389	$469	$1,557
STANDARD PPO				
Employee Only	$102	$102	$142	$599
Employee + Child(ren)	$153	$153	$193	$898
Employee + Spouse	$215	$215	$295	$1,258
Employee + Spouse + Child(ren)	$266	$266	$346	$1,557
CDHP/HSA				
Employee Only	$66	$66	$106	$599
Employee + Child(ren)	$98	$98	$138	$898
Employee + Spouse	$138	$138	$218	$1,258
Employee + Spouse + Child(ren)	$170	$170	$250	$1,557

Using Edison ESS

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system. When using Employee Self Service (ESS) in Edison to add/make changes to benefits, Internet Explorer 11 is the preferred browser. You may not be able to enroll if you use another browser, mobile device or a tablet.

Passwords

- For higher education employees, if you are using the Edison system for the first time or are having trouble logging in, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps or call the Benefits Administration service center.
- For state employees, if you have trouble logging in to Edison, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps to reset your password or call the Edison help desk at 866.376.0104.

	PREMIER PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services Inpatient care; outpatient surgery [4] Inpatient behavioral health and substance use [2] [4]	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 [4] Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Therapy Services Inpatient [4]; outpatient Skilled nursing facility [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [4] 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 [4] 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 for oral surgeons	40% coinsurance for oral surgeons
	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 [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
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	$500	$1,000	$1,000	$2,000
Employee + Child(ren)	$750	$1,500	$1,500	$3,000
Employee + Spouse	$1,000	$2,000	$2,000	$4,000
Employee + Spouse + Child(ren)	$1,250	$2,500	$2,500	$5,000
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED				
Employee Only	$3,600	$4,000	$4,000	$4,500
Employee + Child(ren)	$5,400	$6,000	$6,000	$6,750
Employee + Spouse	$7,200	$8,000	$8,000	$9,000
Employee + Spouse + Child(ren)	$9,000	$10,000	$10,000	$11,250
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION				
For individuals who enroll in the CDHP/HSA	N/A		N/A	

CDHP/HSA	
IN-NETWORK	**OUT-OF-NETWORK [1]**
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	
100% covered up to MAC (after the deductible has been met)	
20% coinsurance	40% coinsurance
20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
20% coinsurance	40% coinsurance
N/A - no network	40% coinsurance
$1,500	$3,000
$3,000	$6,000
$3,000	$6,000
$3,000	$6,000
$2,500	$4,500
$5,000	$9,000
$5,000	$9,000
$5,000	$9,000
State contribution to HSA: $250 for employee only; $500 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

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 (MAC) will not be counted. **For PPO Plans,** 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. **For CDHP Plan,** the deductible and out-of-pocket maximum amount can be met by one or more persons. **For CDHP Plan,** coinsurance is after deductible is met unless otherwise noted.

[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 the 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/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] 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.)

Disability Insurance

The state offers voluntary disability benefits to full-time state and higher education employees.

- Full-time **state employees** may enroll in short term disability insurance and/or long term disability insurance.
- Full-time **higher education employees** may enroll in short term disability insurance. Higher education employees should contact their agency benefits coordinators for more information on long term disability insurance available to them.
- Those who enroll will pay 100% of the premium with after-tax dollars. By paying with after-tax dollars, any benefits paid to you will result in a tax free benefit.
- If you intend to enroll in both short term and long term disability, you should consider enrolling in one of the long term disability options with a 180 day elimination period. The 26-week short term disability insurance will best cover the 180 day elimination period for your long term disability, at a lower monthly cost.
- **You must use all of your accumulated leave (sick, annual and comp time) before your disability payments begin.**

Why is having disability insurance important?

If you are unable to work due to illness or injury, disability insurance can help pay your most important expenses. These include:

- Mortgage or rent
- Car payments
- Food
- Child care/tuition
- Utilities

Short term disability insurance (available to state and higher education employees)

Short term disability insurance replaces a portion of your income during a disability, which could last up to 26 weeks. It may be good for those who:

- Have little annual or sick leave
- Take part in high-risk activities
- Don't have six-month emergency funds

To calculate your monthly premium, go to metlife.com/StateOfTN, click on state employees or higher education employees, and then click on **Rates** at the top.

Long term disability insurance (available to state employees only)

Long term disability insurance replaces a portion of your income during a disability that is expected to last for an extended period of time. This period of time is typically longer than 90 or 180 days. It may be good for those who:

- Need their income to pay for housing, food and other bills
- Would have trouble supporting themselves if out of work more than 90 days

For more information and to calculate your rates, go to metlife.com/StateOfTN.

The State Group Insurance long term disability and short term disability insurance plans are both managed by MetLife. Please call the MetLife State of Tennessee Dedicated Customer Service Line with questions: 855.700.8001, Mon.-Fri., 7 a.m.-10 p.m., Central time.

2018 Monthly Premiums for Long Term Disability (LTD)

LTD: EMPLOYEE'S AGE (PER $100 OF COVERED MONTHLY SALARY)										
Benefit %/ Elimination Period	**Under 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
Option 1 60%/90 days	$.20	$.20	$.40	$.59	$.75	$.92	$1.10	$1.46	$.97	$.97
Option 2 60%/180 days	$.16	$.16	$.31	$.46	$.59	$.72	$.86	$1.14	$.76	$.76
Option 3 63%/90 days	$.24	$.24	$.49	$.72	$.91	$1.12	$1.34	$1.78	$1.18	$1.18
Option 4 63%/180 days	$.19	$.19	$.39	$.57	$.72	$.89	$1.06	$1.41	$.94	$.94

Long Term Disability Options

	Option 1	**Option 2**	**Option 3**	**Option 4**
Eligibility	All employees working not less than 30 hours/week or seasonal employees hired prior to July 1, 2015 with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June), or is deemed eligible by applicable federal law, state law, or action of the State Insurance Committee.			
% of Gross Annual Base Salary Paid Monthly	60% of salary paid monthly		63% of salary paid monthly	
Maximum Monthly Benefit	Up to $7,500 per month (covers annual salary of $150,000)		Up to $10,000 per month (covers annual salary of $190,476.24)	
Minimum Monthly Benefit	Greater of 10% of benefit or $100 per month			
Elimination (Waiting) Period	90 calendar days	180 calendar days	90 calendar days	180 calendar days
Own Occupation	24 months	24 months	36 months	36 months
Duration of Benefit	Social Security Normal Retirement Age			
Evidence of Insurability (EOI)	Guaranteed Issue (no health questions asked) for 2018 Annual Enrollment and New Hires who enroll within 31 days of eligibility date. EOI will be required for late enrollees and 2018 plan participants who choose a higher plan of benefit during the 2019 Annual Enrollment Period.			
Pre-existing Condition	Three months prior to effective date and 12 months from effective date			

2018 Monthly Premiums for Short Term Disability (STD)

STD COST: PER $100 OF MEMBER'S COVERED MONTHLY SALARY	
Option A: 60%, 14-day elimination period	$1.34
Option B: 60%, 30-day elimination period	$1.08

Short Term Disability Options

	Option A	Option B
Eligibility	All employees working not less than 30 hours/week or seasonal employees hired prior to July 1, 2015, with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June), or deemed eligible by applicable federal law, state law or action of the State Insurance Committee.	
% of Gross Annual Base Salary Paid Weekly	60% of salary paid weekly	
Maximum Weekly Benefit	Up to $2,500	
Mimimum Weekly Benefit	$25	
Elimination (Waiting) Period	14 calendar days	30 calendar days
Duration of Benefit	26 weeks	
Evidence of Insurability (EOI)	Guaranteed Issue (no health questions asked) for 2018 Annual Enrollment and new hires who enroll within 31 days of eligibility date. EOI will be required for late enrollees and 2018 plan participants who choose a higher plan of benefit during the 2019 Annual Enrollment Period.	
Pre-existing Condition	None	

Dental Insurance

Voluntary dental coverage is available to all state and higher education employees and their dependents. You must pay 100 percent of the premium if you elect this coverage. Two dental insurance plans are available—a prepaid plan and a dental preferred provider organization (DPPO) plan.

In the prepaid plan, you must select from a specific group of dentists. Under the DPPO plan, you may visit the dentist of your choice; however, members get maximum savings when visiting a 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 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 (Cigna)

- Must select and use a general dentist from the prepaid dental plan list for each covered family member — the network is Cigna Dental HMO (DHMO)
- Copays for dental treatments
- No claim forms
- Preexisting conditions are covered
- Referrals to specialists are required
- 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

DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider — the network is PDP
- $1,500 calendar year benefit maximum per person
- Deductible applies for basic and major dental care. Coinsurance for basic, major, orthodontic and out-of-network covered services
- You or your dentist will file claims for covered services
- Referrals to specialists are not required
- 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

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	$13.44	$23.18
Employee + Child(ren)	$27.91	$53.29
Employee + Spouse	$23.83	$43.84
Employee + Spouse + Child(ren)	$32.76	$85.78

Dental Insurance Benefits at a Glance

Here is a comparison of deductibles, copays and your share of coinsurance under the dental options. Costs represent what the member pays.

	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
COVERED SERVICES	**GENERAL DENTIST**	**SPECIALIST DENTIST**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	none		$25 single; $75 family, per policy year [1]	$100 single; $300 family, per policy year [1]
Annual Maximum Benefit	none		$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	$10 copay [2]		no charge	20% of MAC
Periodic Oral Evaluation	no charge		no charge	20% of MAC
Routine Cleaning – Adult	no charge		no charge	20% of MAC
Routine Cleaning – Child	no charge	$15 copay	no charge	20% of MAC
X-ray — Intraoral, Complete Series	no charge	$5 copay	no charge	20% of MAC
Amalgam (silver) Filling Permanent teeth	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$125 copay	$600 copay	20% of MAC	40 % of MAC
Major Restorations — Crowns	$200 copay, plus lab fees [3]		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 [3]		50% of MAC [4]	
Orthodontics	$140 monthly copay for treatment equal or less than 24 months. Then, full charge.[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	$3,360 copay ($140 x 24 months) for treatment fee only. Then, member pays full charge after initial 24 months. [6]		$1,250 [5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge is the lesser of the amount charged by the dentist or the maximum payment amount that in-network dentists have agreed to accept in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

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

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

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

[4] A six-month waiting period applies.

[5] The orthodontics lifetime maximum is for a dependent member enrolled in the state group dental insurance program even if the member has been covered under different employing agencies.

[6] Additional copays apply for specific orthodontic procedures. Orthodontic treatment after a member's effective date will not be covered under the Cigna plan if it began prior to the member's effective date.

Vision Insurance

Voluntary vision coverage is available to all state and higher education employees and dependents. You must pay 100 percent of the premium for this coverage. Two options are available: a Basic and an Expanded plan. Both plans offer:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglasses or contact lenses once every calendar year
- 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.

The Basic and Expanded plans are both administered by Davis Vision. You will receive the maximum benefit when visiting a provider in their 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.

Davis Vision offers some value-added services which include:

- Zero copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location
- Free pair of eyeglass frames from "The Exclusive Collection" under the in-network Expanded plan
- Free pair of "Fashion Selection" eyeglass frames from "The Exclusive Collection" under the in-network Basic plan
- Free pair of frames at Visionworks retail locations
- 40% discount off retail under the in-network Expanded plan and 30% discount off retail under the in-network Basic plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations
- 20% discount off retail cost of additional pair of conventional or disposable contact lenses under in-network Expanded plan
- One year warranty for breakage of most eyeglasses
- 30% to 60% off the cost of brand name hearing aids through EPIC Hearing Healthcare

Monthly Premiums for Active Members

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.07	$5.56
Employee + Child(ren)	$6.13	$11.12
Employee + Spouse	$5.82	$10.57
Employee + Spouse + Child(ren)	$9.01	$16.35

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	$39 copay	$39 copay
Frames	$55 allowance; 20% discount off balance above the allowance	$150 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass)		
• Single	$0 copay	$0 copay
• Bifocal, trifocal, lenticular	$0 copay	$0 copay
• Standard progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $65 out-of-pocket	$50 copay
• Premium progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $105 out-of-pocket	$50-140 copay [1]
Eyeglass Lens Options (upgrades)	20% discount off all options with out-of-pocket not to exceed amount shown below	
• Anti-reflective	Up to $40	$40 copay
• Polycarbonate	Adults $35; Children $0	Adults $30; Children $0
• Photochromic	Up to $70	20% off retail price; not to exceed $70 out-of-pocket
• Scratch resistance coating	$0	$0 copay
• UV coating	Up to $15	$10 copay
• Tints	Up to $15	$15 copay
• Polarized	Up to $75	20% off retail; not to exceed $75 out-of-pocket
• Premium anti-reflective	Up to $55	$40-69 copay [1]
• Scratch protection plan: single vision/multifocal lenses	$20 copay/$40 copay	$20 copay/$40 copay
• All other eyeglass lens options		20% discount
Exam for Contact Lenses (fitting and evaluation)	20% discount off retail price	$50-60 copay
Contact Lenses [2]		
• Elective Conventional or disposable	$55 allowance; 20% off balance over $55	$140 allowance; 20% off balance over $140
• Medically necessary [3]	$155 allowance; 20% off balance over $155	covered at 100%
LASIK/Refractive Surgery (for select providers)	15% discount off retail price or 5% off promotional price	15% discount off retail price or 5% off promotional price
Out-of-Network Benefits		
• All eye exams	$35 allowance	up to $50 allowance
• Frames	up to $55 allowance (frames and lenses combined)	up to $75 allowance
• Eyeglass lenses		
• Single vision		up to $35 allowance
• Lined bifocal		up to $55 allowance
• Lined trifocal		up to $70 allowance
• Elective contacts (conventional or disposable)	$30 allowance	up to $55 allowance
• Medically necessary contacts [3]	$80 allowance	up to $200 allowance
• Lens options-UV, polycarbonate, photochromic/ transitions plastic		up to $10 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] Copays for premium progressive lens and premium anti-reflective coating are subject to change
[2] Instead of eyeglass lenses
[3] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

Employee Assistance Program

Your Employee Assistance Program (EAP) is administered by Optum. It is available to all benefits-eligible employees and eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

Master's level specialists are available around the clock to assist with stress, legal, financial, mediation and work/life services. They can even help you find a network provider, a plumber who works nights, find services for your elderly parents, theater tickets, all-night pharmacies and so much more.

Optum knows you are busy, and they want to provide you with information when you need it. All you have to do is call 855.Here4TN (855.437.3486).

Behavioral Health & Substance Use Services

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Your enrolled dependents can use these benefits too.

Optum is your behavioral healthcare vendor. Using one of Optum's network providers gets you the most from this benefit, which is included when you and your dependents enroll in a health plan.

In addition to office visits, this benefit includes Telemental Health — virtual visits. What does that mean? You can meet with a provider through private, secure video conferencing. Telemental Health allows you to get the care you need sooner and in the privacy of your home. The cost for Telemental Health is the same as an office visit. To get started, go to Here4TN.com, scroll down, select provider search, and click on Telemental Health to find a provider licensed in Tennessee, or call 855.Here4TN for assistance. Learn more about your behavioral health benefit by visiting Here4TN.com.

ParTNers for Health Wellness Program

In 2018, state and higher education members and enrolled spouses can get cash rewards for participating in the voluntary wellness program. You can get money deposited through payroll* by completing certain activities and programs.

Here's how it works:

Regardless of the health plan you choose, members and enrolled spouses will first complete two requirements that may make them eligible for other programs. These requirements are:

- Health risk assessment (online questionnaire)
- Biometric screening

After members complete these two requirements, they will receive a cash deposit into their paycheck. Then, they'll find out if they qualify for other rewards and programs. Members who qualify can also get cash rewards for completing one or more programs. These additional programs could include:

- Weight loss/weight management program
- Tobacco cessation program
- Wellness counseling (diet, stress, exercise, etc.)
- Disease management program
- Diabetes Prevention Program (DPP)

There will also be wellness challenges, educational tools and other online wellness resources to help members track their results and progress.

*Members must be in a positive pay status to receive an incentive. The cash incentive for both the employee and eligible spouse will be deposited directly into the member's paycheck and will be taxed.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program available to all state and higher education employees and spouses enrolled in health coverage. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You will also be asked to complete a biometric screening, which will include a sample of your blood to determine blood sugar and cholesterol levels, blood pressure, height, weight and BMI. You are not required to complete the assessment or to participate in the biometric screening or other medical examinations.

Although you are not required to complete the health questionnaire or participate in the biometric screening, only employees and spouses who do so are eligible to receive cash incentives.

If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the ParTNers for Health Wellness Program at 888.741.3390.

The information from your health questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer you services through the wellness program such as weight management, Diabetes Prevention Program and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information (PHI). Although the wellness program and the State of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the ParTNers for Health Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness vendor (nutritionists, nurses, nurse practitioners, registered dietitians, health coaches and other healthcare professionals) and their vendor partners (case managers with the medical and behavioral health vendors, weight management vendor and the biometric screening vendor) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ParTNers for Health at partners.wellness@tn.gov.

Life Insurance

Basic Group Term Life and Accidental Death & Dismemberment Insurance

The state provides, at no cost to you, $20,000 of basic term life insurance and $40,000 of basic accidental death & dismemberment coverage. If you enroll in health insurance as the head of contract, the amount of coverage increases as your salary increases, with premiums for coverage above $20,000/$40,000 deducted from your paycheck. The maximum amount of coverage is $50,000 for basic term life and $100,000 for accidental death & dismemberment. The face amount of coverage declines at ages above 65. If you do not enroll in health coverage, the amount of coverage does not increase regardless of salary.

Changes in coverage based upon age or salary take effect on the first day of October based on your age and salary as of September 1.

Eligible dependents (spouse and children) enrolled in health insurance are covered for $3,000 of basic dependent term life coverage. Dependents are eligible for basic accidental death insurance, with the amounts of coverage based on salary and family composition. If you do not enroll in health coverage, your dependents are not eligible for basic term life or basic accident coverage.

Voluntary Accidental Death & Dismemberment

You and your dependents (spouse and children) may enroll in this coverage at low group rates, no questions asked. It is in addition to the basic accidental death coverage and you must pay a premium. Benefits are paid for dismemberment if the loss occurs within 90 days of the accident, as long as you or your dependent is covered on the date of the accident and meet the criteria. Coverage amounts are based on salary and age. The maximum benefit for you is $60,000.

Voluntary Term Life Insurance

You and your dependents (spouse and children) may enroll in this coverage whether or not you enroll in health coverage. A premium is required. For employee guaranteed issue coverage, you must enroll during the first 31 calendar days of employment with the state. The effective date of coverage is the first of the month after you have completed three full calendar months of employment. If you do not enroll when first eligible, you can apply for coverage during the annual enrollment period by answering health questions.

You may select up to five times your annual base salary (subject to a maximum of $500,000) if you apply when first eligible. You may apply for up to seven times your annual base salary (subject to a maximum of $500,000), but evidence of good health is required. The minimum coverage level is $5,000.

Your spouse may apply for $5,000, $10,000 or $15,000 of term life insurance at any age. Spouses below age 55 may apply for increments of $5,000, subject to an overall maximum of $30,000. Spouses must be performing normal duties of a healthy person of similar age and gender and not have been hospitalized, advised to seek medical treatment or received disability benefits within six months prior to the application to enroll date for coverage to be issued without answering any additional health questions. A spouse who does not meet the previous criteria may apply for coverage by answering specific health questions which the insurance company will use to decide if coverage will be allowed. You do not have to enroll in this coverage in order for your spouse to participate.

Children may be covered under either a $5,000 or a $10,000 term rider. The rider is added to either your contract or your spouse's contract, but not both. These amounts will cover all eligible dependent children who meet the dependent definition. Coverage for children is guaranteed issue.

The voluntary term life insurance provides a death benefit and the premiums increase with age. It also offers an advance benefit rider, which allows part of the life insurance proceeds if an insured encounters a terminal illness.

Flexible Spending Accounts

State and higher education employees (excludes off-line employees) are eligible for flexible spending accounts. Flexible spending accounts (FSAs) help make your money go farther. Here's how they work:

They help you decrease your taxable income and increase your take-home pay. It allows you to pay certain expenses from your pre-tax income rather than after-tax income. The maximum amount you can contribute to a FSA is set by the Internal Revenue Service (IRS). The limits are subject to change yearly.

Note: Flexible benefits for state and higher education employees are only available to benefits-eligible employees; part-time employees may not enroll in these benefits.

Unless you have an approved family status change, you cannot enroll in or cancel a medical or dependent care reimbursement account in the middle of a calendar year.

Medical Reimbursement Account

Used to pay for certain medical, dental, vision and prescription costs not covered by your insurance. Up to $500 of your unused FSA balance can be carried over into the next plan year instead of you "losing it." If you enroll in the CDHP/HSA, you do not qualify for a FSA for medical expenses. You can still have a limited purpose FSA to use for dental and vision expenses.

Limited Purpose Account

May only be used to pay for certain dental and vision costs not covered by insurance. For employees enrolled in the CDHP/HSA, the limited purpose FSA is a great way to save on vision and dental expenses.

Dependent Care Reimbursement Account

Used to pay for certain dependent-care costs, such as after school care, baby-sitting fees, adult or child daycare and preschool. Certain requirements must be met by the eligible employee and/or his or her spouse. For details, review the governing Plan Document located at tn.gov/finance/fa-benefits/publications.

Transportation and Parking Reimbursement Accounts

Available to state employees only. Used to pay for certain work-related commuting and/or parking expenses.

State employees are eligible for transportation and parking reimbursement accounts. These accounts let you use tax-free dollars to pay for your transportation to and from work as well as work-related parking costs. You may enroll in a transportation or parking reimbursement account at any time.

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. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses the plan has already paid for, you may be subject to collections activity.

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 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, behavioral 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, behavioral 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

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697

If you speak a language other than English, help in your language is available for free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

1.(800-848-0298 هاتف الصم والبكم: 1 ,866-576-0029- رقم مجاني. اتصل برقم إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان :ملحوظة

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው

ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید.

The Notice of Privacy Practice

Your health record contains personal information about you and your health. This information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). The Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), including Privacy and Security Rules. The notice also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practice is located on the Benefits Administration website at tn.gov/finance/fa-benefits. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. By law, we are required to inform plan members of this coverage yearly. You can find a copy of the required notice regarding your options on the Benefits Administration website.

If you are actively employed or a pre-65 retiree enrolled in health coverage, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age. Once your retiree group health coverage terminates due to becoming Medicare eligible you may want to enroll in Medicare prescription drug coverage if you need pharmacy benefits.

Summary of Benefits and Coverage

As required by law, the State of Tennessee Group Health Plan has created a Summary of Benefits and Coverage (SBC). The SBC describes your 2018 health coverage options. You can view it online at tn.gov/finance/fa-benefits/sbc or request that we send you a paper copy free of charge. To ask for a paper copy, call Benefits Administration at 855.809.0071.

Plan Document

The information contained in this guide provides a detailed overview of the benefits available to you through the State of Tennessee. More information is contained within the formal plan documents. If there is any discrepancy between the information in this guide and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at tn.gov/finance/fa-benefits/publications.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at tn.gov/finance/fa-benefits/publications, including, but not limited to, a sample basic term life/basic AD&D certificate, sample optional AD&D certificate, Medicare supplement plan document, brochures and handbooks for medical, pharmacy, dental, vision, life insurance and the Medicare supplement.

Notes

Notes

STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
19TH FLOOR, 312 ROSA L. PARKS AVENUE • WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102