PARTNERS FOR HEALTH

State of Tennessee
Group Insurance Program

New Employee Benefits Orientation

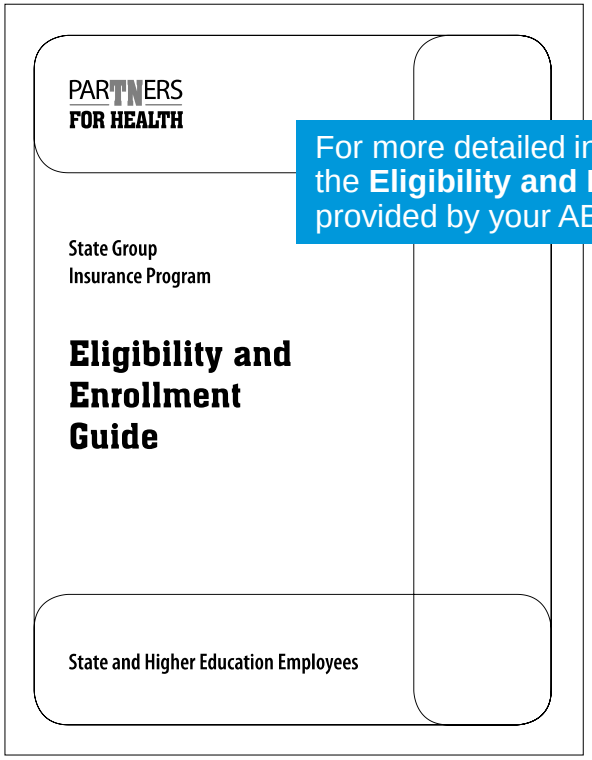
Local Education and Local Government Employees

January 1 – December 31, 2017

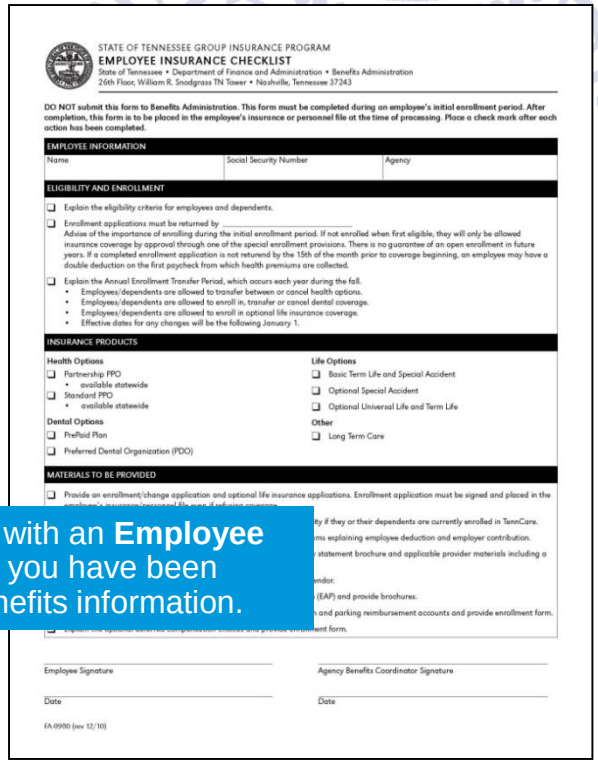
Importance of Your Decisions

- The decisions you make **now** as a new employee will have lasting effects on your benefits
- **Please note:** Some decisions can only be made during the new hire period or the next Annual Enrollment period
- Be aware of all the options available to you and make an informed decision
- Submit questions to your Agency Benefits Coordinator (ABC)

Resource Materials



For more detailed information, refer to the **Eligibility and Enrollment Guide** provided by your ABC.



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

EMPLOYEE INSURANCE CHECKLIST

State of Tennessee • Department of Finance and Administration • Benefits Administration
26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243

DO NOT submit this form to Benefits Administration. This form must be completed during an employee's initial enrollment period. After completion, this form is to be placed in the employee's insurance or personnel file at the time of processing. Place a check mark after each action has been completed.

EMPLOYEE INFORMATION

Name | Social Security Number | Agency

ELIGIBILITY AND ENROLLMENT

- ☐ Explain the eligibility criteria for employees and dependents.
- ☐ Enrollment applications must be returned by _____
  Advise of the importance of enrolling during the initial enrollment period. If not enrolled when first eligible, they will only be allowed insurance coverage by approval through one of the special enrollment provisions. There is no guarantee of an open enrollment in future years. If a completed enrollment application is not returned by the 15th of the month prior to coverage beginning, an employee may have a double deduction on the first paycheck from which health premiums are collected.
- ☐ Explain the Annual Enrollment Transfer Period, which occurs each year during the fall.
  - Employees/dependents are allowed to transfer between or cancel health options.
  - Employees/dependents are allowed to enroll in, transfer or cancel dental coverage.
  - Employees/dependents are allowed to enroll in optional life insurance coverage.
  - Effective dates for any changes will be the following January 1.

INSURANCE PRODUCTS

Health Options
- ☐ Partnership PPO
  - available statewide
- ☐ Standard PPO
  - available statewide

Dental Options
- ☐ PrePaid Plan
- ☐ Preferred Dental Organization (PDO)

Life Options
- ☐ Basic Term Life and Special Accident
- ☐ Optional Special Accident
- ☐ Optional Universal Life and Term Life

Other
- ☐ Long Term Care

MATERIALS TO BE PROVIDED

- ☐ Provide an enrollment/change application and optional life insurance applications. Enrollment application must be signed and placed in the

Employee Signature | Agency Benefits Coordinator Signature

Date | Date

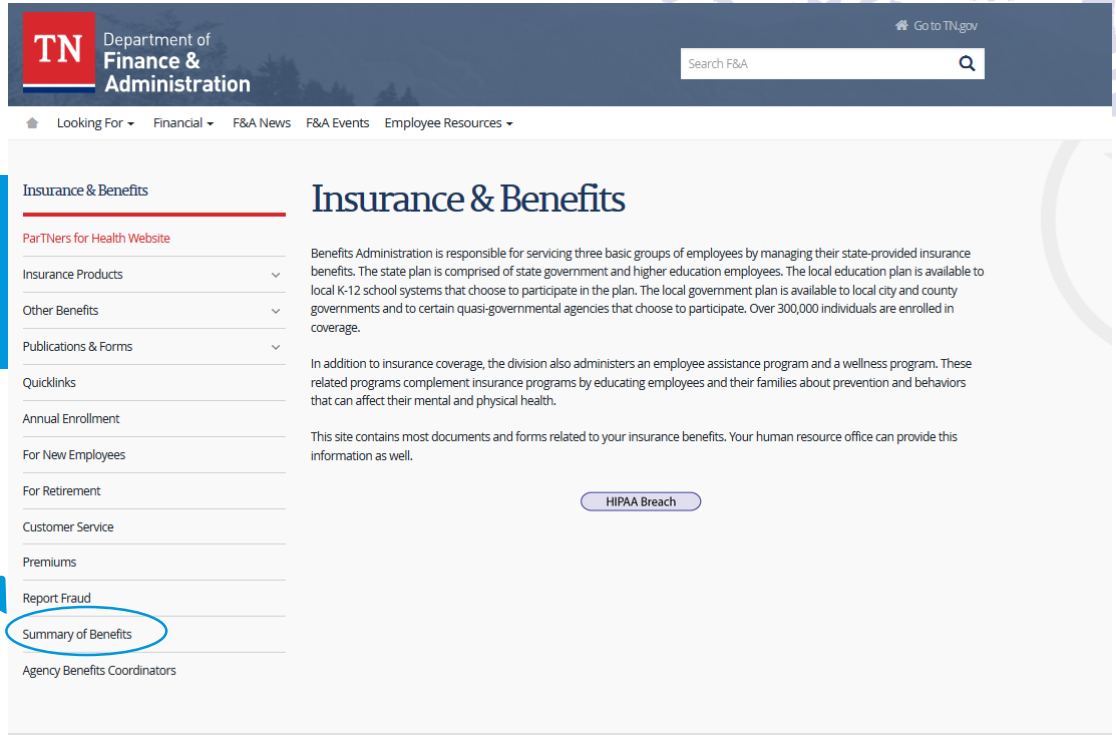
FA-0980 (rev 12/10)

You will also be provided with an **Employee Checklist** to confirm that you have been informed of important benefits information.

Resource Materials

tn.gov/finance/section/fa-benefits

The Summary of Benefits Coverage (SBC) describes your health coverage options. You can print a copy on the Benefits Administration website, or ask your ABC for a copy.



About the Plan

- The State Group Insurance Program (the Plan) covers:
  - State and Higher Education Employees
  - Local Education Employees
  - Local Government Employees
- We spend about $1.3 billion annually and cover nearly 300,000 members
- The health plan is **self-insured.** The State, not an insurance company, pays claims from premiums collected from members and their employers
- The Division of Benefits Administration manages the Plan.

Who is Eligible for Coverage?

- Full-time employees and their dependents, who may include:
- Legally married spouses
- Children up to age 26, (natural, adopted, step-children or children for whom the employee is the legal guardian)
  - Special circumstances for disabled dependents may allow for coverage after age 26. Refer to your Eligibility and Enrollment Guide or consult your ABC for more information.
- Employees cannot be enrolled in TennCare **and** a State Group Health Insurance Plan
  - Contact your caseworker at TennCare within 10 days of your date of employment to report your new job, salary and that you have access to medical insurance with your new employer

Adding Coverage

Three times you may add health coverage:

1. As a new employee
2. Annual Enrollment in the fall
3. If you experience a special qualifying event
   - A special qualifying event could be marriage, birth of a baby or something that results in loss of other coverage
   - Submit the enrollment within 60 days of the event or loss of other coverage
   - A complete list is provided on page three of the enrollment application

Annual Enrollment

- During Annual Enrollment you may:
  - Enroll in or cancel health insurance for yourself or your eligible dependents
  - Change your health insurance option
  - Choose your health insurance network
  - Enroll in, cancel or transfer between dental options (if offered by your agency)
  - Enroll in, cancel or transfer between vision coverage (if offered by your agency)
- Changes are effective January 1 of the following year

Annual Enrollment occurs during the fall

Canceling Coverage

- You may only cancel health, dental or vision coverage for yourself or your dependents:
  1. During Annual Enrollment
  2. If you become ineligible to continue coverage
  3. If you and/or your dependents become newly eligible for coverage under another plan due to an event like marriage, divorce, birth or adoption of a child.

Definitions

- **Premiums** - amount you pay each month for your coverage regardless of whether or not you receive health services
- **Copay** - flat amount you pay for services and products (office visits, prescriptions etc.)
- **Deductible** - set amount you must pay each year for services
- **Coinsurance** - percentage of cost for a service after you meet deductible
- **CDHP** – Consumer – driven health plan is a type of medical insurance plan typically with a higher deductible and lower premium
- **PPO** – Preferred Provider Organization also a type of medical insurance plan that gives members direct access to a network of doctors and facilities

Definitions

- **Out-of-pocket maximum** - limit on amount you pay each year in deductibles, co-insurance and copays
- **Network** - group of doctors, hospitals and other providers contracted with a health insurance plan to provide services to members at pre-negotiated (usually discounted) fees
- **Maximum allowable charge (MAC) -** the most a plan will pay for a service

For a complete list of definitions, see the Eligibility and Enrollment Guide or visit our website.

Health Benefits

Your Enrollment Decision Steps

- Partnership PPO
- Standard PPO
- Limited PPO
- Local HealthSavings CDHP

Plan

Coverage Type

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

- BCBST Network S
- Cigna LocalPlus
- Cigna Open Access Plus (OAP)

Network

Member Choice

- Plan
- Coverage Type
- Network
- Voluntary Benefits

After your new hire period, changes can only be made if you experience a special qualifying event or during Annual Enrollment in the fall.

Health Insurance Options

First, you'll choose your health insurance option:

- **Partnership PPO - <u>Two options give you the same benefits</u>, but the cost is different:**
  - **Partnership Promise PPO** – Agree to the 2017 Partnership Promise, and you will save money! Your premiums will be $50 or $100 dollars **less** than the No Partnership Promise PPO each month.
  - **No Partnership Promise PPO** – This option does not include the Partnership Promise. Your premiums will be $50 to $100 **more** than the Partnership Promise PPO each month.
- **Limited PPO –** This option does not include the Partnership Promise and cost sharing (copays, coinsurance, etc.) is higher than the Partnership PPO options.
- **Standard PPO** – This option does not include the Partnership Promise and cost sharing (copays, coinsurance, etc.) is higher than the Partnership PPO options.
- **Local HealthSavings CDHP** - This option does not include the Partnership Promise and you will pay coinsurance instead of copays for services.

Health Insurance Options

- **All health options cover the same services and treatments:**
  - But medical necessity decisions can vary by carrier (BCBS or Cigna)
- **In-network preventive care at no cost**
  - Flu shots, annual exams, screenings
- **All health options include:**
  - Medical, behavioral health and pharmacy benefits
  - Fixed copays or coinsurance for some services depending on plan
  - Out-of-pocket maximums to limit costs
  - Access to the wellness program

Carriers may offer discounts for services not covered. Refer to the carrier's member handbooks or websites for more information.

Health Insurance Networks

Next, you would choose your health insurance network

- **BlueCross BlueShield of Tennessee Network S**
- **Cigna LocalPlus**
- **Cigna Open Access Plus (OAP)** – this is a **large network, includes Baptist Memphis and will cost you more each month.**
  - A surcharge applies:
    - $40 more employee/employee+children coverage each month
    - $80 more for employee+spouse/employee+spouse+children coverage each month

Voluntary Benefits

Then, you choose your voluntary benefits

- Dental (if offered by your agency)
- Vision (if offered by your agency)
- Long-term care (if offered by your agency, not available in Edison)

Health Benefits

Local HealthSavings CDHP (Consumer-driven health plan)

CDHPs:

- Lower monthly premium - but a higher deductible
- Can help you save money
- Includes a tax-free health savings account (HSA), which you own
- Can be used to pay for qualified medical, behavioral health, dental and vision expenses
- Employees can make pre-tax payroll deduction contributions (if offered by your employer) or post-tax contributions into the HSA and take an above-the-line tax credit when filing your taxes.

Health Benefits

How does a CDHP work?

- You pay for services up to your deductible before the plan starts paying for anything — but you can use the money in your HSA to pay for your deductible and qualified medical costs

- After meeting the deductible, you pay coinsurance (a set percentage of the discounted network cost) instead of copays (a set amount), until your reach your out-of-pocket maximum

Health Benefits

Local HealthSavings CDHP Pharmacy Benefits

1. You pay the full negotiated cost of prescription drugs up to annual deductible
2. Then you pay coinsurance until the annual out-of-pocket maximum is reached
3. Plan covers 100% of in-network costs after you reach the out-of-pocket maximum

For 90-day chronic maintenance drugs (e.g., hypertension, high cholesterol, etc.) you pay coinsurance only – don't have to meet the deductible first when filled through mail order or a Retail-90 network pharmacy.

Important Note:
Members pay medications at the time of purchase. Even at the negotiated or discounted rate, some drugs can be expensive, particularly specialty drugs, so CDHP members may need to know costs and plan for those costs until the deductible is met

Health Benefits

CDHP Enrollment Restrictions

- You cannot enroll in a HealthSavings CDHP if you are enrolled in another plan, including the PPO, your spouse's plan or any government plan (e.g., Medicare A and/or B, Medicaid, or Social Security benefits). Also, if your spouse has a FSA or HRA you cannot contribute to a HSA.

- If you are eligible for VA, Tricare or Indian Health Service (IHS) medical benefits and did not get benefits during the past three months, you can enroll in and put money in your HSA. If you get VA benefits in the future, then you CANNOT put money in your account for another three months. However, if your veteran's hospital care or medical service was for a service-connected disability, you may contribute to your HSA. Veterans are responsible for determining their eligibility.

- **Other restrictions may apply. Go to IRS.gov to learn more.**

Health Benefits

HSA Benefits:

- Money in your HSA rolls over each year – you keep it when you leave or retire
- Your HSA earns interest
- You can invest your HSA money (when HSA is over $1,000)
- HSA offers tax advantages on money in your account:
  - 1. Both employer and employee contributions are tax free
  - 2. Withdrawals for qualified medical expenses are tax free
- You can use your HSA card to pay for your qualified medical expenses (from payroll deductions and other contributions) and your deductible
- Qualified expenses such as hearing aids, contact lenses, acupuncture, etc., that may not be covered by your plan
- HSA can also serve as a retirement savings account. Money in the account can be used tax free for health costs when you retire. And, when you turn 65, it can be used for non-medical expenses. Non-medical expenses are taxed prior to age 65
- You should keep all receipts and EOBs (explanation of benefits) used to pay funds from your HSA for tax purposes

Health Benefits

How does the Health Savings Account (HSA) work?

- Once you enroll in a CDHP, a HSA is set up for you. You can put money in your HSA by taking money from your paycheck and/or putting money directly into your account. There is a maximum amount you can contribute each year.

What is the maximum I contribute to a HSA each year?

- In 2017, IRS guidelines allow total annual tax-free contributions up to $3,400 for individuals and $6,750 for families.
- At age 55 and older, you can make an additional $1,000/year contribution ($4,400 for individuals or $7,750 for families).
- The maximum includes any employer contribution.

Health Benefits

HSA vs. FSA

- If you enroll in a HealthSavings CDHP, you cannot use a flexible spending account (FSA) for medical costs. You can enroll in a limited purpose FSA (LPFSA) to use for dental and vision costs (if a LPFSA is offered by your employer).
  - Remember, HSA dollars are not “use-it-or-lose-it” like an FSA, so you may put the maximum amount allowed in your HSA without fear of losing those dollars.

Health Benefits

Health Savings Account

- After you enroll in a HealthSavings CDHP, you will need to activate your account with PayFlex
    - **You will register and access your PayFlex HSA online at stateoftn.payflexdirect.com**
- PayFlex will send you information about the account after you enroll
- Go to their website for a Quick Reference guide and other information
- PayFlex will send you a debit card to pay for your eligible expenses
    - Convenient way to pay for eligible expenses
    - Expenses are paid automatically, as long as funds are available
    - Keep your receipts for audit purposes

Health Benefits

Health Savings Account

Pay yourself back

- Pay for your eligible medical expenses with cash, check or personal credit card
- Then withdraw funds for your HSA to pay yourself back
- Can have your payment deposited directly into your checking or savings account

- **Pay your provider**
  - Use PayFlex's online feature to pay your provider directly from your account

- **Contribute post-tax dollars** from your checking or savings account online

  - **Account fees:** The state will pay the monthly maintenance fee for your HSA as long as you are enrolled in a HealthSavings CDHP. You are responsible for standard banking fees. However, if you leave your job, retire or choose a PPO option in the future, you will be responsible for paying any applicable HSA fees.

Pharmacy Benefits

CVS/caremark is the Pharmacy Benefits Manager

- All state health insurance plans include pharmacy benefits
- Covered drug list is the same in each plan, but costs differ from plan to plan
- More than 67,000 independent and chain pharmacies throughout the U.S.

- For each plan, how much you pay depends on the prescription tier:
  - Lowest cost: Tier one/generic drug
  - Higher cost: Tier two/preferred brand drug
  - Highest cost: Tier three/non-preferred brand
  - **New specialty pharmacy tier**

Tobacco Cessation: The state's prescription drug coverage provides free tobacco quit aids to members who want to stop using tobacco products.

Prescription Drug Copays

	Partnership PPO (promise and no promise)		Standard PPO		Limited PPO		Local HealthSavings CDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
30-Day Supply (only from pharmacies in the 30-day network)	$7 copay generic $40 copay preferred brand $90 copay non-preferred brand	Copay, plus any amount exceeding MAC	$14 copay for generic $50 copay for preferred brand $100 copay for non-preferred brand		$14 copay generic $60 copay preferred brand $110 copay non-preferred brand	Copay, plus any amount exceeding MAC	After deductible is met - 30% coinsurance	After deductible is met - 50% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 copay generic $80 copay preferred brand $180 copay non-preferred brand	N/A – no network	$28 copay for generic $100 copay for preferred brand $200 copay for non-preferred brand	N/A – no network	$28 copay generic $120 copay preferred brand $220 copay non-preferred brand	N/A – no network	After deductible is met - 30% coinsurance	N/A – no network
90-Day Supply (certain maintenance medications from 90-day pharmacy or mail order)	$7 copay generic $40 copay preferred brand $160 copay non-preferred brand	N/A – no network	$14 copay generic $50 copay preferred brand $180 copay non-preferred brand	N/A – no network	$14 copay generic $60 copay preferred brand $200 copay non-preferred brand	N/A – no network	20% coinsurance without first having to meet deductible	N/A – no network
Specialty Tier (coinsurance)	10% (min $50; max $150)	N/A – no network	10% (min $50; max $150)		10% (min $50; max $150)	N/A – no network	30% after deductible	N/A – no network

Pharmacy Benefits

Copay Installment Program for Maintenance Medications

- You can spread the cost of your **90-day mail order prescriptions** over a three-month period – at no additional cost to you
- Enroll online or by calling CVS/caremark customer care:
  - 877.522.8679
  - Info.caremark.com/stateoftn > register and log in
- Does not apply to specialty medications

2017 Partnership Promise

Take Action – Save Money – Improve Health

- The goal of the Partnership Promise is to help you get and stay healthy. If you agree to the 2017 Partnership Promise, you are not only taking steps toward better health, you can save money on premiums.
- If you choose the Partnership Promise PPO, **you will pay $50 to $100 less** in monthly premiums than if enrolled in the No Partnership Promise PPO.
  - **The Partnership Promise is an annual commitment - you do not have to sign a new promise each year.**
  - **You and all eligible family members must enroll in the same healthcare option. Your dependent spouse must also agree to the Partnership Promise.**
  - **Children are not required to complete the steps.**
  - **Healthways administers the Partnership Promise.**
  - **Requirements may change each year.**

2017 Partnership Promise New Member Requirements

2017 new members and covered spouses must:

1. Complete the online Well-Being Assessment (WBA)
   - **Go to partnersforhealthtn.gov** - click on the "**My Wellness Tab"**
   - **Must complete the Healthways WBA**
2. Get a biometric health screening from your physician
   - Includes height, weight, blood pressure, waist circumference, glucose and cholesterol levels

- **Steps 1 and 2 must be completed within 120 days from the day your coverage begins.**

Behavioral Health Benefits

Optum Health – Behavioral Health Vendor

- Optum Health is the behavioral health and substance abuse vendor.
- Members enrolled in health coverage automatically have access to this benefit.
- Also, you have the option of TeleBehavioral Health counseling services and can have a counseling session with a provider over the phone.
- To get maximum benefits, you should use an in-network provider and some services require prior authorization.

Learn more by visiting HERE4TN.com or calling 855.437.3486

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides you and your family with both workplace and personal resources. Benefits are administered by Optum Health.

- Services are confidential and available at no cost to enrolled plan members and eligible dependents.
- COBRA participants are also eligible.
- Services are available 24 hours a day, 365 days a year
- TeleBehavioral Health – talk to a provider over the phone
- You may use up to five counseling sessions per episode

- EAP has resources that can help you and your family with:

Family or relationship issues	**Child and elder care**
Feeling anxious or depressed	**Difficulties and conflicts at work**
Dealing with addiction	**Grief and loss**
Legal or financial issues	**Work/life balance**

- **Call Toll Free 24/7 at 1.855.HERE4TN (855.437.3486)**

Choosing Your Premium Level

- Four premium levels (tiers) available:
  - Employee Only
  - Employee + Child(ren)
  - Employee + Spouse
  - Employee + Spouse + Child(ren)

- If your spouse works for a local government or education agency whose health insurance is through the State
  - You can choose premium level, health option and insurance carrier separately

  NOTE: An individual may only be covered under one state policy

Premiums for 2017: Local Education

Total Share of Monthly Premiums

Premium Level	Partnership Promise PPO	No Partnership Promise PPO	Standard PPO	Limited PPO	HealthSavings CDHP
Employee Only	**$571**	**$621**	**$585**	**$426**	**$383**
Employee + Child(ren)	**$941**	**$991**	**$965**	**$702**	**$632**
Employee + Spouse	**$1,113**	**$1,213**	**$1,140**	**$830**	**$747**
Employee + Spouse + Child(ren)	**$1,483**	**$1,583**	**$1,520**	**$1,106**	**$995**

- Premiums shown are for the employee share for **active local education employees**. A complete chart is available in the Eligibility Guide on the ParTNers for Health website.
- Premiums are for the BCBS Network S or Cigna LocalPlus network
- Premiums do NOT include the cost for the larger Cigna Open Access Plus network – this adds $40 to $80 more EACH MONTH depending on your tier

Premiums for 2017: Local Government

Total Share of Monthly Premiums

Premium Level	Partnership Promise PPO	No Partnership Promise PPO	Standard PPO	Limited PPO	HealthSavings CDHP
Employee Only	**$618**	**$668**	**$625**	**$426**	**$384**
Employee + Child(ren)	**$958**	**$1,008**	**$968**	**$661**	**$595**
Employee + Spouse	**$1,329**	**$1,429**	**$1,343**	**$916**	**$825**
Employee + Spouse + Child(ren)	**$1,669**	**$1,769**	**$1,686**	**$1,150**	**$1,035**

- Premiums shown are for the employee share for **active local government employees**. A complete chart is available in the Decision Guide and on the ParTNers for Health website.
- Premiums are for the BCBS Network S or Cigna LocalPlus network
- Premiums do NOT include the cost for the larger Cigna Open Access Plus network – this adds $40 to $80 more EACH MONTH depending on your tier

2017 Deductibles and Out-of-Pocket Maximums

	Partnership PPO	Standard PPO	Limited PPO	HealthSavings CDHP
	In-Network	In-Network	In- Network	In-Network
Deductibles				
Employee only	**$500**	**$1,000**	**$1,600**	**$2,000**
Employee + Child(ren)	**$750**	**$1,500**	**$2,200**	**$4,000**
Employee + Spouse	**$1,000**	**$2,000**	**$2,500**	**$4,000**
Employee + Spouse + Child(ren)	**$1,250**	**$2,500**	**$3,200**	**$4,000**
Out of Pocket Max (medical and pharmacy combined)				
Employee only	**$3,600**	**$4,000**	**$6,600**	**$3,500**
Employee + Child(ren)	**$5,400**	**$6,000**	**$13,200**	**$7,000**
Employee + Spouse	**$7,200**	**$8,000**	**$13,200**	**$7,000**
Employee + Spouse + Child(ren)	**$9,000**	**$10,000**	**$13,200**	**$7,000**

Take Note!

- Deductibles and out-of-pocket maximums for in-network and out-of-network services add up **separately** in PPOs and the CDHP.

Example: Employee Only Coverage - Partnership PPO

- **In-network** services count toward in-network deductible and out-of-pocket maximum

	Deductible	Out-of-Pocket Max
In-Network	$500	$3,600

- **Out-of-network** services count toward out-of-network deductible and out-of-pocket maximum

	Deductible	Out-of-Pocket Max
Out-of-Network	$1,000	$4,000

Ineligible expenses, including non-covered services and expenses over the MAC don't count toward deductibles and out-of-pocket maximums.

Dental Benefits (if offered by your agency)

Eligible employees can choose between two dental options:

Cigna Prepaid Plan

- Fixed copays
- Participating dentists only

MetLife Dental Preferred Plan

- Coinsurance and deductibles
- Any dentist
- Pay less with network providers

- Eligible employees can enroll in one of the two options
- What you pay depends on the plan you choose

Dental Benefits

Cigna Prepaid Plan

Provides services at fixed copay amounts. A limited network of participating dentists and specialists must be used to receive benefits.

- Must select a general dentist from the Cigna dental provider list and notify Cigna of your choice. You must use your selected dentist to receive benefits. **The state network is part of the Dental Care (HMO) network.**
- There may be some areas in the state where network dentists are limited or not available. Be sure to carefully review the provider directory for your location.
  - With this plan, you can cancel coverage during the year if there are no network general dentists within a 40-mile radius of your home
- You pay predetermined member copay amounts (reduced fees) for dental treatments.
- No deductibles to meet, no claims to file, no waiting periods, no annual dollar maximum.
- Preexisting conditions are covered.
- Orthodontic treatment fee lifetime maximum.
- **Referrals to specialists are required.**

Dental Benefits

MetLife Dental

Provides services with coinsurance. Any dentist may be used to receive benefits but you will pay less if an in-network provider is used.

- Can use any dentist — receive maximum benefits when visiting an in-network MetLife DPPO provider. **The state network is part of the PDP network.**
- Deductible applies for basic and major dental care.
- You pay coinsurance for basic, major, orthodontic and out-of-network covered services.
- You or your dentist will file claims for covered services.
- Some services (e.g., crowns, dentures, implants and complete or partial dentures) require a 6-month waiting period from member's effective date before benefits begin.
- There is a 12-month waiting period from the member's effective coverage date on replacement of a missing tooth and for orthodontics.
- **Referrals to specialists are not required**.
- Pre-treatment estimates are recommended for services with significant expense.

Dental Benefits

Monthly Premiums for Active Members

Premiums	Cigna Prepaid	MetLife DPPO
Employee Only	**$12.99**	**$22.37**
Employee + Child(ren)	**$26.97**	**$51.44**
Employee + Spouse	**$23.02**	**$42.32**
Employee + Spouse + Child(ren)	**$31.65**	**$82.80**

Dental services for both the Prepaid Plan and the DPPO Plan include:

- Periodic oral evaluations
- Endodontics-Root Canal
- Major restorations
- Routine Cleanings
- X-rays
- Orthodontics
- Amalgam fillings
- Extractions
- Dentures

Vision Benefits (if offered by your agency)

Vision Plan - Administered by EyeMed Vision Care

- There are two plan options – both plans offer the same services:

Basic Plan	Expanded Plan
Discounted rates	**Copays**
Allowances	**Allowances**
	Discounted rates

- **2017 Premiums**

	Basic	Expanded
Employee Only	**$3.35**	**$5.86**
Employee + Child(ren)	**$6.69**	**$11.72**
Employee + Spouse	**$6.35**	**$11.14**
Employee + Spouse + Child(ren)	**$9.83**	**$17.23**

Additional Benefits

- Eligible employees also have access to:
  - ParTNers for Health Wellness Program
  - Long-term Care Insurance (if offered by your agency)

Did You Know?

All local education and local government plan members have access to the Wellness Program even if enrolled in the Standard PPO, Limited PPO or Local HealthSavings CDHP.

ParTNers for Health Wellness Program

- **All health plan members have access to the ParTNers for Health Wellness Program**, which gives you the tools, information and support you need to take charge of your health and feel your best.

- ParTNers for Health Wellness Program is provided at no additional cost to all members.

- **Wellness Resources:**
  - Coaching – call and get support from a coach on your well-being goals
  - Well-Being Assessment (WBA) – online well-being questionnaire
  - Nurse advice line – medical information and support at no cost to you
  - Wellness challenges - a fun way to develop a healthier lifestyle with group support
  - Weight Watchers at Work and Fitness Center discounts
  - Additional wellness and fitness discounts through the EAP program and our carriers BlueCross BlueShield and Cigna

Long-Term Care Insurance (if offered by your agency)

- Covers services for individuals no longer able to care for themselves:
  - Nursing home care
  - Assisted living
  - Home healthcare
  - Home care
  - Adult Day Care
- You have 90 days to enroll with guaranteed-issue coverage
  - Who is eligible?
    - You, your spouse, eligible dependent children, parents and parents-in-law may also apply
- Premiums are based on age of the insured at the time of enrollment

Long-Term Care Insurance

Long-Term Care Insurance

- Benefits available for different daily benefit amounts ($100, $150 or $200) for either three- year or five-year coverage
- Available with or without inflation protection
- You pay 100% of the premium, unless your agency pays toward your premium
- Premiums are based on age at the time of enrollment
- Choose to have the premium taken from your payroll check or opt for a direct bill arrangement
- Enroll long-term care website: www.ltc.tn.com
    - Or enroll by calling 866.615.5824

Enrolling in Benefits

- **Employees can either enroll in Edison Employee Self Service (ESS) or submit a paper application to your ABC for health, dental and vision coverage**
- Enrollment must be completed within **31 days** of your hire date
- Required dependent verification must also be submitted during this timeframe
  - Example dependent verification documents include:
    - Federal Income Tax Return for a spouse
    - Birth certificate for a child

Online Enrollment through ESS

If you use ESS to select your health insurance and other benefit options:

- Log on to Edison
  - » www.edison.tn.gov
  - » Use username and temporary password provided by your Human Resource office
  - » Go to Self Service > Employee Work Center > My Benefits > Benefits Enrollment
  - » Click **SELECT**
  - » Follow the prompts
- If covering dependents, submit dependent verification by:
  - » Uploading electronic documentation
  - » Faxing documentation to Benefits Administration service center

When Will Coverage Begin?

- Health, dental and vision begin on the first day of the month
- If you are hired on Sept. 15, coverage would begin on Oct. 1 or Nov. 1*
- Voluntary Long-Term Care effective date is included with the Certificate of Coverage issued by MedAmerica
- Ask your ABC if you have questions about when your coverage begins

*Coverage begins the first day of the month after you are eligible. Ask your agency if you are eligible as of your hire date or some other date

When Are Premiums Paid?

- Your ABC will tell you when your premiums will be deducted from your paycheck
- If you do not enter your benefit selections early, in some instances, you could end up with a double deduction from your paycheck.
  - For example, you could be double-deducted if you make your insurance selections after your agency confirms your paycheck that the first deduction is supposed to be taken.

When Will My ID Cards Arrive?

- Within three weeks of the date your application is processed

BlueCross BlueShield	Cigna
• Sends up to two ID cards automatically, both with member's name	• Sends separate ID cards for each insured family member with each participant's name
• These may be used by any covered dependent	• There may be up to four ID cards in each envelope

- **CVS/Caremark** will send separate ID cards for pharmacy benefits
- If you enroll in dental or vision benefits, you will receive your ID cards within three weeks

Your Privacy

- Your personal health information is strictly confidential
- Your health privacy rights are protected through a federal law called “HIPAA”
- Benefits Administration can only discuss benefits information with the head of contract (HOC)
- The **Authorization for Release of Protected Health Information** form must be completed before Benefits Administration can discuss benefits information with your spouse or other authorized representative

To print and complete a release form, visit www.tn.gov/finance/section/fa-benefits. On this page, select the “Forms” tab.

Retiree Insurance

- Retiree health insurance coverage (pre-65 retirees) is not available to employees whose employment first began on or after July 1, 2015.
- Medicare supplement insurance will not be available to any employee whose first employment is on or after July 1, 2015.
- Any employee whose first employment with a participating local education/local government agency began before July 1, 2015, and who returns to employment with a participating Local Education agency after July 1, 2015, may participate in retiree coverage if the employee meets all other eligibility requirements for retirement insurance.
- If you have questions about the above or your insurance options, we encourage you to talk to your Agency Benefits Coordinator (ABC).

Your Privacy

- Your personal health information is strictly confidential
- Your health privacy rights are protected through a federal law called “HIPAA”
- Benefits Administration can only discuss benefits information with the head of contract (HOC)
- The **Authorization for Release of Protected Health Information** form must be completed before Benefits Administration can discuss benefits information with your spouse or other authorized representative

To print and complete a release form, visit www.tn.gov/finance/section/fa-benefits. On this page, select the “Forms” tab.

Insurance Carrier Websites

- BlueCross BlueShield, Cigna and CVS/caremark each offer member websites that allow you to:
  - View detailed information about your claims
  - Print temporary ID cards
  - Access other helpful member services

➢ **BlueCross BlueShield**

www.bcbst.com/members/tn_state/

➢ **Cigna**

www.cigna.com/site/stateoftn

➢ **CVS/caremark**

www.info.caremark.com/stateoftn

Who to Contact

- Your primary point of contact is your **Agency Benefits Coordinator** (ABC)
- For questions about a provider or insurance claim, contact your insurance carrier directly via the carrier's member website or the number on the back of your ID card
- For questions about eligibility and enrollment, call the Benefits Administration service center at **1-800-253-9981**

- **ParTNers for Health**
  www.partnersforhealthtn.gov
- **Benefits Administration**
  www. tn.gov/finance/section/fa-benefits

PARTNERS FOR HEALTH

Thank you for your attention during this presentation.

More information is available at
www. tn.gov/finance/section/fa-benefits

If you have questions, please ask your Agency Benefits Coordinator.