

AGENCY BENEFITS
COORDINATOR
(ABC) GUIDE



AGENCY BENEFITS COORDINATOR (ABC) GUIDE

Use this helpful guide to help get you started in your new role.



Helpful Contact Information

Benefits Administration

Hours of operation:

Monday - Friday
8 a.m. - 4:30 p.m. CST
(Closed on state holidays)

Phone:
800.253.9981
615.741.3590

Fax:
615.741.8196

Email:

benefits.administration@tn.gov

Zendesk

Submitting a ticket through Zendesk is the best and quickest way to contact us.

Reminders

- Your Annual HIPAA training is required – Within **30 days** after gaining access to Edison.
- Your one-time, mandatory New ABC Training must be completed within **60 days** after gaining access to Edison.

Pro Tip: As time goes on, try revisiting the training for a helpful refresher.

TABLE OF CONTENTS



[Helpful Links](#)

- Health Insurance Carriers
- Vision Insurance Carriers
- Dental Insurance Carriers
- Pharmacy Carriers
- Behavioral Health
- Employee Assistance Program (EAP)
- Telehealth
- Wellness

[Commonly Used Forms](#)

- Enrollment Change Application
- Cancel Request Form
- Corrections and Clarifications (CC) Form

[How Zendesk Works](#)

[How Edison Works](#)

[Eligibility Dates](#)

[Termination Dates](#)

[Queries](#)

- Queries Run Anytime
- Queries To Run At The Same Time Each Month
- How to Run a Query?
- Full List of Queries

[Adding A New Employee](#)

[Additional Information](#)

- Plan Document and Annual Enrollment
- Conference Calls and Weekly Emails
- A Note On Insurance Cards

Helpful Links

Health Insurance Carriers

[Cigna](#)

[BlueCross BlueShield of TN](#)

Vision Insurance Carriers

[Davis Vision](#)

Dental Insurance Carriers

[Cigna Dental](#)

[MetLife DPPO](#)

Pharmacy Benefits

[CVS/Caremark](#)

Behavioral Health

Employee Assistance Program (EAP)

[Here4TN](#)

Telehealth

Health Savings Account & Flexible Spending Accounts

[**Optum**](#)

[**Payflex**](#)

Wellness

[Weight Watchers at Work](#)

[Fitness Center Discounts](#)

[Diabetes Prevention Program](#)

Commonly Used Forms

[Enrollment Change Application](#)

This form is used for employees to select and/or make changes to their benefits.

However, there are other times this form will be used.

- If you have an employee who wants to edit their elections within their 31-day eligibility period, and they are not using Employee Self-Service (ESS), this form can be submitted to Benefits Administration (BA) through Zendesk.
- Other events including, but not limited to, marriage, divorce, birth, adoption, etc.

[Click here to see an example of a completed form](#)

[Cancel Request Form](#)

This is the form used if an employee and/or their dependents want to voluntarily cancel insurance. Have the employee complete and sign the form and return to us at BA by uploading the document in Zendesk.

Note: *Cancelling is only permitted outside of Annual Enrollment due to one of the specified qualifying events listed on the form.*

[Click here to see an example of a completed form](#)

[Corrections and Clarifications \(CC\) Form](#)

For BA to make a change within Edison on information such as employee or dependent names, addresses, or social security numbers, this form should be completed and can be sent to BA by uploading the document in Zendesk.

[Click here to see an example of a completed form](#)

How Zendesk Works

[Zendesk](#) is a ticketing-based system that serves as your primary mode of communication with Benefits Administration.

ABCs can search the knowledge base in Zendesk for Frequently Asked Questions, policies and procedures, among other topics.

For topics and situations that require further research, a user can submit a ticket to the BA team.

One of the great features of Zendesk is that it allows for transcripts of each and every interaction to be recorded within Zendesk for future reference.

By signing into your account, you have the ability to check the status of a pending request.

BA strives to resolve the issue within 1.5 business days or less. Some examples of issues in which a ticket should be created by an ABC include billing questions, enrollment delays, eligibility questions, and/or general questions.

Helpful Zendesk Links

- [Step-by-step walkthrough for how to use Zendesk](#)
- [How to upload documents in Zendesk](#)
- [Video Guide](#)

How Edison Works

[Edison](#) is the main database used by the State of Tennessee. It is used to collect and organize all personal and job data for all ABC's and employees enrolled in the State Group Insurance Program. Edison maintains all benefit selections and corresponding dependent verification documents, if applicable. As an ABC you will use Edison to hire, transfer, and terminate employees who are benefit eligible.

Helpful Edison Links

- [E-Forms/Data Entry](#)
- [Self Service](#)
- [Video Guide](#)

Eligibility Dates

***Pro Tip:** Use this [Time and Date Calculator](#) to help determine the exact dates to use in Edison.*

Use the employee's actual hire date and benefits will start first day of the month following the completion of 1 full calendar month of employment.

Termination Dates

Active Insurance will terminate on the last day of the month the employee is in active pay status. The last day of active pay status is the last day of employment.

Examples:

1. If an employee's last day of work is on 1/31, and the date of termination in Edison is 2/01, Insurance would terminate on 2/29.
 2. If an employee's last day of work is on 1/05, and the date of termination in Edison is 1/06, Insurance would terminate on 1/31.
-

Queries

Queries to Run Anytime

TN_BA219_MED_DEN_COVERAGE – After the Annual Enrollment events are closed, this query will show any new coverage that is effective Jan 1. This query can also be run throughout the year for new hire enrollments or changes for special qualifying events. This query also includes vision.

When should I run this?

This query can be run any time. It most commonly run after annual enrollment, though, as you can set the report to show you coverage that will start the first of a specific month.

TN_BA219_MED_DEN_ELECTIONS – This query will show all elections made in Edison between a specific date range.

When should I run this?

This query can be run on as-needed basis. If you know the range of dates that you entered your employees' benefits selection, you can run this query to show the selections that were made by each employee. This is a good way to double-check that the enrollments selected in Edison are correct with the information that you were provided by your employees.

Queries To Run At The Same Time Every Month

TN_BA142_TEMP_PRIMARY_NID_DEP – This query will show you all of the dependents that have a temporary Social Security Number and the name of the employee for that dependent. If you do not have the permanent SSN, you will need to get this information from the employee.

TN_BA313_ADDRESS_CHANGES – Shows all the addresses that have been updated for an agency within a specified date range.

[How To Run A Query Manual](#)

[Full Query List](#)

Adding A New Employee

When an employee is hired in your agency, follow this step-by-step process to enroll them into benefits.

1. Complete the [New Employee Checklist](#)
2. Provide [New Employee Presentation](#) to new employee
3. Enter personal and job information into Edison for new employee. Benefits can be entered using any of the following methods:

E-Forms Process – An automation process, in Edison, for an ABC to enter benefits selections and upload dependent verification for an employee.

[Helpful Guide for E-Forms](#)

Employee Self Service – The method in which an employee can make enrollment selections that does not require a paper application. The employee will enter their benefits selections in Edison.

[Helpful Guide for Employee Self Service \(ESS\)](#)

Pro Tip: State Agencies will use eForms for Benefits purposes only; not to hire employees.

You can also refer to the [For New Employees](#) section of the Partners for Health website.

Additional Information

[Plan Document](#)

[Annual Enrollment](#)

2020 Annual Enrollment Dates:

Oct. 1-16, 2020

Conference Calls and Weekly Emails

ABC Conference calls are held the second Tuesday of each month. If you missed a conference call or weekly email, please reference the links below. This is our way of getting important information to you and your employees. It is important that you attend the monthly conference calls and read each weekly email update.

- [Conference Call Notes](#)
 - [Weekly Emails](#)
-

A Note About Insurance Cards

[BlueCross BlueShield of TN](#)

Phone: 1-800-558-6213

- Up to two ID cards sent automatically (both with member's name).
- May be used by any covered dependent.

[Cigna](#)

Phone: 1-800-997-1617

- Sends separate ID cards for each insured family member – with participant's name.
- May be up to four (4) ID cards in each mailing.

Members can acquire additional cards by contacting their insurance carrier (BCBSTN or Cigna).

Note: *Subscriber IDs and Group Numbers can be found on your insurance cards.*



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196



PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

| | | | | | |
|---|---|---|---|--|--|
| TYPE OF ACTION <input type="checkbox"/> Add coverage <input type="checkbox"/> Change coverage *Form not for cancellation | COVERAGE <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Disability | PARTICIPANTS AFFECTED <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) | REASON FOR THIS ACTION <input type="checkbox"/> New Hire/Newly Eligible <input type="checkbox"/> Court Order <input type="checkbox"/> Other _____ | Life Event <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Adoption | Special Enrollment (also complete pg 3) <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Eligibility |
|---|---|---|---|--|--|

PART 2: EMPLOYEE INFORMATION

| | | | | | |
|------------------------|------------------|--|---|---|---|
| FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER <input type="checkbox"/> M <input type="checkbox"/> F | MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W |
| SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | | EMPLOYER GROUP: <input type="checkbox"/> HED <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov | | YOUR CURRENT STATUS <input type="checkbox"/> Active <input type="checkbox"/> COBRA |
| HOME ADDRESS | | <input type="checkbox"/> UPDATE MY ADDRESS | CITY | ST | ZIP CODE |
| COUNTY | | | | | |

PART 3: HEALTH COVERAGE SELECTION

| | | | | | |
|---|---|--|--|---|---|
| SELECT AN OPTION <input type="checkbox"/> Premier PPO <input type="checkbox"/> CDHP/HSA (state) <input type="checkbox"/> Standard PPO | LOCAL ED & GOV ONLY MAY ALSO CHOOSE <input type="checkbox"/> Limited PPO <input type="checkbox"/> Local CDHP/HSA | EMPLOYEE HSA CONTRIBUTION (STATE ONLY) Annual contribution \$ _____ | SELECT A CARRIER <input type="checkbox"/> BlueCross BlueShield Network S <input type="checkbox"/> Cigna LocalPlus <input type="checkbox"/> Cigna Open Access (surcharge applies) | REGION WHERE YOU LIVE OR WORK <input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West | SELECT A HEALTH PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren) |
|---|---|--|--|---|---|

PART 4: DENTAL COVERAGE SELECTION

| | | | | |
|--|---|---|---|--|
| SELECT A PLAN <input type="checkbox"/> MetLife DPPO <input type="checkbox"/> Cigna Prepaid DHMO | SELECT A DENTAL PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren) | SELECT A PLAN <input type="checkbox"/> Basic Plan <input type="checkbox"/> Expanded Plan | SELECT A VISION PREMIUM LEVEL <input type="checkbox"/> employee only <input type="checkbox"/> employee + child(ren) <input type="checkbox"/> employee + spouse <input type="checkbox"/> employee + spouse + child(ren) | PART 6: DISABILITY SELECTION (ST/UT/TBR) SHORT TERM DISABILITY <input type="checkbox"/> 60%/14 day Elimination Period <input type="checkbox"/> 60%/30 day Elimination Period LONG TERM DISABILITY (ST ONLY) <input type="checkbox"/> 60%/90 day Elim Period <input type="checkbox"/> 60%/180 day Elim Period <input type="checkbox"/> 63%/90 day Elim Period <input type="checkbox"/> 63%/180 day Elim Period |
|--|---|---|---|--|

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

| NAME (FIRST, MI, LAST) | DATE OF BIRTH | RELATIONSHIP | GENDER | ACQUIRE DATE * | SOCIAL SECURITY NUMBER | HEALTH | DENTAL | VISION |
|------------------------|---------------|--------------|---|----------------|------------------------|--------------------------|--------------------------|--------------------------|
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

* The acquire date is the date of marriage, birth, adoption or guardianship.
 Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2). A separate sheet with more dependents is attached

PART 8: EMPLOYEE AUTHORIZATION

Accept I confirm that all of the information above is true. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my benefits coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.

Refuse I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

| | | | |
|--|---------------------------|-----------------------|--------------------------|
| EMPLOYEE SIGNATURE John M. Smith | DATE 06/15/2020 | HOME PHONE (REQUIRED) | EMAIL ADDRESS (REQUIRED) |
|--|---------------------------|-----------------------|--------------------------|

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

| | | | | |
|---|---------------------|-----------------|---------------------------|--|
| ORIGINAL HIRE DATE | COVERAGE BEGIN DATE | POSITION NUMBER | EDISON ID | NOTES TO BENEFITS ADMINISTRATION |
| AGENCY BENEFITS COORDINATOR SIGNATURE Sara Benefits | | | DATE 06/15/2020 | <input type="checkbox"/> PPACA Eligible <input type="checkbox"/> 1450 Eligible |

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
INSURANCE CANCEL REQUEST APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
 312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196



| | | |
|------|-----------|---|
| NAME | EDISON ID | EMPLOYER GROUP: <input type="checkbox"/> HED <input type="checkbox"/> STATE <input type="checkbox"/> LOCAL ED <input type="checkbox"/> LOCAL GOV |
|------|-----------|---|

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)

I request to cancel medical dental STD LTD vision FSA/medical FSA/dep care FSA/limited Voluntary AD&D coverage on the participant(s) below due to:

Reason marked in Part 2 below

Prepaid dental; no participating general dentist within a 40-mile radius of my home (skip Parts 2 and 3 below)

Disability; requires 30 days advance written notice (skip Parts 2 and 3 below)

Employee Spouse Child(ren) (names):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)

1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is received by Benefits Administration.

The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON TO REQUEST TO CANCEL

| REASON | DOCUMENTATION REQUIRED |
|---|---|
| <input type="checkbox"/> Marriage, divorce, legal separation, annulment | Copy of marriage certificate or full divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above) If divorce, please provide ex-spouse's current address here: |
| <input type="checkbox"/> Birth, adoption, placement for adoption | Copy of birth certificate or adoption documents and proof of other coverage (see #1 above) |
| <input type="checkbox"/> Death of spouse, dependent | Copy of death certificate |
| <input type="checkbox"/> New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent) | Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status |
| <input type="checkbox"/> Entitlement to Medicare, Medicaid, TRICARE | Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card |
| <input type="checkbox"/> Court decree or order | Copy of court decree or order signed by judge |
| <input type="checkbox"/> Open enrollment | Letter, on company letterhead, certifying date of eligibility for other coverage |
| <input type="checkbox"/> A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.) | Letter stating date of location change with member's new address |
| <input type="checkbox"/> Marketplace Enrollment | I attest that I am enrolled or intend to enroll in the Marketplace |

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.

| |
|---|
| LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY) |
|---|

PART 4 — AUTHORIZATION

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel coverage for the reason(s) marked in Part 1 of this form. I also attest that I can cancel disability coverage for any reason. I further attest that the information I am submitting is true and accurate. I understand that by making this request, the participant(s) whose coverage is cancelled may not be eligible for COBRA and that any future request for coverage will be subject to the Plan's eligibility and enrollment rules.

| | | |
|---|--------------------------|-------|
| EMPLOYEE SIGNATURE John M. Smith | DATE 07/1/2020 | PHONE |
| AGENCY BENEFITS COORDINATOR SIGNATURE Sara Benefits | DATE 07/1/2020 | NOTES |

Benefits Administration
Corrections and Clarifications Form

to be completed by an Agency Benefits Coordinator

Fax Number (615) 741-8196

Please do not send this form to BA if you have access to make the change in Edison

Employee Name

Employee SSN Employee ID

Agency Type ST LE
 UT/TBR LG

Personal Information Correction

For Employee For Dependent - Name:

| | Name | Date of Birth | Social Security Number |
|----------------|--|--|--|
| Incorrect Info | <input style="width: 340px; height: 25px;" type="text"/> | <input style="width: 100px; height: 25px;" type="text"/> | <input style="width: 150px; height: 25px;" type="text"/> |
| Correct Info | <input style="width: 340px; height: 25px;" type="text"/> | <input style="width: 100px; height: 25px;" type="text"/> | <input style="width: 150px; height: 25px;" type="text"/> |

ABC Unable to Key Address Change

New Address

| | |
|---|--|
| Street Address: <input style="width: 560px; height: 25px;" type="text"/> | Address Change Effective Date <input style="width: 160px; height: 25px;" type="text"/> |
| City: <input style="width: 300px;" type="text"/> State: <input style="width: 100px;" type="text"/> | |
| Zip Code: <input style="width: 300px;" type="text"/> County: <input style="width: 100px;" type="text"/> | |

ABC Unable to Key Position Number Change (within an agency)

Old Position Number New Position Number

Clarification (usually in response to a request from BA)

| |
|--|
| <input style="width: 860px;" type="text"/> |
| <input style="width: 860px;" type="text"/> |
| <input style="width: 860px;" type="text"/> |

Agency Benefits Coordinator Authorization

ABC Signature ABC sign here Date