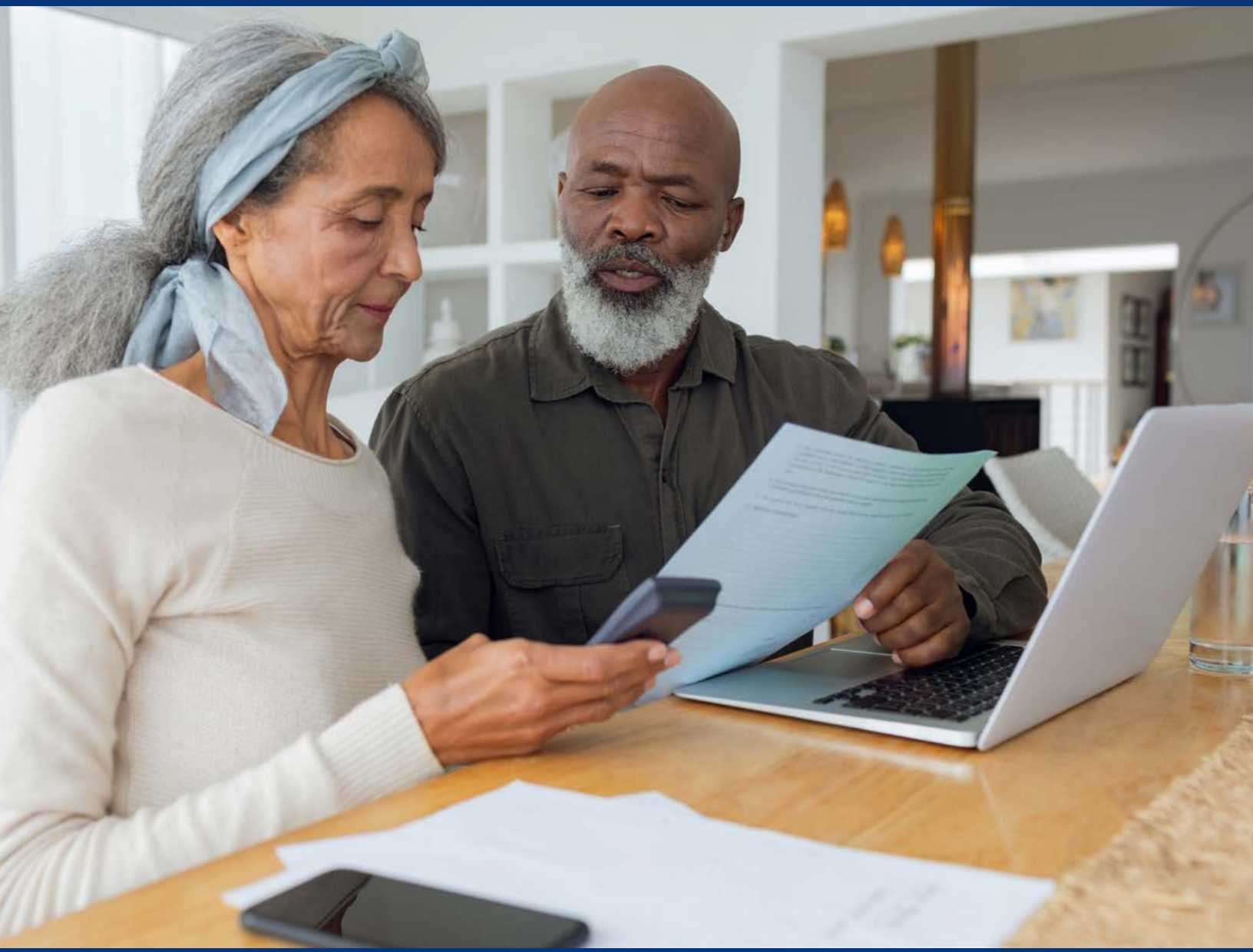
Continuing Insurance at Retirement

State Group Insurance Program
LOCAL GOVERNMENT



PARTNERS FOR HEALTH

January 2024

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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.

If you are Medicare eligible, you are not eligible to continue your group health plan coverage or apply to cover your dependents on the state group health plan. The Tennessee Plan section in this guide explains the state's supplemental medical insurance for retirees with Medicare.

Overview

This guide explains the insurance options available to you at retirement and the rules for each type of coverage. **There are two eligibility and enrollment sections. It is important that you refer to the section that applies to you.** If you are a Tennessee Consolidated Retirement System participant, see the requirements on page two. If you are a non-TCRS participant, see page four.

For More Information

Your agency benefits coordinator is your primary contact. He or 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 website www.tn.gov/partnersforhealth. You can also get copies by calling our office at 615-741-3590 or 800-253-9981 or emailing retirement.insurance@tn.gov. You need to include your Edison ID (found on your Caremark card), date of birth and your address in your email. If you do not have your Edison ID then please include the last four digits of your Social Security number.

If you have questions about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care 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.

ELIGIBILITY AND ENROLLMENT

TCRS Participants

Continuing Group Health Coverage

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

To continue health insurance benefits, the agency from which you retire must continue to participate in the state plan. If your former agency leaves the State Group Insurance Program, your coverage on the state retiree group health plan will be cancelled.

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 insurance at retirement.

If your spouse is also an employee enrolled in state group health insurance, you may continue coverage as a dependent on their 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.

The eligibility guidelines for continuing health insurance are:

- Ten years (120 months) 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.
- Twenty years (240 months) 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.
- 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. This requirement for immediate commencement of 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.

Creditable Service:
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 an agency participating in the state or local education plans or service with another local government agency cannot be counted.

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. If enrollment is approved, you will continue in the same health insurance option in which you are currently enrolled.

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 your initial date of employment with a qualifying employer is prior to July 1, 2015, you may be eligible to apply for the state's Supplemental Medical Insurance for Retirees with Medicare program called The Tennessee Plan.

Application for The Tennessee Plan Coverage

The Tennessee Plan is a supplemental medical insurance program designed to cover certain expenses not fully paid by your Medicare parts A and B coverage. 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.

If you are enrolled in at least Medicare Part A and receive a monthly TCRS pension benefit at retirement, you can select The Tennessee Plan coverage on the Application to Continue Insurance at Retirement. You may also apply to cover your dependents who are eligible for Medicare when you enroll in The Tennessee Plan. You have 60 days from the initial eligibility date to enroll. 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.

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 the date of retirement is the later date and falls on the first of the month, your coverage may be effective on that date.

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. If you are enrolled in a state-sponsored dental plan, you have two options for continuing coverage:

COBRA Dental
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. Retiree vision coverage is only available to retirees and dependents enrolled in one of the state-sponsored health insurance programs. If you are enrolled in the state-sponsored vision plan, you have two options for continuing coverage:

COBRA Vision
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 and receive a monthly pension from TCRS based on your own service, 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 enrolled in retiree group health coverage. Dependent-only vision coverage is available when you are no longer enrolled on the retiree group health plan, provided they remain eligible dependents covered on the retiree group health plan.

ELIGIBILITY AND ENROLLMENT

Non-TCRS Participants

Continuing Group Health Coverage

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

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

If your spouse is an employee enrolled in state group health insurance, you may continue coverage as a dependent on their 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.

The eligibility guidelines are:

- Ten years (120 months) 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.
- Twenty years (240 months) 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.
- 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 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.

Creditable Service:
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 an agency participating in the state or local education plans or service with another local government agency cannot be counted.

Application to Continue Group Health Coverage

You must submit an Application to Continue Insurance at Retirement to your ABC within one full calendar month of the end of active insurance. If enrollment is approved, you will continue in the same health insurance option in which you are currently enrolled.

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, you are no longer eligible for the group health plan and are not eligible to apply to cover your dependents on the group health plan. The state's supplemental medical insurance for retirees with Medicare program, called The Tennessee Plan, is not available to you if you are a non-TCRS local government member.

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 a 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 PLAN MEMBERS

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 state 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 government health plan.

Dependent Coverage

You may continue coverage for eligible dependents if they are covered at your retirement. If you want to cover newly acquired dependents, they must be added within 30 days. If you are no longer eligible for the group health plan you cannot add dependents to your coverage.

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, custodian or conservator

All eligible dependents must be listed by name on the application to Continue Insurance at Retirement in part seven (www.tn.gov/content/dam/tn/partnersforhealth/documents/2023_forms/1045_2023.pdf). You are also required to provide a valid Social Security number for a dependent (if they are eligible for one). Other required information includes date of birth, relationship and gender.

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 usually eligible for coverage through the last day of the month of their 26th birthday. Orders for guardianship, custody or conservatorship may expire at an earlier age. If you have a dependent who is not your child, but is placed with you by a placement order, coverage will be terminated when the order expires unless additional eligibility requirements are met.

Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency who are placed with the head of contract for temporary or long-term foster care
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

Children who are mentally or physically incapacitated and not able to earn a living may continue health, dental and vision coverage beyond age 26 if they were incapacitated before their 26th birthday and they were enrolled in the State Group Insurance Program prior to and on their 26th birthday.

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. Benefits Administration will determine if all plan requirements have been met by confirming if the insurance carrier's review of submitted documentation establishes incapacity and participating in annual reviews as required to confirm continued incapacity. Coverage will end and will not be restored once the child is no longer incapacitated or if other plan requirements are not satisfied. Following termination, the child will not be enrolled again as an incapacitated dependent.

Adding New Dependents

To add new dependents to your coverage, submit a retiree insurance change application within 30 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 (www.tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf). Premium changes start on the first day of the month in which a child is added due to birth, adoption or placement for adoption. Premium changes when adding a new spouse and/or a new stepchild, or a child pursuant to an order of guardianship will start the first day of the first calendar month after Benefits Administration receives the request for special enrollment. A child named under a qualified medical support order must be added within 40 days of the court order.

If adding dependents due to the birth, adoption or placement for adoption 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 30 days after the acquire date, see sections on Annual Enrollment period and special enrollment provisions in 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 Jan. 1. Coverage will remain in effect through Dec. 31 subject to eligibility.

Canceling Health, Vision and Dental Coverage

You may only cancel coverage outside of the annual enrollment period for yourself and/or your dependents, if:

- You lose eligibility for the State Group Insurance Program, or
- You experience an event that results in you/your dependents becoming newly eligible for coverage under another plan, or
- You are enrolled in the Dental Health Maintenance Organization-Prepaid Provider plan and there is not a participating general dentist within a 25-mile radius of your home address

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 canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for a child generally ends on the last day of the month in which the child reaches age 26, unless otherwise stated in the plan.

You have 60 days from the date that you and/or your dependents become newly eligible for other coverage to turn in an insurance cancel request application and proof to Benefits Administration. This application is available in the forms section of the Benefits Administration website under retirement (www.tn.gov/content/dam/tn/partnersforhealth/documents/2023_forms/1048_2023.pdf). Cancellation reasons and the required documentation are shown on the application.

Divorce —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 36-4-106 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.

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

If you or a dependent lose eligibility for coverage under any other group health insurance plan, or if you acquire a new dependent during the plan year, you may have additional opportunities to enroll in health coverage.

Enrollment opportunities for voluntary programs like dental and vision are available to you and your dependents if you meet the requirements stated in the certificates of coverage for those programs. Certificates of coverage can be found at www.tn.gov/PartnersForHealth under Publications.

NOTE: Application for special enrollment (www.tn.gov/content/dam/tn/partnersforhealth/documents/2023_forms/1044_2023.pdf) must be made:

- within 60 days of the loss of eligibility for other health insurance coverage; or
- within 30 days of a new dependent's acquire date.

You must also submit proof as listed on the enrollment application.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except in the event of a birth, adoption or placement for adoption**. For all other events, the earliest effective date allowed for health coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Note: Effective dates for voluntary dental and vision are specified in the certificates of coverage for those programs. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date.

You can find events that afford special enrollment opportunities, the effective dates for coverage and the documentation you will need to provide on page 3 of the 1044 application.

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.

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
Coverage under your policy will terminate at the end of the month in which you pass away. 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 the time of your 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 the 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.

The surviving spouse should contact BA to confirm eligibility. Application must be made 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.

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 Dec. 31.

If you pay your premiums by automatic deduction 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 Jan. 15.

Non-payment of Premiums
The plan permits a period of one full calendar month 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 one full calendar month of the due date. If your coverage is cancelled due to failure to pay premiums you may request a one-time-only exception for reinstatement within 30 days of being notified that coverage was canceled.

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 at www.tn.gov/partnersforhealth, or consult your member materials.

Health Insurance

You have a choice of four health insurance options with either BlueCross BlueShield of Tennessee or Cigna. Each carrier offers two networks. Your choices determine how much your monthly premium will cost. You can see any doctor you want, but your cost is higher if you use out-of-network providers. There is no guarantee that providers and hospitals in a network when you enroll will stay in that network. A provider or hospital leaving a network is not a qualifying event and does not allow you to make changes. Visit www.tn.gov/partnersforhealth/health-options/health for more information.

Pharmacy and Behavioral Health Benefits

All health plan members and enrolled dependents have access to pharmacy benefits and behavioral health and substance use disorder services.

- For information on pharmacy benefits, visit www.tn.gov/partnersforhealth/health-options/pharmacy.
- For all behavioral health programs and services, and to find a provider, contact Optum at 855-Here4TN (855.437.3486), 24/7, or Here4TN.com.

Emotional Wellbeing Solutions

Emotional Wellbeing Solutions is a service available to you if you are enrolled in health coverage. Services are also available to your eligible dependents even if they are not enrolled in a health plan. Information is at tn.gov/PartnersForHealth under Other Benefits and Emotional Wellbeing Solutions. For all programs and services, and to find a provider, contact Optum at 855-Here4TN (855.437.3486), 24/7, or Here4TN.com.

Dental Insurance

The state offers two dental options, the Cigna Dental Health Maintenance Organization Prepaid Provider which requires use of a network general dentist and the Delta Dental Preferred Provider Organization which allows you to use any dentist. You pay the full monthly premium. Dental coverage is offered to you if are an eligible retiree receiving a monthly pension from TCRS based on your own service. Visit www.tn.gov/partnersforhealth/other-benefits/dental for more information.

Vision Insurance

Voluntary vision coverage through EyeMed is available to local government TCRS retirees and dependents who are enrolled on the state group health plan. You must pay 100% of the premium for coverage. A basic and an expanded plan are available. Visit www.tn.gov/partnersforhealth/other-benefits/vision for more information.

Wellness Program

To help you achieve your health goals, the 2024 wellness program is offered to enrolled retirees and adult dependents who qualify.

Sharecare is the wellness program vendor for 2024. Members enrolled in health benefits will have access to lifestyle counseling, chronic condition management, a weight management program, digital health devices and biometric screenings. A diabetes remission and Diabetes Prevention Program will also be offered to members who qualify.

Information about programs and activities are at www.tn.gov/partnersforhealth/other-benefits/wellness-program.

Notice Regarding Wellness Program

The Partners for Health Wellness Program is a voluntary wellness program. Local education and local government employees 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 the 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 health care 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, health benefits will be coordinated for reimbursement. At no time should the combined reimbursement of all plans and your member cost share exceed 100% of charges. When this plan pays secondary, you will be responsible for your member cost share.

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:

- As a retiree, your health insurance coverage through your former employer is generally considered primary for you unless you have Medicare.
- Your health plan may be primary for a period of time if you have Medicare due to end-stage renal disease.
- 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 or 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.

Coordination of dental benefits should be reviewed in each program's certificate of coverage. Vision benefits do not coordinate with other plans.

Subrogation

The medical plan and The Tennessee Plan have the right to subrogate claims. This means that the medical plan and The Tennessee 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, they 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 health care. 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. Please

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

How You Can Help

- Pay close attention to the explanation of benefits forms sent to you when a claim is filed under your contract and always call the carrier to question any charge that you do not understand
- Report anyone who permits a relative or friend to "borrow" his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who makes false claims or alters amounts charged on claim forms

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 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 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and 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, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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 OR U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 OR Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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).

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

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

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

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

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

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

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር 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).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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 866-576-0029 (TTY:1-800-848-0298) まで、お電話にてご連絡くい。

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 है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करे।ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848- 0298).

زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان فراهم می باشد. با تماس تلفنی به شماره 1-800-848-0298) (TTY: 866-576-0029 برای شما بگیرید

The Notice of Privacy Practices

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. 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, 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 Practices is located on the Benefits Administration website at www.tn.gov/partnersforhealth. 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 for the state- sponsored health plans. The summary describes your health coverage options. You can view it online at www.tn.gov/partnersforhealth/summary-of-benefits-and-coverage 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 www.tn.gov/partnersforhealth/publications.

Other Publications
In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at www.tn.gov/partnersforhealth/publications, including, but not limited to, a sample basic term life/basic AD&D certificate, sample voluntary AD&D certificate, brochures and handbooks for medical, pharmacy, dental, vision, life insurance and the plan document, brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).

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 your 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 your spouse 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 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 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 will 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 carrier's 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?
Yes. If you select the DHMO 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 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 www.tn.gov/partnersforhealth/publications/forms.

Who do I call if I have questions about my dental benefit?
For information on covered services, please contact the dental carriers directly.

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	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	Optum Financial	866.600.4984 — 24/7	optumbank.com/Tennessee
Pharmacy Benefits	CVS Caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Use and Emotional Wellbeing Solutions	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	Sharecare	888.741.3390 — M-F, 8-8 CT	sharecare.com/tnwellness/
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	Delta Dental	800-552-2498 — M-F, 7-5	tennessee.deltadental.com/stateoftn/
Vision Insurance	EyeMed	855.779.5046 Mon.-Sat., 7 a.m. – 10 p.m. CT, Sun. 10 a.m. – 7 p.m. CT. Retiree Basic Code: 1038916 Retiree Expanded Code: 1038919 COBRA Basic Code: 1038917 COBRA Expanded Code: 1038920	eyemed.com/stateoftn
The Tennessee Plan	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 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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