

**PARTNERS
FOR HEALTH**

**State Group
Insurance Program**

**Continuing
Insurance at
Retirement**

Local Government
January 2020

If you need help...

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/partnersforhealth
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbs.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 Use and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	ActiveHealth Management	888.741.3390 — M-F, 8-8	http://go.activehealth.com/wellnesstn
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
The Tennessee Plan	Pomco/UMR	888.477.9307	umr.com/thetennesseeplaninfo

Online resources...

Visit the ParTNers for Health website at tn.gov/partnersforhealth. It has the enrollment forms and handbooks referenced in this guide. It also has information about all the benefits described in this guide. The website is updated often with new information.

Our Zendesk help center is located at <https://benefitssupport.tn.gov/hc/en-us>, where you can search the help center, find articles or submit questions. To access Zendesk, you can also click the “Questions?” button on the website.

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INTRODUCTION

Notice: You may only apply to continue coverage as a pre-65 retiree in the state-sponsored local government insurance plan if your local government agency has opted in to retiree coverage. Ask your agency benefits coordinator (ABC) if you have any questions. If your agency has opted in to retiree coverage, you can find eligibility and enrollment information in this guide and in the Local Government Plan Document online at the ParTNers For Health website under publications, <https://www.tn.gov/partnersforhealth.html>.

Overview

The insurance options available to you at retirement are outlined in this guide. The first section explains eligibility and enrollment requirements and includes two subsections. The first is for Tennessee Consolidated Retirement System (TCRS) participants. The second is for non-TCRS participants. It is important that you refer to the subsection that applies to you. If your agency does not participate in the Tennessee Consolidated Retirement System, you should review the non-TCRS section.

For More Information

Your agency benefits coordinator (ABC) is your primary contact. He/she can provide you with forms and handbooks you need. For questions about eligibility, contact Benefits Administration. Our service center is your main point of contact regarding insurance once you retire.

All forms and handbooks referenced in this guide are on the Benefits Administration (BA) website. You can also get copies by calling our office or emailing retirement.insurance@tn.gov. You need to include your Edison ID (found on your Caremark card) and your address in your email.

If you have questions about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your healthcare provider or insurance company) contact the insurance company's member service number on your insurance card. See also, information at the end of this guide about your appeal rights.

Authority

The Local Government Insurance Committee determines the premiums, benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the Local Government Plan. You will be given written notice of changes.

Local Government Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- One member appointed by the Tennessee Municipal League
- One member appointed by the Tennessee County Services Association

ELIGIBILITY AND ENROLLMENT

TCRS PARTICIPANTS (SEE NOTICE ON PAGE 2)

Continuing Coverage at Retirement

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement until you become eligible for Medicare. Covered dependents can also continue coverage until they become eligible for Medicare or no longer qualify as eligible dependents.

If you are eligible for Medicare, you may be eligible for Supplemental Medical Insurance for Retirees with Medicare coverage (The Tennessee Plan). More information about The Tennessee Plan is included in this guide.

To continue health and vision insurance benefits, the agency from which you retire must continue to participate in the local government plan. If your former agency leaves the State Group Insurance Program, you and your dependent's health and vision coverage will be cancelled.

If your spouse is an employee enrolled in state group health insurance, you may continue coverage as a dependent on his/her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retirees who are Medicare eligible are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the state group health plan via the special enrollment provision.

You may also be eligible to enroll in dental and vision coverage. This guide explains your options and the rules for each type of coverage.

Service Requirements

You must have at least 10 years of creditable service with the agency you are retiring from to continue insurance coverage. Unused sick leave may be counted. Military service that did not interrupt employment, service that was previously cashed out and not paid back to TCRS, educational leave, leave of absence or service with another local government agency cannot be counted.

The eligibility guidelines are:

- Ten years of creditable service, must be age 55 or older and at least three years of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.
- Twenty years of creditable service, must be age 55 or older and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.
- Thirty years of creditable service and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.

The requirement for immediate commencement of retirement benefits will be waived if you become insured by the state, a participating local education agency or another participating local government agency with no lapse in coverage.

The one-year and three-year participation requirements will be waived if the local government agency has joined the state plan for the first time and has not participated in the plan for that length of time.

You must receive a monthly TCRS retirement benefit to continue coverage. If you choose a lump-sum retirement benefit you are not eligible to continue health and vision insurance at retirement.

Detailed information on the rules to continue health insurance as a retiree can be found in the Local Government Plan Document. This document is available on the publications webpage of the Benefits Administration website located here: <https://www.tn.gov/partnersforhealth/publications/publications.html>.

Application to Continue Group Health Coverage

You must submit an application to continue coverage at retirement to your ABC within one full calendar month of the end of active insurance. You must continue in the same health insurance option in which you are currently enrolled. You will be able to make changes to your insurance during the annual enrollment period each fall.

Effective Date of Retiree Group Health Coverage

Retiree coverage is effective on the first day of the month following the end of active insurance coverage.

Individuals Eligible for Medicare

If you are eligible for Medicare Part A, you cannot continue in group health coverage, unless grandfathered by the Local Government Insurance Committee. **If your initial date of employment with the qualifying employer is prior to July 1, 2015,** you may apply for the state's Supplemental Medical Insurance for Retirees with Medicare called The Tennessee Plan. You must be enrolled in at least Medicare Part A and receive a monthly TCRS pension benefit. You may also apply to cover your dependents who are eligible for Medicare when you enroll in The Tennessee Plan. If you qualify and enroll within 60 days of initial eligibility, you cannot be turned down for coverage due to age or health. The initial eligibility date is the date of TCRS retirement, the date active state group health coverage ends or the date of Medicare eligibility, whichever is later.

The Tennessee Plan is supplemental to Medicare parts A and B and helps fill most of the coverage gaps that Medicare creates. It does not cover prescription drugs. If you participate in The Tennessee Plan, you will need a separate Part D plan for your prescription drug needs. The Tennessee Plan will not coordinate benefits if you are currently enrolled in or join a Medicare advantage plan. This means if you have a Medicare advantage plan, The Tennessee Plan will not pay out any benefits.

Application for The Tennessee Plan Coverage

If you are eligible for Medicare at retirement you can select The Tennessee Plan coverage on the application to continue insurance at retirement. You have 60 days from the initial eligibility date to enroll. Coverage is effective the first of the month following the end of your active insurance coverage or the first of the month following your date of retirement, whichever is later.

If you become eligible for Medicare due to age after retirement you will be sent an application approximately three months before your 65th birthday. The application must be submitted within 60 days of Medicare eligibility. Coverage will become effective on your date of Medicare entitlement provided the application is received timely. If you enroll in The Tennessee Plan and your spouse becomes entitled to Medicare at a later date, you have 60 days from the date of your spouse's eligibility to apply to add him/her to coverage.

If enrollment is not selected within 60 days of initial eligibility, you and your eligible dependent may apply through medical underwriting. Enrollment is subject to approval and may be denied. Benefits Administration will submit the application for review to the vendor. You must be enrolled in The Tennessee Plan to cover a dependent.

Once approved, you will receive an ID card from the vendor. It will show your name and identification number. If you are not satisfied with The Tennessee Plan, you can cancel it within 30 days after receipt. You will receive a refund of premiums paid in advance. Any claims paid during this period will be recovered.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement.

COBRA Dental

If you are enrolled in the state-sponsored dental plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. Please note on the COBRA enrollment form that you are a TCRS retiree.

Retiree Dental

You may also choose to enroll in retiree dental coverage. Just select dental on your application to continue insurance at retirement. To enroll you must receive a monthly TCRS pension benefit. Dependent-only coverage is not available.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement.

COBRA Vision

If you are enrolled in the state-sponsored vision plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. COBRA vision premiums cannot be deducted from your TCRS pension check.

Retiree Vision

If you continue health insurance at retirement, you are eligible for retiree vision coverage. If you do not select vision coverage at retirement, you can enroll during the annual enrollment period. Coverage will end when your group health enrollment ends. You may also cover dependents who are enrolled in retiree group health coverage. Dependent only vision coverage is available when you are no longer enrolled on the retiree group health plan, as long as they remain eligible dependents covered on the retiree group health plan.

ELIGIBILITY AND ENROLLMENT

NON-TCRS PARTICIPANTS (SEE NOTICE ON PAGE 2)

Continuing Coverage at Retirement

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement until you become eligible for Medicare. Covered dependents can also continue coverage until they become eligible for Medicare or no longer qualify as eligible dependents.

To continue insurance benefits, the agency from which you retire must continue to participate in the local government plan. If your former agency leaves the State Group Insurance Program, your and your dependent's coverage will be cancelled.

If your spouse is also an employee enrolled in state group health insurance, you may continue coverage as a dependent on his/her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retirees who are Medicare eligible are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the state group health plan via the special enrollment provision.

You may also be eligible to continue dental and vision coverage. This section explains your options and the rules for each type of coverage.

Service Requirements

You must have at least 10 years of creditable service with the agency you are retiring from to continue insurance coverage. Unused sick leave may be counted. Military service that did not interrupt employment, educational leave, leave of absence or service with another local government agency cannot be counted.

The eligibility guidelines are:

- Ten years of creditable service, must be age 55 or older and at least three years of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.
- Twenty years of creditable service, must be age 55 or older and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.
- Thirty years of creditable service and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.

Public safety employees (police and firemen)

To be eligible to continue insurance at retirement, you must:

- Have 25 years of creditable service, be age 50, be enrolled in the plan for one full year of coverage immediately prior to retirement and be qualified for an unreduced benefit.

Utility board members

To be eligible to continue insurance at retirement, you must:

- Have 20 years of creditable service, be age 55 and be enrolled in the plan for one full year of coverage immediately prior to retirement.
- Have 30 years of creditable service and be enrolled in the plan for one full year of coverage immediately prior to retirement.

The date retirement benefits start must immediately follow active coverage ending.

The requirement for immediate commencement of retirement benefits will be waived if you become insured by the state, a participating local education agency or another participating local government agency with no lapse in coverage.

The one-year and three-year participation requirements will be waived if the local government agency has joined the state plan for the first time and has not participated in the plan for that length of time.

Application to Continue Group Health Coverage

You must submit an application to continue coverage at retirement to your ABC within one full calendar month of the end of active insurance. You must continue in the same health insurance option in which you are currently enrolled. You will be able to make changes to your insurance during the annual enrollment period each fall.

Effective Date of Retiree Group Health Coverage

Retiree coverage is effective on the first day of the month following the end of active insurance coverage.

Individuals Eligible for Medicare

If you are eligible for Medicare Part A, you cannot continue in group health coverage, unless grandfathered by the Local Government Insurance Committee. The state's The Tennessee Plan is not available to non-TCRS local government members.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement. If you are enrolled in the state-sponsored dental plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. Retiree dental coverage is not available to non-TCRS participants.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement. If you are enrolled in the state-sponsored vision plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. Retiree vision coverage is not available to non-TCRS participants.

GENERAL INFORMATION FOR ALL MEMBERS

Dependent Coverage

You may continue coverage for eligible dependents if they are covered on your active insurance at the time of your retirement. Newly acquired dependents must be added within 60 days. If you are no longer enrolled in the group health plan you cannot add dependents to the group health plan.

Dependent Eligibility

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 on the application to continue insurance at retirement. A dependent can only be covered once within the Local Government 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 health, dental and vision 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.

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)
- Live-in companions who are not legally married to the employee

Adding New Dependents

To add new dependents to your coverage, submit a retiree insurance change application within 60 days of the date the 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. Proof of the dependent's eligibility is required. Refer to the dependent definitions and required documents chart for the types of proof you must provide. Premium changes start on the first day of the month in which the dependent is acquired or the first of the next month depending on the coverage start date. A child named under a qualified medical support order must be added within 40 days of the court order.

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

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

If you have single coverage

- The new dependent can enroll if he/she has 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 he/she has 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 is sufficient to include the 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 about qualifying events is provided under the special enrollment provisions topic in this section of this guide.

Updating Personal Information

You must update personal information, such as home address and email, by contacting the Benefits Administration service center. You will be required to provide the last four digits of your social security number or Edison ID, date of birth and previous address. You must also confirm authorization of the change before our office can update your information. It is your responsibility to keep your address and phone number current with Benefits Administration. TCRS retirees must submit a separate request directly to TCRS.

Annual Enrollment Period

During the fall of each year, you can make changes in your health, vision or dental coverage. Information is mailed to your home address and provided on the Partners for Health website in detail prior to the enrollment period. The options you choose during the enrollment period will take effect on the following January 1. Coverage will remain in effect through December 31.

Cancelling Health, Vision and Dental Coverage

Outside of the annual enrollment period, you can only cancel coverage for yourself and your dependents, if:

- You lose eligibility for the State Group Insurance Program, or
- You experience a special qualifying event, family status change or other approved qualifying event, or
- You are enrolled in the prepaid dental option and there is not a participating general dentist within a 40-mile radius of your home

You must notify Benefits Administration within one full calendar month 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 cancelled for loss of eligibility, coverage ends the last day of the month eligibility is lost. If you request to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 34-4-106 and the requirement that you provide notice of termination of health insurance to your covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. As the retiree, it is your responsibility to make sure that any request to terminate your dependent spouse is consistent with those legal requirements.

Cancelling coverage in the middle of the plan year — 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, divorce, legal separation, annulment
- Birth, adoption/placement for adoption
- Death of spouse, dependent
- New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependents)
- Entitlement to Medicare, Medicaid or TRICARE
- Court decree or order
- Open enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment

To cancel coverage, you must submit an insurance cancel request application. This form is available in the forms section of the Benefits Administration website in the retirement section.

If You Do Not Apply When First Eligible

If you do not apply to continue health coverage within a full calendar month of your initial eligibility, you may only apply later if you experience a special qualifying event. To apply you must still be eligible for retiree health coverage and meet the criteria to continue coverage at the time your employment ended. If you are no longer eligible for health coverage, you may not enroll your dependents through a special enrollment event.

Special Enrollment Provisions

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that allows employees to enroll in a group health plan due to certain life events. Retirees may also enroll themselves and their eligible dependents subject to special enrollment provisions. The State Group Insurance Program will only consider special enrollment requests for health, dental and vision coverage.

The following are considered special qualifying events if they result in a loss of coverage:

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

If you experience one of these events, contact Benefits Administration or complete the retiree insurance change application. Application must be made within 60 days of the loss of coverage.

Important Reminders

- If enrolling dependents who qualify, you may change to another health option, if eligible
- Premiums for coverage type selected must be paid before the coverage can start
- Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause

Reinstatement Following Voluntary Cancellation

If you cancel coverage and change your mind, coverage can be reinstated if you meet all of the following conditions:

- Premiums are paid current on the coverage termination date;
- You and your dependents continue to meet the eligibility requirements; and
- You submit a written request for reinstatement within one full calendar month of the coverage termination date.

Disability Participants

If you experience an injury or illness which results in disability and you have at least five years of creditable service, you may be able to continue health coverage as a disability retiree. There can be no lapse in coverage. The date retirement benefits start (retirement date) must be on or before the date your active coverage ceased. If you are eligible for a service retirement, you must prove that total disability existed at the time of retirement. Proof of total disability must be shown by submitting an award letter from the Social Security Administration or approval by TCRS based on review of medical records. The required proof must show total disability existed on or before the date your active coverage ended.

If the effective date of your disability retirement is determined to be after the date that your active coverage ended, you are not eligible for reinstatement of health coverage.

If eligible for Medicare, you cannot continue coverage under the local group health government plan.

Coverage for Dependents in the Event of Your Death

Survivor insurance is a continuation of insurance that allows covered dependents to apply to continue enrollment in the event of your death. There is no provision to allow enrollment of your non-covered dependents after your death.

Group Health

Your surviving dependents will receive up to six months of extended health insurance coverage without charge. Dependents must be covered at the time of your death and continue to meet eligibility rules. The surviving dependent must apply to continue coverage within 60 days of the expiration of the six months of extended coverage or within 60 days of the notice of the termination of coverage, whichever is later.

The Tennessee Plan

Coverage under your policy will terminate at the end of the month in which you pass away. Your surviving dependents may continue coverage if they were enrolled in The Tennessee Plan at the time of your death. Surviving dependents must apply to continue coverage within 60 days of the end of coverage under your enrollment or within 60 days of the notice of the termination of coverage, whichever is later.

Dental and Vision Coverage

Your dependents may be eligible for continuation of dental and vision coverage through COBRA or the retirement program as outlined below.

Your surviving dependents covered under your dental and/or vision plan on the date of your death may continue their enrollment in the plan with one of the two options listed below. (Note: your dependents must continue enrollment in the retiree health plan to be able to continue retiree vision insurance.)

- If you are eligible for continuation of coverage as a retiree at time of death, your dependents may elect COBRA or RETIREE continuation of dental and/or vision elections in effect for them on the date of your death; or
- If you are not eligible for continuation of coverage as a retiree at time of your death, your dependents may elect COBRA continuation for dental and/or vision elections in effect for them on the date of your death.

All eligibility questions to continue coverage for surviving dependents on the state plans should be directed to Benefits Administration.

Premiums for Surviving Dependents

Premiums will be deducted from any continuing TCRS retirement benefits. Otherwise, individuals will be billed directly. Dependents acquired by the survivor(s) after your death are not eligible for coverage.

Premium Payment

TCRS Retiree

Premiums are deducted from your monthly TCRS pension benefit. If the premium is greater than your retirement benefit, you will be billed directly by Benefits Administration each month. If the premium is greater than your retirement benefit, you can also choose to pay by bank draft.

Non-TCRS Retiree

You will be billed directly by Benefits Administration each month or you can choose to pay by bank draft.

Direct Billing

If you send a check for your premium, it must be received by the last day of the month for the next month's coverage. For example, your January premium is due no later than December 31.

If you pay your premiums by automatic deduction (ACH) from your bank account, the premium is withdrawn for the current month on or after the 15th of the month. For example, your January premium will be withdrawn from your bank account on or after January 15.

Non-payment of Premiums

The plan permits a 30-day deferral of premium for premiums being billed directly instead of through payroll deductions. Coverage will be cancelled retroactively to the last month paid if premiums are not paid in full within 30 days of the due date. If your coverage is cancelled due to failure to pay premiums within 30 days of the due date, coverage will not be reinstated.

Claims

If continuing group health coverage, you will continue to use your current ID cards after you retire. You may receive a new card if changes are made. Questions regarding payment of claims should be directed to the insurance company. Questions about Medicare claims processing should be directed to Medicare.

AVAILABLE BENEFITS

This section provides a brief overview of the benefits available to you. For more detailed information, visit the Benefits Administration website or consult your member handbook.

Health Insurance

You have a choice of four health insurance options:

- Premier PPO
- Standard PPO
- Limited PPO
- Local CDHP/HSA

You also have a choice of three insurance carrier networks:

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

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

Dental Insurance

The state offers two dental options.

- Prepaid Dental Plan (Cigna Dental Care[®] Prepaid Plan) provides services at fixed copay amounts. A limited network of dentists and specialists must be used to receive benefits.
- Dental Preferred Provider Organization (MetLife DPPO) provides services with coinsurance. Any dentist may be used to receive benefits, but you will pay less if an in-network provider is used.

Prepaid Plan

- Must select and use a Network General Dentist (NGD) from the prepaid dental plan list for each covered family member — the network is a select number of dentists in Cigna Dental HMO (DHMO). You may select a network Pediatric Dentist as the NGD for your dependent child under age 13. At age 13, you must switch the child to a NGD or pay the full charge from the pediatric dentist. The list of providers for the state may be found by visiting the website, <https://www.cigna.com/sites/stateoftn/>.
- Copays for dental treatments, including adult and child orthodontia for up to 24 months
- An Office Visit Fee Copay applies per patient, per office visit, and is in addition to any other applicable patient charges
- No claim forms
- Preexisting conditions are covered if they are listed in the Patient Charge Schedule (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/dental_prepaid_charge_schedule_20.pdf), unless treatment starts before coverage begins
- Certain Limitations and Exclusions apply. Please refer to the Patient Charge Schedule and the Cigna Dental Certificate (<https://www.tn.gov/partnersforhealth/publications/publications.html>) for additional details
- 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 applies

- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna. The completion of crowns, bridges, dentures or root canal treatment already in progress on the member's effective date of coverage is also not covered.

DPPO Plan

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. The list of network providers in the MetLife DPPO network for the state may be found by visiting the website, metlife.com/StateOfTN.
- \$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
- Pre-treatment estimates are recommended for more expensive services
- Benefits for covered services are paid at the lesser of dentist charge, maximum allowable charge or Alternate Benefit Amount
- Some services require waiting periods of six months and up to one year, and certain limitations and exclusions apply
- Lifetime benefit maximum of \$1,250 for orthodontia

Vision Insurance

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
- Discount on hearing aids (includes Free Hearing Exam) through Your Hearing Network (YHN)

What you pay for services depends on the plan you choose. The Basic Plan pays for your eye exam and various "allowances" (dollar amounts) for materials. The Expanded Plan includes greater "allowances" (dollar amounts) and additional materials versus the Basic Plan.

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/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 “Fashion Selection” eyeglass frames from Davis Vision’s “The Exclusive Collection” under the in-network Basic Plan. “Designer” and “Premier” Selections have \$15 and \$40 copays respectively
- Free pair of eyeglass frames from any Davis Vision’s “The Exclusive Collection”, which includes “Fashion, Designer and Premier” Selections under the in-network Expanded 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

New Benefits Effective January 1, 2020

- High Index Lenses — 1.74
- Progressive Lenses — Ultimate Tier
- Anti-reflective Coating — Ultimate Tier
- Premium Scratch-resistant Coating
- Digital Single Vision Lenses
- Trivex Lenses
- Blue Light Filtering (Coatings & Lens Options)
- Scratch Protection Plan

Note: A complete description of the benefits, provisions, conditions, limitations and exclusions for the Davis Vision Basic and Expanded plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. The documents are available at <https://www.tn.gov/partnersforhealth/publications/publications.html>.

Employee Assistance Program

Your Employee Assistance Program (EAP) is administered by Optum. It is available to all retiree members enrolled in medical insurance and their benefits-eligible (not necessarily enrolled) dependents. Receive five EAP visits, per problem, per year at no cost to you. EAP sessions are issued and authorized on a per-problem-per-year-per-person basis. For example the member receives five EAP counseling sessions for each problem. Should a different unrelated problem arise within the same plan year, the member would receive an additional five sessions to address the new problem. A different problem is either: 1) a new issue for which the member has received no previous counseling or 2) an existing issue that has not been treated in that plan year. Examples of different problems (not an exhaustive list): relationship issues, job stress, parenting issues, caregiving of a loved one, and death of a loved one.

Prior authorization is required to see an EAP provider and can be obtained by either logging in to [Here4TN.com](https://www.here4tn.com) or calling 855-Here4TN (855-437-3486). Available in person or by virtual visit. Virtual visits allow you to get the care you need sooner, in the privacy of your own home.

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, services for your elderly parents, theater tickets, all- night pharmacies and so much more.

Retiree members have access to a telephonic coaching program called Take Charge at Work which helps people dealing with stress or depression at work. It’s available at no additional cost to all retirees no matter where you work, if you qualify and are working either full or part time .

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) or go to [HERE4TN.com](https://www.here4tn.com).

Here4TN Behavioral Health & Substance Use Services

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. New in 2020, all enrolled members will get an ID card from Optum to use for your behavioral health services.

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Optum can help you find a provider (in person or virtual visits), explain benefits, identify best treatment options, schedule appointments and answer your questions.

New this year, costs are waived for members who use certain preferred substance use treatment facilities. PPO members who use these facilities won't pay a deductible or coinsurance for facility-based substance use treatment. Local CDHP/HSA members' coinsurance is waived after meeting their deductible. However, copays for PPO members and the deductible/coinsurance for Local CDHP/HSA members will still apply for standard outpatient treatment services.

To receive maximum benefit coverage, participants must use an in-network provider. For assistance finding a network provider, call 855.HERE4TN (855.437.3486).

For virtual visits, you can meet with a provider through private, secure video conferencing. Virtual visits allow you to get the care you need sooner and in the privacy of your home. Virtual visit copays are the same as an office visit.

To get started, go to [Here4TN.com](https://www.here4tn.com), scroll down, select provider search, and filter results by virtual visits to find a provider licensed in Tennessee, or call 855.Here4TN (855.437.3486) for assistance.

Learn more about your behavioral health benefit by visiting [Here4TN.com](https://www.here4tn.com).

ParTNers for Health Wellness Program

In 2020, two wellness programs will be offered to enrolled local education retirees, spouses and adult dependents. Note: members must meet certain criteria to qualify for these programs:

Disease management: Is managed by ActiveHealth Management and available for members with chronic diseases that include asthma, diabetes, coronary artery disease (CAD), congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) to better manage your chronic condition. If you qualify for any of these programs, ActiveHealth will send you emails about the coaching support that's available to you. It is completely voluntary and won't cost you anything. You'll also have access to the web portal and mobile app where you can get access to your coaches, the health assessment and online resources.

Members also have access to the online health assessment with ActiveHealth. After members complete the health assessment, they may use the online educational resources, including health education and digital coaching on their website. For more information, go to <http://go.activehealth.com/wellnesstn>.

Diabetes Prevention Program

Health plan members also have access to a free Diabetes Prevention Program if you meet eligibility criteria. The program can help you prevent or delay type 2 diabetes. It's offered as part of your health insurance at no cost if you use an in-network provider. There are two online programs offered; one for Cigna members through Omada, and another for BlueCross BlueShield members through RetroFit. For details, go to tn.gov/PartnersForHealth under Other Benefits and Wellness and scroll down to the Diabetes Prevention Program (DPP) webpage.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program. Local education, local government and retirees enrolled in health coverage have access to certain programs like disease management and the web portal. 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 are not required to complete the assessment or other medical examinations.

The information from your health questionnaire 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 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) 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 promptly.

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.

OTHER INFORMATION

Coordination of Benefits

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

As a retiree, your health insurance coverage through your former employer is generally considered primary for you unless you have Medicare. Even then, your health plan may be primary for a period of time if you have Medicare due to end-stage renal disease. Should you have other coverage, the consideration of primary and secondary benefits can depend on factors such as whether you are the head of contract or a dependent in those plans and whether the plan is an employee or retiree plan. If you are the head of contract in more than one retiree plan, the oldest plan is considered your primary coverage. If your spouse has coverage through his/her employer, that coverage will generally 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.

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

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 workers' 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.

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 retirees and dependents are covered in detail in this guide.

If your covered dependent becomes ineligible, you must inform Benefits Administration and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he/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 Benefits

Administration. 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 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 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/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 have a problem with coverage or payment of medical, behavioral health and substance use or pharmacy services, there are internal and external procedures to help you. 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 member service numbers provided at the front of this guide. You can also find those numbers on your insurance cards. Benefits Administration is not involved in the appeal process. The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

Benefit Appeals

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

Different insurance carriers manage approvals and payments related to your medical, behavioral health, substance use and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you submit your request on time and direct it to the correct insurance carrier. For example, you or your authorized representative will have 180 days to start an internal appeal with the medical insurance carrier following notice of an adverse determination with regard to your medical benefits.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), you or your authorized representative should call the toll-free member service number on your insurance card. You or your authorized representative may file an appeal/member grievance by completing the correct 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.

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).

866 (800-848-0298) 1. مقرب لصتا . نإم لال دعواسم ل تامدخ نإف ، ذغ ل ل ركذا ثدحتت تنك انإ ؛ ذظوح ل م -0029-576- مقرب) 866-0298- : مكبال او مصل افتاه -

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 cho bạn. 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).

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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 નિ:શુલ્ક 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 दे: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 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).

مہارف 866-576-0029 (TTY: 1-800-848-0298) امش یارب ناگیار تروصب ی نابز تالی هست، دی نک یم وگتفگ ی سراف نابز هب رگا: هجوت دی ریگب سامت اب. دشاب یم.

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 <https://www.tn.gov/partnersforhealth.html>. 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) for the state-sponsored health plans. The summary describes your 2020 health coverage options. You can view it online at <https://www.tn.gov/partnersforhealth/summary-of-benefits-and-coverage.html> 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 <https://www.tn.gov/partnersforhealth/publications.html>.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at <https://www.tn.gov/partnersforhealth/publications.html>, including, but not limited to, brochures and handbooks for medical, pharmacy, dental and vision, the plan document, a brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).

TERMS AND DEFINITIONS

Acquire Date

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

Balance Billing

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

Claims

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

Coinsurance

Coinsurance is the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service.

Copay

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

Creditable Service

You earn creditable service when an agency that participates in the state group health plan contributes to your pension with TCRS for your service with the state of Tennessee or a participating local education or local government agency. Local government service cannot be combined with any other local government, local education or state service. Vested members may also establish credit in TCRS for up to four years of eligible military service. If this service did not interrupt your state employment, it cannot be counted for insurance eligibility purposes. At retirement, unused sick leave may be converted to retirement service credit. If you cashed out TCRS service and did not buy it back, you will not be able to count those years as creditable service for insurance purposes or as your first date of hire with the state or participating local education agency. Non-TCRS participants earn creditable service for insurance based on the years of service with the employer that participates in the state plan in which the employee qualified for insurance coverage.

Date of Retirement

For TCRS participants, your date of retirement is the effective date of your retirement pension.

Deductible

A fixed dollar amount you must pay each year before the plan pays for services that require coinsurance.

Drug List

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

Drug Tiers

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

Due to Age (Medicare Eligibility)

Due to age refers to the first of the month that a member turns age 65. If your birthday falls on the first day of the month, then you will be considered eligible due to age on the first of the prior month. You may also become Medicare eligible prior to age 65 due to disability.

Fully Insured Plan

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

Generic Drug (Tier One)

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

Group Health Plan

Group health plan refers to the healthcare options offered by the State Group Insurance Program. It does not include The Tennessee Plan, supplemental medical insurance for retirees with Medicare.

Guarantee Issue

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

Head of Contract

The head of contract is the retiree who worked for a participating employer group and enrolled in coverage. Two married retirees who both worked for participating employer groups could each be the head of their own contract or one could be the head of contract and the other a covered dependent spouse. A surviving spouse who continues coverage based on the eligibility through a deceased retiree also becomes a head of contract on the new enrollment.

Health Insurance Portability and Accountability Act (HIPAA)

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

In-Network Care

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

Maximum Allowable Charge (MAC)

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

Meeting Your Deductible

Meeting your deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays for services that require coinsurance.

Network

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

Non-Preferred Brand Drug (Tier Three)

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

Out-of-Network Care

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

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you will pay for services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services. A separate out-of-pocket maximum applies to in-network pharmacy in the standard and partnership options.

Preferred Brand Drug (Tier Two)

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

Preferred Provider Organization (PPO)

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

Premium

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

Preventive Care

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

Primary Care Physician

Primary care physician (also known as PCP) refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician's assistants and nurse midwives (licensed healthcare facility only) may also be considered primary type providers when working under the supervision of a primary care provider.

Self-Insured Plan

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

Special Enrollment Provision

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

Special Qualifying Event

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

The Plan

In the broadest sense of the word, plan is the applicable State of Tennessee Comprehensive Medical and Hospitalization Program. Plan may also refer to specific group plans within the larger comprehensive plan, such as the state plan, the local education plan or the local government plan.

Q&A

If I am Medicare eligible when I retire, can I continue to cover my spouse who is not yet Medicare eligible?

If you meet the criteria to continue group health coverage and are in paying status (if you are a TCRS participant), you may continue your spouse's group health coverage. If you do not continue spouse coverage immediately upon retirement, you cannot add them to coverage at a later date.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If I become eligible for Medicare prior to the age of 65, will my insurance be terminated? What about my dependents?

If you or your covered dependent becomes entitled to Medicare prior to the age of 65, coverage will be terminated for the pre-65 Medicare entitled member.

Is my spouse eligible for The Tennessee Plan?

If you are enrolled in The Tennessee Plan, you may apply to cover your Medicare-enrolled spouse. If you do not apply within 60 days of your spouse's initial eligibility, your spouse must apply as a late applicant and will be subject to approval.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If you do not receive a monthly TCRS benefit, you and your spouse are not eligible to apply for The Tennessee Plan.

If I do not continue group health coverage when I retire because I will have coverage through my spouse, can I apply for coverage later?

If you met the minimum criteria to continue group health coverage when you retired, you may apply for the state's group health plan through a special enrollment provision if you lose other creditable health coverage. You must still meet the plan eligibility rules.

Can I change my health insurance option or carrier when I continue coverage at retirement?

You must continue with the same health insurance option you were enrolled in immediately prior to retirement.

VISION COVERAGE

If I am over age 65 and enrolled in the state's The Tennessee Plan, am I eligible to enroll in the retiree vision plan?

No. You must be covered by the retiree group health plan to enroll in the retiree vision plan. If you were covered by the vision plan as an active employee, you should receive a COBRA notification and may apply to continue the vision coverage through COBRA. Premiums for COBRA vision will be billed directly to you.

If I continue coverage in the retiree group health plan for my spouse only, can my spouse enroll in the retiree vision plan?

If you receive a monthly TCRS pension and your spouse is covered under the retiree group health plan, you may apply for spouse-only coverage in the retiree vision plan.

If I continue coverage in the retiree group health plan for myself only, can my spouse and I both enroll in the retiree vision plan?

No. If your spouse is not enrolled in the health plan, you cannot enroll him or her in vision.

DENTAL COVERAGE

How do I know if I am eligible for retiree dental benefits?

To qualify for retiree dental coverage, you must receive a monthly retirement check from TCRS.

How do I know if my dependents are eligible for dental benefits?

If you are eligible for retiree dental coverage, your dependents are also eligible. You must provide documentation to verify your dependents' eligibility before they can be enrolled in coverage.

How do I find out which dentists are considered in network?

To find up-to-date network information, call the dental carrier directly or do an online search on the carriers' website.

How will the state deduct my dental premiums?

Premiums will be deducted from your TCRS check each month. If there is not enough money in your TCRS check, the state will send a bill to your home.

If I live out of state, can I still enroll in dental coverage?

As long as you receive a monthly TCRS pension benefit you can enroll in coverage. If you select the prepaid plan you must still select and use a network dentist.

What if I recently retired and now have COBRA dental coverage?

If you had dental coverage when you stopped working, then you can often keep this coverage at the COBRA premium. This coverage lasts for 18 months. If you meet the eligibility criteria, you can enroll in retiree dental coverage when your COBRA coverage expires. You will need to contact Benefits Administration 60 days prior to the expiration of your COBRA coverage to request an application. You must indicate the requested future effective date when you submit your application.

Can I cancel retiree dental coverage if I change my mind?

You may only cancel coverage during the fall enrollment period unless you have a qualifying event. Requests to cancel coverage due to a family status change must be submitted within 60 days of the qualifying event. Supporting documents must be provided. The insurance cancel request application provides information about qualifying events. It is available on the forms section of the Benefits Administration website at <https://www.tn.gov/partnersforhealth/publications/forms.html>.

Who do I call if I have questions about my dental benefit?

For information on covered services, please contact the dental carriers directly.