

**PARTNERS
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State of Tennessee Group Insurance Program

New Employee Orientation
Enrollment and Health Insurance Benefits
Local Education and Local Government Employees
January 1 – December 31, 2018



- Welcome to the State of Tennessee Group Insurance Program New Employee Eligibility and Health Insurance Benefits Orientation for local education and local government employees.
- This presentation will provide an overview of your enrollment, health insurance and other benefits available to you.

Importance of Your Decisions

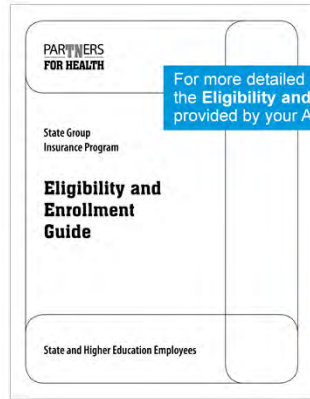
- The decisions you make **now** as a new employee will have lasting effects on your benefits
- **Please note: Some decisions can only be made during the new-hire period**
- Be aware of all the options available to you and make informed decisions
- Submit questions to your **Agency Benefits Coordinator (ABC)** - this person is usually in your HR office

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- The State provides a comprehensive benefits package for you and your eligible dependents. It includes health, pharmacy and behavioral health benefits, as well as dental and vision insurance – if offered by your agency.
- You have many options. Some of the benefits explained in this presentation are only available during the new hire period.
- Your **Agency Benefits Coordinator (ABC)**, the person in your Human Resources office, can tell you how long your new hire period lasts.
- If you have questions after the presentation, please make sure to follow up with your ABC.

Resource Materials



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

EMPLOYEE INFORMATION	
NAME	
ADDRESS	
CITY	
STATE	
ZIP	
PHONE	
EMAIL	

SELECTED PLAN INFORMATION	
<input type="checkbox"/> Health Plan	<input type="checkbox"/> Life Insurance
<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Disability Insurance
<input type="checkbox"/> Vision Plan	<input type="checkbox"/> Other

BENEFICIARY INFORMATION	
NAME	
ADDRESS	
CITY	
STATE	
ZIP	
PHONE	
EMAIL	

EMPLOYEE SIGNATURE: _____ DATE: _____

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

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- More detailed information about the topics in this presentation can be found in the Eligibility and Enrollment Guide on the Benefits Administration website (www.tn.gov/finance/fa-benefits) under the “Publications” page.
- Your ABC will provide you with an employee checklist to confirm that you have received this important benefit information. After the presentation, please sign the checklist and return it to your ABC.

Resource Materials

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

[tn.gov/finance/fa-benefits](http://www.tn.gov/finance/fa-benefits)

Department of Finance & Administration

Looking For: Financial • FSA News • FSA Events • Employee Resources

Insurance & Benefits

Partners for Health Website

Insurance Products

Other Benefits

Publications & Forms

Quicklinks

Annual Enrollment

For New Employees

For Retirement

Customer Service

Premiums

Report Fraud

Summary of Benefits

Agency Benefits Coordinators

Insurance & Benefits

Benefits Administration is responsible for servicing three basic groups of employees by managing their state provided insurance benefits. The state plan is comprised of state government and higher education employees. The local education plan is available to local K-12 school systems that choose to participate in the plan. The local government plan is available to local city and county governments and to certain quasi-governmental agencies that choose to participate. Over 300,000 individuals are enrolled in coverage.

In addition to insurance coverage, the division also administers an employee assistance program and a wellness program. These related programs complement insurance programs by educating employees and their families about prevention and behaviors that can affect their mental and physical health.

This site contains most documents and forms related to your insurance benefits. Your human resource office can provide this information as well.

HRSA Brand

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- As required by law, the State of Tennessee Group Health Program has created a Summary of Benefits and Coverage, or SBC for short. It describes your health coverage options.
- You can read and print it from the main page of the Benefits Administration website at www.tn.gov/finance/fa-benefits by clicking on Summary of Benefits. You may also request a free, printed copy from your ABC.
- Most information found in the SBC is covered in more detail in other publications like the Eligibility and Enrollment Guide, Plan Document and member handbooks. These can be found under the “**Publications**” tab on the same website.

Need More Help?

You can contact **Benefits Administration (BA)** for **eligibility and enrollment** questions at 800.253.9981 or 615.741.3590, Mon.- Fri., 8 a.m. to 4:30 p.m. Central time.

- You can also search the help desk, find articles or submit a question at <https://benefitssupport.tn.gov/hc/en-us>.

Links to animated videos on the ParTNers for Health website at partnersforhealthtn.gov. These videos can help you learn about your benefits and what everything means. You can also find definitions, insurance terms and frequently asked questions (FAQs).

Publications and forms are available on the Benefits Administration website at <https://www.tn.gov/finance/fa-benefits>. Brochures, handbooks, plan documents and summaries of benefits and coverage (SBCs).

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There are additional resources to help you:

You can contact the Benefits Administration (BA) Service Center for help with eligibility and enrollment at 800.253.9981 or 615.741.3590, Mon.- Fri., 8 a.m. to 4:30 p.m. Central time.

- You can also search the help desk, find articles or submit a question at <https://benefitssupport.tn.gov/hc/en-us>

You can also find links to animated videos on the ParTNers for Health website at www.partnersforhealthtn.gov. These videos can help you enroll, learn about your benefits and what everything means. You can find also definitions, insurance terms and frequently asked questions (FAQs).

All publications and forms are available on the Benefits Administration website at <https://www.tn.gov/finance/fa-benefits>. These include brochures, handbooks, plan documents and the summaries of benefits and coverage (SBCs).

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.

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- The State of Tennessee Group Insurance Program covers three groups:
 - The State Plan for State and Higher Education employees
 - The Local Education Plan for K-12 teachers and support staff and
 - The Local Government Plan for employees of quasi-governmental agencies and municipalities
- We spend about \$1.3 billion annually in claims costs for our nearly 300,000 members.
- The Plan is self-insured. All claims are paid through the combined premiums of our members and any contributions that your employer makes toward your monthly premium. The State is the plan administrator rather than an insurance company. The State contracts with insurance carriers to manage the Plan's provider networks, provide member services and manage claims payments on behalf of the State.
- Benefits Administration manages the Plan and works with your ABC to communicate program information. Your ABC will help you with any benefits-related questions or concerns you may have.

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

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- Full-time employees are eligible for benefits. For insurance purposes, a full-time employee is defined as someone regularly scheduled to work no less than 30 hours per week in a non-seasonal, non-temporary position.
- If you have a family, you may choose to also cover your eligible dependents. A dependent can be a legally married spouse or a child up to age 26. To be considered an eligible dependent, children must be natural, adopted or step-children or children for whom you are the legal guardian.
- If you have a disabled child, you may be able to continue coverage for your child after age 26.
- If you are currently enrolled in TennCare, you must inform your caseworker at TennCare of your new employment within 10 days of your hire date. You must report your new job, salary and that you have access to medical insurance with your new employer.
- **If you have a dependent child on another plan including TennCare, the child can be carried on another plan.**
- For more information refer to the Eligibility and Enrollment Guide or consult your ABC.

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

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- There are only three times when you may add health coverage:
 - The first is right now, when you are a new employee
 - The second is during Annual Enrollment in the fall
 - And the third is if you experience a special qualifying event during the year such as marriage, the birth of a baby or a spouse losing his or her coverage.
 - If you do not select coverage now, but you later experience a special qualifying event, **you must submit paperwork within 60 days** of the event to add coverage.
 - For a complete list of special qualifying events contact your ABC.

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 (doctors and facilities)**
 - Enroll in, cancel or transfer between **dental** and **vision** insurance (if offered by your agency)
- **Changes are effective January 1 of the following year**

Annual Enrollment occurs during the fall

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During the Annual Enrollment period is when you can review your benefits and make changes.

- You can enroll in and change your health insurance, network of doctors and facilities, and make changes to your voluntary dental and vision coverage, if offered by your agency.
- The Annual Enrollment period occurs during the fall and changes are effective the January 1 of the following year.

Choosing Your Premium Level

- Four premium levels (tiers) available:
 - Employee Only
 - Employee + Child(ren)
 - Employee + Spouse
 - Employee + Spouse + Child(ren)
- If you're enrolling as a family, everyone must be enrolled in the same state group health insurance option with the same insurance carrier.
- If your spouse works for the state, or a higher education, local government or local education agency whose health insurance is through the State, you can enroll separately and choose your own premium level, health benefit option and insurance carrier.
 - NOTE: An individual may only be covered under one state policy

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- The amount you pay in premiums depends on the option you choose and the number of people you cover under the plan. There are four premium levels available: Employee Only, Employee + Child or Children, Employee + Spouse and Employee + Spouse + Child or Children.
- For most people, choosing a premium level is easy. The level depends on the eligible dependents you want to cover your health plan.
 - Just remember, if you're enrolling as a family, everyone must be enrolled in the same state group health insurance option with the same insurance carrier.
- If you are married to an employee who works for the State, Higher Education or a participating Local Government or Local Education agency, you can each enroll in employee-only coverage. If you do that, you can each choose your own health benefit option and insurance carrier, just like any two plan members who are **not** married. If you have dependent children, consider your options carefully and choose the one that makes the most sense for you and your family.
 - Note: An individual may only be covered under one state policy.

Canceling Coverage

- You may only cancel most insurance 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.

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- There are three times that you can cancel your coverage later:
 - During Annual Enrollment.
 - If you become ineligible to continue coverage. For example, this could occur if you switch from full-time to part-time employment.
 - Or if you experience one of the qualifying events listed on the Insurance Cancel Request Application.
- It's important to remember that, outside of Annual Enrollment, you cannot cancel insurance coverage at any other time during the plan year unless you experience one of the approved qualifying events or you become ineligible to continue coverage.

Health Insurance

You get the choice of a health plan and a network

Four health options — you choose one.

Each option has **different out-of-pocket costs** for copays, deductibles, coinsurance and out-of-pocket maximums. You won't pay anything for eligible preventive care — it's covered at 100% as long as you use an in-network provider. **Here are your options in more detail:**

- **Premier PPO:** Highest premiums, but you **pay less** for copays at the doctor's office and pharmacy than the Standard PPO and less in coinsurance.
- **Standard PPO:** Lower premiums than the Premier PPO, but you **pay more** for copays at the doctor's office and pharmacy.
- **Limited PPO:** Lower premiums than the other PPOs, but you pay more for copays at the doctor's office and pharmacy.
- **Local Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA):** Lower premiums, but you have a higher deductible. You get a HSA (health savings account) to use for qualified healthcare expenses, including your deductible and to save for retirement.

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Here are your health insurance options. You get the choice of a health plan and choice of a network:

There are four health options — you choose one.

- Each option has different out-of-pocket costs for copays, deductibles, coinsurance and out-of-pocket maximums. You won't pay anything for eligible preventive care — it's covered at 100% as long as you use an in-network provider.

Here are your options in more detail:

- **Premier PPO (PPO means Preferred Provider Organization):** It has the highest premiums, but you **pay less** for copays at the doctor's office and pharmacy than the Standard PPO and less in coinsurance than the other plans.
- **Standard PPO:** Lower premiums than the Premier PPO, but you **pay more** for copays at the doctor's office and pharmacy, and more in coinsurance than the Premier PPO.
- **Limited PPO:** Limited PPO: Lower premiums than the other PPOs, but you pay more for copays at the doctor's office and pharmacy.
- **Local Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA):** Lower premiums, but you have a higher deductible. You get a HSA to use for qualified healthcare expenses, including your deductible and to save for retirement.

All health options cover the same services and treatments but medical necessity decisions can vary by carrier (BCBS and Cigna). The carriers (BCBS and Cigna) also offer discounts for certain value-added benefits not covered by traditional insurance. This could include programs for weight loss, fitness club membership or laser vision care. You can refer to the carrier handbooks or websites for more information.

Health Insurance

How does the Local CDHP/HSA work?

You pay for your healthcare differently. When you get care or need a prescription, you pay for those expenses until you reach your deductible. Then you pay coinsurance for your medical and pharmacy costs until you reach your out-of-pocket maximum.

- **For all of your care, as long as you use network providers, you get discounted network rates.**
 - For **certain 90-day maintenance drugs** (e.g., hypertension, high cholesterol), you only pay coinsurance, and you do not have to meet your deductible first. You must use a Retail-90 network pharmacy or mail order to fill a 90-day supply of your medication to receive this benefit. Check with your pharmacist or CVS/caremark if you have questions.

Note: For Local CDHP Plan, the deductible and out-of-pocket maximum amount can be met by one or more persons, depending on premium level, but no one family member may contribute more than \$7,350 to the in-network family out-of-pocket maximum total. The total deductible must be met before coinsurance applies for any family member unless otherwise noted in the Eligibility and Enrollment Guide.

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How does the Local CDHP/HSA work?

You pay for your healthcare differently. When you get care or need a prescription, you pay for those expenses until you reach your deductible. Then you pay coinsurance for your medical and pharmacy costs until you reach your out-of-pocket maximum.

- **For all of your care, as long as you use network providers, you get discounted network rates.**
 - For **certain 90-day maintenance drugs** (e.g., hypertension, high cholesterol), you only pay coinsurance, and you do not have to meet your deductible first. You must use a Retail-90 network pharmacy or mail order to fill a 90 day supply of your medication to receive this benefit. Check with your pharmacist or CVS/caremark if you have questions.

Note: When you use funds from your HSA, you should keep all of your receipts and EOBs (explanations of benefits) used to pay funds from your HSA for tax purposes.

Health Insurance

How does the Local CDHP/HSA work?

You get a HSA to save! You can contribute and some employers do too. Check with your employer on your options. For example, you can put the difference in premiums between the Local CDHP and a PPO (premium savings) into your HSA each month.

You can use your HSA money to pay for your deductible, coinsurance for doctor's visits and prescriptions. Your HSA money rolls over each year — you keep it if you leave or retire.

- When you turn 65, you can use money in your HSA for non-medical expenses (before age 65 non-medical expenses are both taxed and subject to a 20% penalty. After age 65, non-medical expenses are taxed, but the 20% penalty does not apply).

2018 maximum HSA contribution amounts (includes employer contributions):

- \$3,450 for employee only (includes any employer contribution – if available)
- \$6,900 for all other tiers (includes any employer contribution – if available)
- Members 55 or older can save an extra \$1,000 in a catch up contribution during the plan year

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How does the Local CDHP/HSA work?

You get a HSA to save! You can contribute to this account, and some employers do too. Check with your employer on your options. For example, you can put the difference in premiums between the Local CDHP and PPO (premium savings) into your account each month.

You can use your HSA money to pay for your out-of-pocket costs like your deductible, coinsurance for doctor's visits and prescription drugs. Your HSA money rolls over each year — you keep it if you leave or retire.

- When you turn 65, you can use money in your HSA for non-medical expenses (before age 65 non-medical expenses are both taxed and subject to a 20% penalty. After age 65, non-medical expenses are taxed, but the 20% penalty does not apply).

There is a limit on how much money you can put in your HSA each year (includes employer contributions):

2018 maximum HSA contribution amounts:

- \$3,450 for employee only (includes any employer contribution if available)
- \$6,900 for all other tiers (includes any employer contribution if available)
- Members 55 or older can save an extra \$1,000 in a catch up contribution during the plan year

Health Insurance

How does the Local CDHP/HSA work?

- **You save money on taxes!** Your HSA contributions can be pre-tax — you can put money from your paycheck directly into your account by payroll deduction (if offered by your agency). This lowers your taxable income, saving you money.
 - Employer contributions are tax free and qualified medical expenses are also tax free.
- **You get a debit card with your HSA funds:** PayFlex will send you a debit card. You can use it to pay for your qualified healthcare expenses. Go to stateoftn.payflexdirect.com to learn more.

How does the Local CDHP/HSA work?

- **You save money on taxes!** Your HSA contributions can be pre-tax — put money from your paycheck directly into your account by payroll deduction (if offered by your agency). This lowers your taxable income, saving you money.
 - Your employer contributions are tax free, and qualified medical expenses are also tax free.
- **You get a debit card with your HSA funds:** PayFlex will send you a debit card. You can use it to pay for your qualified healthcare expenses. Go to stateoftn.payflexdirect.com to learn more.

Health Insurance

CDHP restrictions:

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

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

However, members may be eligible if the following applies:

- Member did not receive any care from a VA facility for three months, or
- The member only receives care from a VA facility for a service-connected disability (and it must be a disability).
- Go to https://www.irs.gov/irb/2004-33_IRB/ar08.html for HSA eligibility information.

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CDHP restrictions:

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However, members may be eligible if the following applies:

- Member did not receive any care from a VA facility for three months, or
- The member only receives care from a VA facility for a service-connected disability (and it must be a disability).
- Go to https://www.irs.gov/irb/2004-33_IRB/ar08.html for HSA eligibility information.

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

Very important: if you currently have a FSA and are thinking about enrolling in the CDHP/HSA, there are rules about opening up a HSA if you have a FSA balance.

Other restrictions may apply. Go to www.IRS.gov to learn more.

Network Options

You choose one of three networks of doctors and facilities:

- **BlueCross BlueShield Network S:** There is no additional cost for this network. In 2018 in the Memphis market, Methodist facilities will be out-of-network, and Baptist facilities will be in-network. All Methodist **provider** groups will be in-network.
- **Cigna LocalPlus:** There is no additional cost for this network. This is a smaller network than Cigna Open Access Plus (OAP).
- **Cigna OAP:** This is a large network, with a choice of more doctors and facilities, but you will pay more. In 2018 in the Memphis market, Baptist facilities will be out-of-network, but Methodist facilities will be in-network.
 - Monthly surcharges will apply:
 - \$40 more for employee only and employee+child(ren) coverage
 - \$80 more for employee+spouse and employee+spouse+child(ren) coverage

Your network vendor's (BlueCross BlueShield or Cigna) website may have tools and resources to help you find out how much a procedure or test could cost.

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You choose one of three networks of doctors and facilities.

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 - Monthly surcharges will apply:
 - \$40 more for employee only and employee+child(ren) coverage
 - \$80 more for employee+spouse and employee+spouse+child(ren) coverage
- Each network has providers (doctors and facilities) across Tennessee and the country. Providers can move in and out of networks. It's important to check the networks carefully for the doctor(s) or hospital you want when making your choice.
 - Note: If you use providers outside of the network, you will be charged out-of-network rates.
- Your network vendor's (BlueCross BlueShield or Cigna) website may have tools and resources to help you find out how much a procedure or test could cost.

Pharmacy benefits

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. How much you pay for your drug depends on whether it is a generic, brand or non-preferred brand and the day-supply.

*These are the in-network pharmacy benefits. If out of network pharmacy benefits are available, they are different and will cost you more.

** Specialty Network Pharmacy: Specialty drugs must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

PHARMACY (IN-NETWORK)*	PREMIER PPO	STANDARD PPO	LIMITED PPO	LOCAL CDHP
30-DAY SUPPLY				
Generic	\$7	\$14	\$14	30% coinsurance after deductible is met
Brand	\$40	\$50	\$60	
Non-preferred brand	\$90	\$100	\$110	
90-DAY SUPPLY (Retail-90 network pharmacy or mail order)				
Generic	\$14	\$28	\$28	30% coinsurance after deductible is met
Brand	\$80	\$100	\$120	
Non-preferred brand	\$180	\$200	\$220	
90-DAY SUPPLY (certain maintenance medications from a Retail-90 network pharmacy or mail order)				
Generic	\$7	\$14	\$14	20% coinsurance without having to meet deductible
Brand	\$40	\$50	\$60	
Non-preferred brand	\$160	\$180	\$200	
SPECIALITY PHARMACY**				
Coinsurance	10% (min \$50; max \$150)	10% (min \$50; max \$150)	10% (min \$50; max \$150)	30% after deductible

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. How much you pay for your drug depends on whether it is a generic, brand or non-preferred brand and the day-supply.

On the screen are the in-network pharmacy costs. This same information is found in your Eligibility and Enrollment Guide. If you use out-of-network pharmacy benefits, they are different and will cost you more.

Also, we wanted to note that drugs filled in the Specialty Pharmacy tier must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

Pharmacy benefits

Maintenance Drugs: There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication.

- The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD) and diabetes (oral medications, insulins, needles, test strips and lancets).

Certain Low-Dose Statins: Eligible members will be able to receive these medications in-network at zero cost share in 2018.

- These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

Copay Installment Program: Members can spread the cost of 90-day mail order prescriptions over a three-month period — at no additional cost. You may enroll online at info.caremark.com/stateoftn, register and log in, or by calling CVS/caremark customer care at 877.522.8679.

- This benefit is only for 90-day mail order prescriptions provided by CVS/caremark mail order. **This does not apply to specialty medications.**

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Maintenance Drugs: On the previous chart, there are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication.

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- This benefit is only for 90-day mail order prescriptions provided by CVS/caremark mail order. **This does not apply to specialty medications.**

Pharmacy benefits

Weight Management: There are some obesity medications available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to the Caremark website at info.caremark.com/stateoftn to look for covered medications. They are found under “Antiobesity” on the Preferred Drug List (PDL).

Diabetic Supplies: OneTouch diabetic testing supplies are the only diabetic testing supplies covered at the preferred brand copay. Members will have lower copays by using OneTouch supplies. Diabetics may be eligible for a new OneTouch glucose meter at no charge from the manufacturer. For more information call 800.588.4456.

Flu and Pneumonia Vaccines: Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at your doctor’s office. You can go to partnersforhealthtn.gov and click on the Pharmacy page to learn more about vaccines.

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Weight Management: There are some obesity medications available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to the Caremark website at info.caremark.com/stateoftn to look for covered medications. They are found under “Antiobesity” on the Preferred Drug List (PDL).

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Pharmacy benefits

Tobacco Cessation Products: Members who want to stop using tobacco products can get free tobacco quit aids.

The following quit aids are FREE under the pharmacy benefit:

- Chantix
- Bupropion (Generic Zyban)
- Over-the-counter generic nicotine replacement products, including gum, patches and lozenges
- Nicotrol oral and nasal inhalers

Members may receive up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your Caremark card at the pharmacy counter (not at the check-out registers) to fill at \$0 copay. The plan only covers generic over-the-counter tobacco cessation products (not brand names).

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Telehealth

24/7 Care — When You Need It

All health plan members have access to state-sponsored Telehealth medical services. It is available as a part of your health insurance. You can talk to a doctor by phone or computer from anywhere, at any time.

When to use Telehealth

For non-emergency medical issues (allergies, asthma, bronchitis, cold & flu, infections, fever, ear aches, nausea, pink eye, sore throat)

- 24 hours a day, seven days a week — including nights, weekends and holidays
- Your doctor or pediatrician is unavailable
- It's not convenient to leave your home or work
- You are traveling and need medical care

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24/7 Care — When You Need It

All health plan members have access to the state-sponsored Telehealth program. It is available as a part of your health insurance. You can talk to a doctor by phone or computer from anywhere, at any time. It is 24/7 care, when you need it.

When to use Telehealth

Telehealth is good for non-emergency medical issues (allergies, asthma, bronchitis, cold & flu, infections, fever, ear aches, nausea, pink eye, sore throat)

- 24 hours a day, seven days a week — including nights, weekends and holidays
- Your doctor or pediatrician is unavailable
- It's not convenient to leave your home or work
- You are traveling and need medical care

Telehealth

Cost:

- **PPO Members:** Copay is \$15
- **CDHP Members:** You pay the negotiated rate per visit until you reach your deductible, then the primary care office visit coinsurance applies

More Information: You must pre-register with your network vendor to use Telehealth. Network vendor information is below.

BlueCross BlueShield of Tennessee Members

- Log into BlueAccess at bcbst.com
- Look for PhysicianNow
- Or, call 888.283.6691

Cigna Members

- Log into MyCigna.com
- Look for MDLive or Amwell and select the vendor of your choice
- Or, call 888.726.3171 for MDLive or 855.667.9722 for Amwell

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Here are the costs for members:

- **PPO Members:** Copay is \$15
- **CDHP Members:** You pay the negotiated rate per visit until you reach your deductible, then the primary care office visit coinsurance applies

Important: You must pre-register with your network carrier (BCBST or Cigna) and go through the network carrier programs (PhysicianNow, MDLive, Amwell) to use the state-sponsored Telehealth program for medical services. The costs listed above do not apply to Telemedicine services received from a different program or provider. There is no coverage for telephone consultations, unless you use PhysicianNow, MDLive or Amwell through your network carrier.

Network vendor information is below:

BlueCross BlueShield of Tennessee Members

- Log into BlueAccess at bcbst.com
- Look for PhysicianNow
- Or, call 888.283.6691

Cigna Members

- Log into MyCigna.com
- Look for MDLive or Amwell and select the vendor of your choice
- Or, call 888.726.3171 for MDLive or 855.667.9722 for Amwell

Behavioral Health & Substance Use Services

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

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

- In addition to office visits, you can meet with a provider through private, secure video conferencing. It's called **Telemental Health**, and it allows you to get the care you need sooner and in the privacy of your home. The copay for Telemental Health is the same as an office visit.
- To get started, go to **Here4TN.com**, scroll down, select provider search, and click on Telemental Health to find a provider licensed in Tennessee, or call 855-Here4TN for assistance.

Learn more about your behavioral health benefit by visiting **Here4TN.com**. You can search for providers on the website.

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

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- To get started, go to www.Here4TN.com, scroll down, select provider search, and click on Telemental Health to find a provider licensed in Tennessee, or call 855-Here4TN for assistance.

Learn more about your behavioral health benefit by visiting www.Here4TN.com. A provider directory with a search feature is available on the website.

Employee Assistance Program (EAP) — HERE4TN.com

Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all enrolled local education and local government state group insurance program members and their eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

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

Optum knows you are busy, and they want to provide you with information when you need it. Call **855.Here4TN (855.437.3486)**.

Take Charge at Work: You will have access to a telephonic program that helps you identify your triggers, and recognize and manage symptoms of stress and depression. You can find more information at HERE4TN.com

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Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all enrolled local education and local government state group insurance program members and their eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

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

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

2018 Voluntary Wellness Program

- More information about the 2018 Wellness Program will be coming in 2018.
- All members have access to **wellness and fitness center discounts** through the carrier network vendors (BCBST or Cigna).
- Cigna members will have access to the Cigna nurse advice line. BlueCross BlueShield does not have a nurse advice line available.

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- More information about the voluntary 2018 Wellness Program will be coming in 2018.
- As a health plan member, you have access to **wellness and fitness center discounts** through the carrier network vendors (BCBST or Cigna).
- Cigna members will have access to the Cigna nurse advice line. BlueCross BlueShield does not have a nurse advice line available.

Preventive Screenings

And with your health plan you won't pay anything for eligible preventive care – it's covered at 100% as long as you use an in-network provider. Members are encouraged to get age appropriate preventive services, which could include:

- annual preventive visit (i.e., physical exam)
- cholesterol test
- screening for colon cancer
- annual well woman visit
- osteoporosis screening
- screenings for breast or cervical cancer (women only)
- screening for prostate cancer (men only)
- flu vaccine
- pneumococcal vaccine

Talk to your doctor to find out what screenings and tests are right for you.

And with your health plan you won't pay anything for eligible preventive care – it's covered at 100% as long as you use an in-network provider. Members are encouraged to get age appropriate preventive services, which could include:

- annual preventive visit (i.e., physical exam)
- cholesterol test
- screening for colon cancer
- annual well woman visit
- osteoporosis screening
- screenings for breast or cervical cancer (women only)
- screening for prostate cancer (men only)
- flu vaccine
- pneumococcal vaccine

Talk to your doctor to find out what screenings and tests are right for you.

Premiums for 2018: Local Education

Total Cost of Monthly Premiums

Premium Level	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA
Employee Only	\$612	\$573	\$524	\$445
Employee + Child(ren)	\$1,009	\$945	\$863	\$733
Employee + Spouse	\$1,193	\$1,118	\$1,021	\$867
Employee + Spouse + Child(ren)	\$1,590	\$1,489	\$1,361	\$1,155

- Premiums shown are for the employee share for **active employees**.
- A complete chart is available in the Eligibility and Enrollment 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 – which would add \$40 to \$80 more EACH MONTH depending on your tier

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- Here are the health insurance premiums for **active local education employees**.
- The premium amounts shown reflect the total monthly premium. Please see your ABC for your monthly deduction, the state's contribution and your employer's contribution, if applicable.
- A complete chart for all coverage tiers is available in the Eligibility and Enrollment Guide and at www.partnersforhealthtn.gov
- Important to note – premiums do not include the cost for the Cigna Open Access Plus network which would add \$40 to \$80 more **per month** to your premium depending on your coverage tier.

Premiums for 2018: Local Government

Total Cost of Monthly Premiums – Level 1

Premium Level 1	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA
Employee Only	\$649	\$608	\$472	\$425
Employee + Child(ren)	\$1,007	\$943	\$732	\$658
Employee + Spouse	\$1,396	\$1,308	\$1,016	\$913
Employee + Spouse + Child(ren)	\$1,754	\$1,643	\$1,276	\$1,147

- Premiums shown are for the employee share for **active employees, level 1**
- A complete chart is available in the Eligibility and Enrollment 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 – which would add \$40 to \$80 more EACH MONTH depending on your tier

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- Here are the health insurance premiums for **active local government employees – level 1**.
- The premium amounts reflect the total monthly premium. There are different levels based on the demographics of your agency. Please see your ABC for your monthly deduction, your employer's contribution or if you are unsure as to which premium level applies to you.
- A complete chart for all coverage tiers is available in the Eligibility and Enrollment Guide and at www.partnersforhealthtn.gov.
- Important to note – premiums do not include the cost for the Cigna Open Access Plus network which would add \$40 to \$80 more **per month** to your premium depending on your coverage tier.

Premiums for 2018: Local Government

Total Cost of Monthly Premiums – Level 2

Premium Level 1	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA
Employee Only	\$725	\$679	\$527	\$474
Employee + Child(ren)	\$1,124	\$1,053	\$818	\$735
Employee + Spouse	\$1,559	\$1,460	\$1,134	\$1,019
Employee + Spouse + Child(ren)	\$1,958	\$1,834	\$1,424	\$1,280

- Premiums shown are for the employee share for **active employees, level 2**
- A complete chart is available in the Eligibility and Enrollment 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 – which would add \$40 to \$80 more EACH MONTH depending on your tier

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- Here are the health insurance premiums for **active local government employees – level 2**.
- The premium amounts reflect the total monthly premium. There are different levels based on the demographics of your agency. Please see your ABC for your monthly deduction, your employer's contribution or if you are unsure as to which premium level applies to you.
- A complete chart for all coverage tiers is available in the Eligibility and Enrollment Guide and at www.partnersforhealthtn.gov.
- Important to note – premiums do not include the cost for the Cigna Open Access Plus network which would add \$40 to \$80 more **per month** to your premium depending on your coverage tier.

Premiums for 2018: Local Government

Total Cost of Monthly Premiums – Level 3

Premium Level 1	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA
Employee Only	\$788	\$738	\$574	\$515
Employee + Child(ren)	\$1,222	\$1,145	\$889	\$799
Employee + Spouse	\$1,695	\$1,588	\$1,233	\$1,108
Employee + Spouse + Child(ren)	\$2,129	\$1,994	\$1,549	\$1,392

- Premiums shown are for the employee share for **active employees, level 3**
- A complete chart is available in the Eligibility and Enrollment 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 – which would add \$40 to \$80 more EACH MONTH depending on your tier

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- Here are the health insurance premiums for **active local government employees – level 3**.
- The premium amounts reflect the total monthly premium. There are different levels based on the demographics of your agency. Please see your ABC for your monthly deduction, your employer's contribution or if you are unsure as to which premium level applies to you.
- A complete chart for all coverage tiers is available in the Eligibility and Enrollment Guide and at www.partnersforhealthtn.gov.
- Important to note – premiums do not include the cost for the Cigna Open Access Plus network which would add \$40 to \$80 more **per month** to your premium depending on your coverage tier.

2018 Deductibles and Out-of-Pocket Maximums

	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA
	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	\$8,000
Employee + Child(ren)	\$5,400	\$6,000	\$13,200	\$16,000
Employee + Spouse	\$7,200	\$8,000	\$13,200	\$16,000
Employee + Spouse + Child(ren)	\$9,000	\$10,000	\$13,200	\$16,000

- This chart shows the **annual deductible and out-of-pocket maximums**.
- The **annual deductible** is the amount you must pay each year before your plan pays any hospital or other charges that are covered through co-insurance.
 - Your annual deductible is lower for in-network services.
 - For the PPOs, the deductible does **not** apply to primary care visits, prescription drugs or other services or products that require a copay.
- The plans also have **out-of-pocket maximums** for both in-network and out-of-network services.
 - The **out-of-pocket maximums** limit how much co-insurance and copays you would have to pay in any given year if you or a covered family member had a serious illness or injury.
 - After you reach your out-of-pocket maximum level for in-network services, the plan would pay 100% of in-network costs for the rest of the year.
 - The out-of-pocket maximums provide you and your covered dependents with peace of mind and financial protection against a catastrophic illness or injury.

Note: For Local CDHP Plan, the deductible and out-of-pocket maximum amount can be met by one or more persons, depending on premium level, but no one family member may contribute more than \$7,350 to the in-network family out-of-pocket maximum total. The total deductible must be met before coinsurance applies for any family member unless otherwise noted in the Eligibility and Enrollment Guide.

Take Note!

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

Example: Employee Only Coverage - Premier 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	\$1,250	\$9,000

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

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- Your deductibles and out-of-pocket maximums for in-network and out-of-network services add up separately. For the purpose of this example, we are looking at costs for someone with single coverage in the Premier PPO.
- If you incur in-network expenses, that amount goes toward the in-network deductible of \$500 and out-of-pocket maximum of \$3,600. If you incur out-of-network expenses, that amount goes toward the out-of-network deductible of \$1,250 and out-of-pocket maximum of \$9,000.
- Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.
- PPO copays do not count toward your deductible but do apply to out-of-pocket maximums.

Community Resources

We want to make sure you are aware of available resources if you want to continue or start to improve your health! We recommend **Healthier Tennessee®**, which you may already be involved in through your coordinated school health program or your community.

Healthier Tennessee® is an initiative of the Governor's Foundation for Health and Wellness. This initiative promotes a healthy diet, strives to increase the number of Tennesseans who are physically active and works to reduce the number of those who use tobacco.

Healthier Tennessee's wellness tools are built around the concept of Small Starts®: simple, healthy actions you can turn into routine habits in as little as 10 minutes a day. Small Starts® tools are available for individuals. Learn more about the Small Starts® approach, tools and the free Streaks for Small Starts® app at healthiertn.com/streaks-for-small-starts.

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We want to make sure you are aware of available resources if you want to continue or start to improve your health! We recommend **Healthier Tennessee®**, which you may already be involved in through your coordinated school health program or your community.

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Healthier Tennessee's wellness tools are built around the concept of Small Starts®: simple, healthy actions you can turn into routine habits in as little as 10 minutes a day. Small Starts® tools are available for individuals. Learn more about the Small Starts® approach, tools and the free Streaks for Small Starts® app at www.healthiertn.com/streaks-for-small-starts.

Dental benefits (voluntary)

Eligible employees can choose between two voluntary dental options (if offered by your agency):

Prepaid Dental Plan (Cigna Dental Health Maintenance Organization — DHMO)

- Fixed copays
- Participating dentists only
- Lower premiums

Dental Preferred Provider Organization (DPPO — MetLife)

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

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- Eligible employees can choose between two dental options – if offered by your agency. You can check with your ABC on the if this coverage if available to you.
 - Prepaid Dental Plan – which is the Cigna Dental Health Maintenance Organization or DHMO plan, or the
 - Dental Preferred Provider Organization plan, which is the DPPO offered by MetLife
- You'll see some of the differences on the screen. We'll go into more details on the upcoming slides.

Dental benefits

Prepaid (DHMO) Plan — Cigna

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

- The network is Cigna Dental Care DHMO.
- **Must select a general dentist** from the Prepaid (DHMO) Dental Plan list and tell Cigna.
 - You may select a network pediatric dentist as the network general dentist for your dependent child under age seven. At age seven, you must switch the child to a network general dentist or pay the full charge from the pediatric dentist.
- Must use your selected general dentist to receive benefits. There may be some areas in the state where network general dentists are limited or not available. Carefully check the network for your location.
 - With the prepaid dental plan, you may be able to cancel this coverage if you enroll and later there are no network general dentists within 40 mile radius of your home.
- Pay copays for dental treatments.
- No deductibles to meet, no claims to file, no waiting periods, no annual dollar maximum.
- Preexisting conditions are covered.
- **Referrals to specialists are required.**
- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna.

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The **Prepaid Plan** is administered by Cigna and provides services at predetermined copay amounts. You must receive services from a narrow network of participating Cigna general dentists and specialists.

- The **network is Cigna Dental Care DHMO.**
- **You must select a general dentist** from the Prepaid (DHMO) Dental Plan list and let Cigna know of your choice.
 - You may select a network pediatric dentist as the network general dentist for your dependent child under age seven. At age seven, you must switch the child to a network general dentist or pay the full charge from the pediatric dentist.
- You must use your selected general dentist to receive benefits. There may be some areas in the state where network general dentists are limited or not available. Be sure to carefully check the network for your location.
 - With the prepaid dental plan, you may be able to cancel this coverage if you enroll and later there are no network general dentists within 40 mile radius of your home.
- You pay copays for dental treatments.
- There are no deductibles to meet, no claims to file, no waiting periods, no annual dollar maximum.
- Preexisting conditions are covered.
- **Referrals to specialists are required.**
- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna.

Dental benefits

MetLife Dental

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

- **The network is PDP.**
- You can use **any dentist**, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. 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 six-month waiting period from the member's coverage start date before benefits begin.
- There is a 12-month waiting period from the member's coverage start date on replacement of a missing tooth and for orthodontics.
- Referrals to specialists are **not** required.
- Pre-treatment estimates are recommended for more expensive services.
- Dental treatment in progress at time of member's effective date with MetLife may have pro-rated benefits under the MetLife plan.

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- **The Dental Preferred Provider Organization plan is administered by MetLife and provides services with coinsurance. You can use any dentist, but will pay less if you use an in-network provider.**
 - **The network is PDP.**
 - You can use **any dentist**, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. 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 six-month waiting period from the member's coverage start date before benefits begin.
 - There is a 12-month waiting period from the member's coverage start date on replacement of a missing tooth and for orthodontics.
 - Referrals to specialists are **not** required.
 - Pre-treatment estimates are recommended for more expensive services.
 - Dental treatment in progress at time of member's effective date with MetLife may have pro-rated benefits under the MetLife plan.

Dental benefits

Monthly Premiums for Active Members

Premiums	Cigna Prepaid (DHMO Plan)	DPPO - MetLife
Employee Only	\$13.44	\$23.18
Employee + Child(ren)	\$27.91	\$53.29
Employee + Spouse	\$23.83	\$43.84
Employee + Spouse + Child(ren)	\$32.76	\$85.78

Dental services for both the Prepaid (DHMO) Plan and the DPPO Plan include:

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

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- The 2018 dental premiums are on screen. You can also find them in the Eligibility and Enrollment guide.
- Here is a brief list of some of the dental services for both the Cigna Prepaid (DHMO) Plan and the MetLife DPPO plan:
 - Periodic oral evaluations
 - Routine cleanings
 - Amalgam fillings
 - Endodontics – Root canal
 - X-rays
 - Extractions
 - Major restorations
 - Orthodontics (children/dependents)
 - Dentures
- A list of covered services and costs is also included in the Eligibility and Enrollment Guide.
- You may also refer to the ParTNeRS for Health website at www.partnersforhealthtn.gov for more information about dental coverage.

Vision benefits (voluntary)

The state offers voluntary vision benefits through **Davis Vision (if offered by your agency)**.

- It is important to check the network for your provider and other providers in your area.
- You can look for your provider by going to davisvision.com/stateofTN. There is not a specific name to enter.
- There are many added values to vision benefits, including an increased allowance for frames, lenses and contact lenses.

The state offers voluntary vision benefits through Davis Vision – if offered by your agency.

- It is important to check the network for your provider and other providers in your area.
- You can look for your provider by going to davisvision.com/stateofTN. There is not a specific name to enter.
- There are many added values to vision benefits, including an increased allowance for frames, lenses and contact lenses.

Vision benefits

Eligible employees can choose between two voluntary vision options:

Basic Plan

- Discounted rates
- Allowances

Expanded Plan

- Provides services with a combination of copays
- Greater allowances
- Discounted rates

Both options offer the same services including:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglass lenses or contact lenses once every calendar year
- Discount on LASIK/refractive surgery

The Basic and Expanded Plans are both managed by Davis Vision. In-network and out-of-network benefits are available. You will receive the maximum benefit when visiting a provider in Davis Vision's network.

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Eligible employees can choose between two voluntary vision options:

The Basic Plan and the Expanded Plan.

Both options offer the same services including:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglass lenses or contact lenses once every calendar year
- Discount on LASIK/refractive surgery

The Basic and Expanded Plans are both managed by Davis Vision. In-network and out-of-network benefits are available. You will receive the maximum benefit when visiting a provider in Davis Vision's network.

Vision benefits

Additional values offered by Davis Vision:

- Zero (\$0.00) copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location.
- Free pair of eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Expanded Plan.
- Free pair of "Fashion Selection" eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Basic Plan.
- Free pair of frames at Visionworks retail locations.
- 40% discount off retail under the in-network Expanded Plan and 30% discount off retail under the in-network Basic Plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations.
- 20% discount off retail cost of an additional pair of conventional or disposable contact lenses under the in-network Expanded Plan.
- One year warranty for breakage of most eyeglasses.

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There are additional values offered by Davis Vision:

- Zero (\$0.00) copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location.
- Free pair of eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Expanded Plan.
- Free pair of "Fashion Selection" eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Basic Plan.
- Free pair of frames at Visionworks retail locations.
- 40% discount off retail under the in-network Expanded Plan and 30% discount off retail under the in-network Basic Plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations.
- 20% discount off retail cost of an additional pair of conventional or disposable contact lenses under the in-network Expanded Plan.
- One year warranty for breakage of most eyeglasses.

Vision benefits

2018 premiums:

	Basic	Expanded
Employee Only	\$3.07	\$5.56
Employee + Child(ren)	\$6.13	\$11.12
Employee + Spouse	\$5.82	\$10.57
Employee + Spouse + Child(ren)	\$9.01	\$16.35

The 2018 vision premiums are on the screen. These premiums are also found in the Eligibility and Enrollment guide.

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 and Marriage License for a spouse
 - Birth certificate for a child

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- If you choose to enroll in health, vision or dental benefits, there are two ways to enroll:
 - One option is to complete a paper form called the Enrollment Change Application. If you choose to use the paper application, you will return this form to your ABC once you have made your selections and they will enter your selections in Edison through a process called Benefit eForm.
 - A better option is to submit your benefit selections online using Edison Employee Self-Service or ESS for short. ESS allows you to make your selections electronically, which many employees find to be faster and easier than the paper form.
- **Enrollment must be completed within 31 days of your hire date.**
- If you want to cover your spouse or children, you will also need to provide documentation during this time to verify their relationship to you. Examples of dependent verification can include a marriage license and Federal Income Tax Return for a spouse or a birth certificate for a child. A complete list of required documentation for dependent verification can be found on the BA website (www.tn.gov/finance/fa-benefits) under the **Forms** tab in the **Health and Dental** box.

Online Enrollment through ESS

Here is how to enroll in your 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

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- Here is how you can enroll online in Employee Self Service (ESS).
- Simply log in to Edison using the username and temporary password provided by your Human Resource office or ABC. Navigate to the left hand side of the main page and select **Self Service**. You will then click on **Employee Work Center** and will see an option for **Benefits Enrollment** under **My Benefits**. You will then click on the **Select** button to start enrollment. Follow the prompts to make your selections and the system will take you through the rest of the process.
- If you are covering dependents, you can submit your dependent verification by uploading copies of the appropriate documentation in Edison.
- Or, if you do not have electronic copies, you may also fax the required documentation to the Benefits Administration service center at 615-741-8196.
 - **Dependent verification documents must be submitted within your 31 day enrollment time frame or your dependents will not be enrolled.**

When Will Coverage Begin?

- Health, dental and vision insurance begins on the first day of the month
- If you are hired on Sept. 15, coverage would begin on Oct. 1 or Nov. 1*
- 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

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- Once you enroll, your health, vision and dental insurance, will begin on the first day of the month.
- Your ABC can help if you have questions about when your coverage begins.

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.

- Your ABC will tell you when your premiums will be deducted from your paycheck.
- We do recommend entering your benefit selections in ESS or submitting your enrollment forms to your ABC as soon as possible.
- 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
<ul style="list-style-type: none">• Sends up to two ID cards automatically, both with member's name• These may be used by any covered dependent	<ul style="list-style-type: none">• Sends separate ID cards for each insured family member with each participant's name• 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

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- Once your enrollment application has been processed, you will generally receive your new health insurance ID cards within three weeks.
- If you enrolled in health coverage with BlueCross BlueShield, you will receive up to two ID cards automatically. The member's name will be printed on all cards, but these cards may be used by any covered dependent.
- If you choose health coverage with Cigna, you will receive separate ID cards for each insured family member with the participant's name printed on each. Cigna will send up to four ID cards in each envelope and additional ID cards in a separate envelope.
- After you receive your initial cards, if you need additional ID cards, you can request them by contacting the carriers directly.
- In addition to your health insurance ID cards, you will also automatically receive separate pharmacy ID cards. If you are enrolled in family coverage, your ID cards may be sent in separate envelopes.
- If you enroll in dental or vision coverage, you will typically receive your ID cards within three weeks.

Retiree Insurance – Local Education

- Retiree health insurance coverage (pre-65 retirees) is not available to employees whose employment with a participating Local Education agency first began on or after July 1, 2015.
- The Tennessee Plan (Supplemental Insurance for retirees with Medicare) 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 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 did not accept a lump sum payment from TCRS before July 1, 2015, and meets all other eligibility requirements for retirement insurance.
- If you have questions about the above regarding your eligibility for retirement insurance, we encourage you to contact Benefits Administration.
- If you have questions about your insurance options as an employee, we encourage you to talk to your ABC.

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- A new law regarding retiree insurance was approved by the legislature in April of 2015.
- As of July 1, 2015, retiree health insurance coverage for pre-65 retirees will not be available to any employee whose employment with a participating Local Education agency first began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
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- If you have questions about eligibility for retirement insurance, please contact Benefits Administration.
- If you have questions about your insurance options as an employee, talk to your 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/fa-benefits. On this page, select the "Forms" tab.

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- All of our members' personal health information is strictly confidential. Your health privacy rights are protected through a federal law called HIPAA (Health Insurance Portability Accountability Act). It requires your personal health information not be shared without your consent so Benefits Administration can only discuss benefit information with the employee who is enrolling in coverage, also known as the head of contract or HOC.
- If you would like to grant Benefits Administration permission to speak to someone other than you about your benefits, please complete and submit an Authorization for Release of Protected Health Information form to Benefits Administration. This will allow your spouse or another individual of your choosing to receive your health information on your behalf. This form is available in the forms section of our website or from your ABC.
- Please note that your personal health information may be used or disclosed by and within each plan as well as the State Group Insurance Program third-party "business associates" or contractors as needed for your treatment, payment of benefits or other health care plan operations.

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

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- BlueCross BlueShield, Cigna and CVS/caremark each offer member websites that allow you to view detailed information about your claims, print temporary ID cards and access other helpful member services.
- These member websites offer a convenient way to keep track of your health insurance benefit information. All you have to do is create an online account to get started.

Who to Contact

- Your primary point of contact is your 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/fa-benefits

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- We have covered a lot of new information in this presentation, so it's important to know who to ask if you have questions or need more information at a later time. Your ABC will be your primary point of contact, and he or she will be able to answer many of your benefits-related questions or help point you in the right direction.
- If you have questions about a provider or insurance claim, contact your insurance carrier directly. You can find your carrier's number in the Eligibility and Enrollment Guide or by visiting their member website. Once you receive your ID card, you can also find the carrier's phone number listed on the back of your card.
- If you have specific questions regarding eligibility or enrollment in benefits, you may call the Benefits Administration service center at 1-800-253-9981.
- The ParTNers for Health and Benefits Administration websites are great resources as well, and include contact information for all of our benefits vendors.

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**Thank you for your attention
during this presentation.**

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

Have questions? Please ask your ABC at this time.

- This concludes the new employee benefits orientation. To watch this presentation again, or to access the forms and other resources discussed during this presentation, visit the Benefits Administration New Employee Page. Go to www.tn.gov/finance/fa-benefits and click on the New Employee tab on the left side of your screen.
- Thank you for your attention during this presentation. If you have questions, please ask your ABC at this time.