

# Questions and Answers

(updated August 31, 2015)



## Enrollment & Eligibility

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If you are looking for enrollment and eligibility information, [visit our publications page](#) to find the eligibility and enrollment guide and plan documents.

- 1. Can children under age 26 be covered as dependents on their parents' plan if they are eligible for their own coverage (e.g., at another job)?**

Yes, access to other coverage is not a factor.

- 2. Can incapacitated children be covered beyond age 26?**

If they are already enrolled in the state group health insurance plan and incapacitation was prior to age 26, they will be covered as long as they continue to meet eligibility requirements.

- 3. If two plan members are married, do they have to choose the employee + spouse premium level, or can they each sign up for employee only coverage? What if they have children?**

If they prefer, married members can each enroll in employee only coverage. If two married eligible employees have a child(ren), one of them can choose employee only and the other can choose employee + child(ren).

- 4. Can an employee drop a dependent from coverage in the middle of the plan year?**

Coverage can only be dropped during the fall enrollment period or if a member has a qualifying family status change. A list of qualifying events is on the "cancel request" form located on the Benefits Administration website on the forms page.

- 5. Do the preexisting condition exclusions apply anymore?**

There is no longer a preexisting condition exclusion for anyone of any age and no proof of creditable coverage is required.

## Partnership Promise

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If you are looking for information about the Partnership Promise requirements and deadlines, visit our [Partnership Promise](#), [Well-Being Assessment](#), [Biometric Screening](#) and [Coaching](#) pages.

**1. If my spouse and children are covered by my insurance, do they have to fulfill the Partnership Promise too?**

Both you and your covered spouse have to meet the Partnership Promise in order to remain in the Partnership PPO in 2016. Children enrolled in your plan, regardless of age, **do not** have to fulfill the Partnership Promise.

**2. Do I have to sign the Partnership Promise if I am enrolling for the first time?**

Yes. When you sign the enrollment form or click “OK” in Edison employee self-service to enroll in the Partnership PPO, you are committing for you and your covered spouse to complete the Partnership Promise.

**3. I failed to fulfill the Partnership Promise in the past and was transferred to the Standard PPO. When am I eligible to re-enroll in the Partnership PPO?**

If you do not fulfill the Partnership Promise and are transferred to the Standard PPO, you must wait one calendar year before you are eligible to enroll in the Partnership PPO again. You can reenroll in the Partnership PPO during the next annual enrollment period. For example, if you are transferred to the Standard PPO for the 2015 calendar year, you can reenroll during the fall annual enrollment period for coverage to begin on January 1, 2016. You must re-enroll. You will not automatically be transferred back to the Partnership PPO.

**4. If my covered spouse does not meet the Partnership Promise and I drop him or her from my coverage, can I re-enroll in the Partnership PPO for the following year?**

Yes. If the head of contract fulfills the Partnership Promise but the covered spouse does not, the head of contract may re-enroll in the Partnership PPO during annual enrollment **ONLY** if the non-compliant spouse is dropped from coverage.

The head of contract must first drop the non-compliant spouse from coverage before he or she can re-enroll in the Partnership PPO. The employee will have to submit a paper form before the end of the annual enrollment period to notify Benefits Administration that he or she would like to be moved back to the Partnership PPO. This change will be made after the enrollment period ends and Benefits Administration confirms with Healthways that you completed the Promise.

### Well-Being Assessment (WBA)

**5. Do I have to complete a questionnaire?**

Yes. All members and covered spouses must complete the Healthways Well-Being Assessment (WBA) between January 1 and March 15, 2016. Other health questionnaires (e.g.: Cigna or BlueCross BlueShield assessments) will not count toward fulfilling the Partnership Promise. It is recommended that you complete the Well-Being Assessment online. The online WBA offers a better member experience with instant results and access to a personalized Well-Being Plan. Please note: After you finish your Well-Being Assessment, although not required to fulfill the Partnership Promise, you will need to create a Well-Being Plan to have access to the other

resources in Well-Being Connect. There are alternatives to completing the questionnaire online. Please call Healthways at 888.741.3390 for other options.

**6. Do I have to create an online [Well-Being Account](#)?**

If you have not previously set up an online Well-Being Account, you will need to register and create an account before you can complete the Well-Being Assessment, create a Well-Being Plan, and access the tools, trackers and resources. Once you create an account, you will use the same username and password to access Well-Being Connect going forward. In order to create an online Well-Being Account, you are required to provide your legal first and last name, date of birth, mailing ZIP code and your email address. If you do not have an email address, you can create a free email account at websites such as [gmail.com](#) or [yahoo.com](#).

**7. How does the spouse create an online account to complete the Well-Being Assessment?**

Covered spouses will have access to set up his or her own [Well-Being Account](#) by going to the [ParTNers for Health website](#) and clicking on “[My Wellness Login](#).” All employees and spouses enrolled in the Partnership PPO can check their status in the Partnership Promise by calling 888.741.3390 and selecting option 1 to use the automated verification system.

**8. What is a Well-Being Plan?**

The plan is a personalized tool that helps you reach your healthy best. After you complete your online Well-Being Assessment (WBA), you can view your results as well as recommended focus areas, like healthy eating, stress management and tobacco cessation. You can use these recommendations to create your online Well-Being Plan with suggested action items. The Well-Being Plan is not required.

## Biometric Screening

**9. Can I order a Physician Screening Form over the phone?**

Yes, you can call Healthways at 888.741.3390 and select Option 1 and a customer service representative will be happy to assist you.

**10. If I am unable to complete all of the tests of the biometric screening (e.g., blood tests due to needles) will I still meet the requirement?**

Yes, but you will need to complete the other tests required as a part of the biometric screening and your doctor will need to make a note on your Physician Screening Form about the tests not completed.

**11. Will I have to pay a copay for my biometric screening?**

Your annual wellness visit (i.e. physical exam) is considered a preventive service and is offered to members at no cost. However, if you have your biometric screening completed at the same time you receive other medical services or treatments, you may have to pay a co-pay.

**12. If my doctor charges a fee to submit the Physician Screening Form, am I responsible for paying that fee?**

Yes. The state cannot control what a doctor’s office charges to complete a form, and some doctor’s offices may charge an administrative fee to complete the Physician Screening Form.

### **13. Can I submit the Physician Screening Form or should it come from my doctor?**

Yes, you can submit the form as long as it is completed and signed or stamped by your doctor **AND** signed by you.

## Case Management

### **14. What is case management?**

Case management is administered by BlueCross BlueShield, Cigna and Magellan. You must participate in case management if you are contacted by one of these carriers. Case management helps coordinate care across all of your providers for chronic conditions and/or catastrophic illness or injuries. If you are identified based on your insurance claims, you will be contacted by BlueCross BlueShield, Cigna or Magellan and asked to participate in case management.

### **15. What does behavioral health case management by Magellan involve?**

Situations where someone would be contacted for behavioral health case management include inpatient behavioral health or substance abuse treatment and/or the diagnosis of a serious and persistent mental illness. Members in the behavioral health case management program will have access to a licensed behavioral health professional who can help advocate for their care and assist them in navigating the system.

Behavioral health case management is completely separate from the five free sessions offered by the Employee Assistance Program (EAP), which are **not** tied to the Partnership Promise.

## Coaching

### **16. Who do the coaches work for and what are their credentials?**

All coaches are employees of Healthways, the company that the state has contracted with to manage the wellness program. The ParTNers for Health Wellness Program coaches have wide expertise. They include licensed registered nurses and licensed dietitians, certified health educators and those with degrees in exercise physiology, exercise science, health promotion and psychology. This vast experience allows you access to speak with coaches based on your needs and personal health goals.

### **17. How does Healthways decide who is contacted for coaching?**

Healthways decides who is contacted for coaching based on your answers on the Well-Being Assessment (WBA), biometric screening results and health insurance claims. If you are contacted for coaching you will need to continue coaching unless you are notified differently by Healthways.

### **18. How often, when and how do I communicate with my coach?**

A coach may contact you at any time during the plan year (January 1 – December 31). You may talk via phone. There is no set number of phone calls. You and your coach will talk as needed and will develop a schedule that works best for you. The coaches are available Monday – Friday from 8:00 a.m. – 8:00 p.m. and Saturday from 8:00 a.m. – 6:30 p.m. (Central Time).

Your call frequency will be determined by your personal health status and/or chronic conditions. Coaches will work with you to create a plan of care that is best suited for your health needs.

If you miss a call, your coach will try to call you back or you can contact him/her.

**19. What if I miss a call? What happens if my coach is unable to reach me?**

If a coach cannot reach you after two attempts, Healthways will send a letter to your home address. Then, it is up to you to contact your coach. Don't put your Partnership Promise at risk. Coaching is part of your requirements and Healthways wants to partner with you to make sure your requirements are met. You must complete all Partnership Promise requirements to remain in the Partnership PPO.

This is why it is very important to keep your committed calls with your coach and to keep your contact information up to date with your employer or with Healthways.

**20. If I am able to meet my goals for better health, will I still be required to work with a coach to fulfill the Partnership Promise? For how long?**

If you are contacted for coaching or case management, you will need to take part in the ParTNers for Health Wellness Programt. If you are able to improve your health, lower your health risk behaviors and complete your plan of care with your coach, you may graduate from coaching.

Those with chronic conditions such as diabetes, heart disease, COPD, etc., will benefit from remaining in a coaching program for the entire time, but they may not have to talk to a coach as often if they improve and meet some of their goals.

Future changes in your health status might cause your coach to follow up with you to enroll in a disease or lifestyle management program again. You may choose to opt-out of a program, but you will be ineligible for the Partnership PPO in the following year.

**21. What happens if I don't meet the goals I initially set with my coach?**

As long as you are making an effort to work towards your goals and tell your coach about your challenges and successes, you can stay in the Partnership PPO. Your coach will work with you to create reasonable and achievable goals that can be changed at any time when appropriate.

**22. If I talk to my doctor instead, does that satisfy the coaching requirement?**

No. Talking to your doctor does not fulfill the coaching requirement. Coaches provide one-on-one support to help you adopt and maintain healthy behaviors to prevent and control chronic diseases.

**23. Will the coaches work with my doctor and my doctor's orders?**

Your doctor's advice always takes priority over guidance from the ParTNers for Health Wellness Program. Please share your doctor's advice with your coach so that he/she can work as part of your healthcare team. With your permission, your coach can talk with your doctor to share your health goals and plan of care.

Your coach's role is to provide information and support—not a prescriptive plan that a member must follow. You can work with both your coach and doctor to develop a plan that is clinically appropriate.

**24. If my spouse gives me permission to speak to a coach on his/her behalf, can I do that?**

Yes, but your spouse will have to speak to the coach first to give permission.

**25. If I was required to coach in 2015, will I automatically continue coaching in 2016?**

Yes, you will need to continue coaching until you are notified differently by your Healthways coach. Coaching does not necessarily follow a calendar year. Members who were in coaching in 2015 and will need to continue to coach in 2016 will receive a coaching reminder letter.

## **26. How will my spouse be contacted if required to coach?**

A coach will contact him/her using the phone number for the spouse on file with Healthways. If there is not a number on file for the spouse, he or she will receive a letter and will have 14 days to respond. If the spouse does not respond in time, the head of contract (the primary health plan member) and covered spouse will be defaulted to the Standard PPO in 2016. It is very important for your spouse to keep his/her contact information up-to-date with Healthways.

A Spouse can create and log in to the online Well-Being Account to enter a current phone number. If a spouse does not have access to the internet, he/she can also call Healthways at 888.741.3390 to update contact information. This will ensure that Healthways can reach the spouse if he/she will need to participate in coaching.

## **27. Can I work with a coach even if I am not contacted by Healthways to coach?**

Absolutely. All members have access to coaching services. We currently have members who opt in to coaching. When you are not contacted for coaching but choose to opt in, you are not required to complete a coaching program to meet your Partnership Promise and can stop at any time.

## **Healthways Tobacco Cessation Program**

## **28. Am I going to be charged more for being a tobacco user?**

No. There is no surcharge for tobacco use. Remember, if you enroll in the Partnership PPO or the Wellness HealthSavings CDHP you must participate and complete a Healthways' tobacco cessation coaching program (as part of the Partnership Promise coaching requirement). You are not required to quit – just participate in the program and try to quit. If you are not willing to participate in Healthways tobacco cessation coaching, the Standard PPO or the HealthSavings CDHP is a better option for you (or Limited PPO for local government and local education).

## **29. What types of tobacco cessation programs are available?**

In order to meet this Partnership Promise requirement, you must participate and complete a Healthways' tobacco cessation coaching program.

Healthways offers two different levels of engagement depending on your readiness to quit.

If you are a tobacco user who is not ready to quit, you will work with a health coach who will meet you where you are, help you work towards becoming tobacco free and support you in your other well-being improvement goals.

If you are ready to quit, Healthways offers a more intensive program, QuitNet<sup>®</sup>. This program involves setting a quit date, more frequent calls and online support.

While the goal is always to quit using tobacco products, you are not required to quit – just participate in the program and try to quit.

## **30. Am I considered a tobacco user if I only use tobacco occasionally?**

Yes. A tobacco user is someone who uses any tobacco product, including cigarettes, e-cigarettes, cigars or smokeless tobacco. However, **there is one exception**. Someone who smokes an occasional cigar (up to one a month) is not considered a tobacco user (based on similar guidelines from life insurance companies that allow for occasional cigar use).

### 31. What if I am not ready to quit using tobacco, can I sign up for the Partnership PPO?

Healthways tobacco cessation coaching is designed to create a positive experience for the member. The coaches recognize that not everyone is ready to quit and they are trained to work with members in different stages of readiness to quit. A coach will work with you to design a plan that is best for you.

Remember, you are not required to stop using tobacco by the end of 2016, but you must complete the tobacco cessation coaching and make an effort to quit.

If you are not willing to participate in the tobacco cessation program, the Standard PPO or HealthSavings CDHP is a better option for you (or Limited PPO for local government and local education).

## Updating Contact Information

### 32. How do I update my contact information?

- **State employees:** You can change your contact information in Edison or by contacting your agency's human resources office.
- **Higher Education, Local Education and Local Government employees:** You can change your contact information in Edison, by contacting your agency's human resources office or by calling the Benefits Administration service center at 800.253.9981 and selecting option 6.
- **Retirees:** You can change your contact information by contacting the Benefits Administration service center at 800.253.9981 and selecting option 2.
- **Spouses:** Spouses can create and login to their online Well-Being Account to enter their contact phone number OR call Healthways at 888.741.3390, Monday to Friday from 8:00 a.m. to 8:00 p.m. CT to update their information.

### 33. If I update my contact information in Employee Self Service (ESS) in Edison, will my health coach receive my new information?

Yes. Benefits Administration sends a weekly eligibility file to Healthways so they will have your current information. Please know that the number you have listed as your home number is the phone number that is provided to Healthways. If no home number is listed, then the preferred number is sent.

### 34. What if I don't have an email address?

An email address is not required, but you MUST keep your phone number and mailing address up to date. If you do not have an email address, you can create a free email account at websites such as [www.gmail.com](http://www.gmail.com) or [www.yahoo.com](http://www.yahoo.com).

## ParTNers for Health Wellness Program

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For general information about the Wellness Program including wellness and fitness discounts and Weight Watchers at Work, [visit the Wellness Program page](#).

### 1. What security information will coaches ask for to identify members on the phone?

To ensure privacy and security, Healthways will ask the member to verify his or her name, mailing address and date of birth. Healthways will not ask for the member's social security number.

However, if the member is unable to verify his or her personal information, Healthways will not be able to release any information to the member at that time or complete a coaching call. In such a case, the member would need to call back when they can verify all personal information. Healthways strives to protect the personal health information of all members while providing the best customer service.

## **2. How can I verify the identity of my coach when he or she calls?**

If you are concerned about the identity of your coach, simply express your concerns to the coach. He or she will give you the number for the ParTNers for Health Wellness Program and ask you to call back to verify.

## **3. What is a wellness challenge?**

Wellness challenges are offered online and focus on topics such as fitness, nutrition and weight management. They offer fun ways to help members develop healthier lifestyles while providing group support. Challenges in 2015 include *Lose the Excuse* (weight loss), *WonderWalk* (physical activity), *Sugar Shaker* (healthy eating), and *Training Camp* (physical activity).

## **4. How can I contact Healthways if I have questions about the Partnership Promise or coaching?**

You can call Healthways directly at: 888.741.3390, Monday – Friday from 8:00 a.m. – 8:00 p.m. (Central Time).

## **5. Can Standard PPO, Limited PPO and HealthSavings CDHP members use the ParTNers for Health Wellness Program services with no additional cost?**

Yes. All members may use resources such as coaching, wellness challenges, educational mailings, the 24-hour nurse call advice line or other health and wellness services. Coaching and other services will be provided with no additional charge for members in each PPO option as well as the HealthSavings CDHPs.

## **Pharmacy**

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**For general information about pharmacy including finding a network pharmacy, flu and pneumococcal vaccine and tobacco quit aids, visit the [Pharmacy](#) page.**

### **1. What happens if I ask for a brand name medication when my doctor writes a prescription indicating that a generic drug can be substituted?**

When a generic is available and your doctor indicates “may substitute” but you request the brand name drug from the pharmacy, you will pay the difference between the brand name drug and the generic drug plus the brand copay.

### **2. Is the shingles vaccine covered by the state’s health insurance plans, and can the state lower the age limit for receiving the vaccine?**

The Zoster vaccination for Shingles is covered. Immunization schedules are based on the Centers for Disease Control and Prevention guidelines and are subject to change. We follow the CDC recommendation on age, which is that vaccination begins at age 60. There are no anticipated changes in regards to the Shingles vaccine at this time. Current guidelines can be found under the CDC schedules at [cdc.gov/vaccines](http://cdc.gov/vaccines).



**3. Are diabetic drugs and supplies still free?**

Since the beginning of 2012, diabetic drugs and supplies are no longer free. However, they are included in the low-cost maintenance drug tier. With this drug tier, we made other drugs more affordable. Studies show that diabetics often have other conditions that call for long-term use of statins (cholesterol lowering drugs) and/or high blood pressure drugs.

About 75 percent of our approximately 26,000 diabetic members have another condition requiring one of these drugs. For this reason, most members have seen their overall costs go down, even with the small rise in the cost of diabetic drugs. In addition, about 85,000 of our members do not have diabetes but do need one of these drugs to treat high blood pressure or high cholesterol. This drug tier helps these members by lowering their out-of-pocket costs.

**4. What is the maintenance tier?**

To utilize the maintenance tier and to receive the lower copays associated with it, a member must fill a 90-day supply through either a 90-day network pharmacy or via mail order. These medications include:

- Oral diabetic medications, insulin and supplies (test strips, lancets & needles)
- Statins (cholesterol-lowering drugs)
- Antihypertensives (blood pressure medications)
- Depression
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)

Some of the more common drugs that are eligible for the reduced copay are: Metformin, Glimepiride, Actos, Januvia, Novolog, Simvastatin, Crestor, Atorvastatin, Pravastatin, Lovastatin, Lisinopril, Hydrochlorothiazide, Amlodipine and Atenolol.

90-Day Maintenance Co-Pays				90-Day Maintenance Co-Insurance	
Tier	Partnership PPO	Standard PPO	Limited PPO	Wellness HealthSavings	HealthSavings
Generic	\$5	\$10	\$10	10%	20%
Preferred Brand	\$30	\$40	\$50	10%	20%
Non-Preferred Brand	\$160	\$180	\$200	10%	20%

**5. I have diabetes. Can I use any lancets and test strips?**

This benefit changed effective January 1, 2015. See this [flier](#) for important details.

You can use any lancets and test strips, but you will pay more if you use a non-preferred brand (Tier 3). OneTouch test strips and lancets are the only preferred brand products available at the reduced copayments.

**6. How can I find out if my drug is included in the maintenance drug list?**

You can call Caremark at 877.522.TNRX (8679) to find out if your drug qualifies.

**7. What if I take a drug that's not on the Caremark drug list?**

You need to contact Caremark about your options if the drug you are taking is not covered under the approved drug list. Most non-preferred brand name medications are covered, but in choosing to fill these you will have to pay a higher copay.

**8. I tried to get a prescription filled but my claim was denied because the medication is now available over the counter. Does this mean my pharmacy benefits are becoming more limited?**

As medications become available in over-the-counter forms, such as Allegra (fexofenadine), Claritin (loratidine) and Zyrtec (ceterizine), the insurance plans no longer cover them, and members must purchase these out-of-pocket at the pharmacy or store without a prescription. This requirement has existed for years and serves to save the plans money, which in turn helps to keep premium increases to as low of a percentage as possible.

The plan benefits are not decreasing; it is impossible for the insurance plans to continue to cover every single drug once it loses its patent and becomes available over the counter. If the plans continued to cover those medications indefinitely, the increase in premiums would be much higher than employee groups and employees see each year. The plans still serve their intended function to protect plan members and employees against catastrophic loss in the event of a major health issue.

**9. There is a quantity limit on my prescription drug; however, my doctor says I need an amount higher than the limit. What do I do?**

For some drugs, there may be a post-quantity limit authorization available. Your doctor will need to contact Caremark and provide clinical information to request an amount over the plan limit. As the plan's pharmacy benefits manager, Caremark will review this information and decide if the insurance plans should cover the amount above the limit.

**10. I would like to appeal my prescription drug benefits paid with Caremark. What should I do?**

All appeals are handled by Caremark, our pharmacy benefits manager. Call Caremark at 877.522.8679 to begin the process, to ask questions about how to appeal and to check the status of your appeal. If your drug is denied, both you and your doctor will receive a denial letter explaining the reason why it was denied as well as your options for appeal and how to go about filing an appeal.

**11. My pharmacy said my doctor needs to request prior authorization to refill my prescription. How do I do this?**

Contact your doctor and ask him or her to call Caremark directly at 800.626.3046 (doctors only) to request prior authorization for your prescription.

## Other Covered Services

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### 1. What is considered preventive care and what is covered?

Preventive care refers to services or tests that help identify health risks and **is covered at no cost** to you when received in-network. For example, preventive care includes screening mammograms, annual wellness exam/physical and immunizations. In many cases, preventive care helps a patient avoid a serious or even life-threatening disease.

If your annual preventive visit includes discussion or treatment of a specific health issue, you may be required to pay the copay for a regular office visit. Claims are processed based on the diagnosis submitted by the provider, so it is important for the provider to file the claim as preventive.

### 2. Do I have to pay a copay or coinsurance for an annual well-woman visit if I also have an annual physical with my internist or family doctor?

A well-woman visit is an annual preventive visit just like an annual physical or exam. As part of your health insurance, female members can have a well-woman visit and a physical each year. Both of these visits are covered at no cost to the member when received in-network.

### 3. How are mammograms covered by our insurance plan?

Our benefit covers screening mammograms based on your doctor's recommendations. You do not have to pay if you receive a screening mammogram in-network. To learn more about evidence-based recommendations from the U.S. Preventive Services Task Force (USPSTF) and coverage for preventive services required by the Affordable Care Act, visit [uspreventiveservicestaskforce.org](http://uspreventiveservicestaskforce.org).

Diagnostic mammograms are also covered under the plan. As with other non-preventive x-rays, labs and diagnostics (not including advanced x-rays, scans and imaging), the in-network benefit on the PPO plans is 100 percent including reading, interpretation and results AFTER any applicable office visit copay. The in-network benefit on the HealthSavings CDHPs is covered with applicable coinsurance after you have met the deductible.

### 4. How are colonoscopies covered by our insurance plan?

All in-network preventive services, including screening colonoscopies, are covered at no charge. Diagnostic colonoscopies are also covered but require a member payment. Providers determine which type of testing is appropriate based on factors such as a patient's history, other tests and current symptoms and complaints. Payment for colonoscopy services is driven by the provider's billing.

Under current coverage guidelines, a screening colonoscopy every ten years is considered medically necessary for asymptomatic individuals age 50 or older. If medically necessary, due to certain risk factors, screening may begin at an earlier age and occur more frequently.

### 5. What is the difference between a screening and diagnostic colonoscopy?

A screening colonoscopy is performed on an individual without symptoms, who has not been diagnosed with colorectal cancer or additional risk factors for colorectal cancer, such as polyps or inflammatory bowel disease, prior to the start of the screening exam. Please be aware that the insurance companies must process claims based on the provider's billing. If a plan member has a preventive screening colonoscopy billed as a diagnostic exam instead, he or she should contact the provider's office to discuss the services received and to ask if the claim can be resubmitted with preventive coding. If the provider's office does not agree to resubmit the claim, the member should contact the insurance carrier to request a review of the claim. It's possible that claims originally

billed as diagnostic may be reprocessed or adjusted to pay as preventive but only if it can be verified through the provider's office that the exam started out as a preventive screening.

**6. Are allergy shots covered?**

Yes, allergy shots are covered. If you are in one of the PPO plans, there is no copay for the allergy shot but you could be asked to pay an office visit copay if your doctor's office charges for an office visit in addition to the allergy shot. If enrolled in a HealthSavings CDHP, your doctor's office may charge the cost of the office visit or you may pay the coinsurance rate, depending on if your deductible has been met.

**7. Do advanced imaging and outpatient surgery require a copay or coinsurance?**

The deductible, coinsurance and the out-of-pocket maximum will apply to advanced imaging and outpatient surgery.

**8. Does dialysis require a copay or coinsurance?**

Members will pay coinsurance for dialysis and be subject to the deductible. This means the member is protected by the out-of-pocket maximum. Because dialysis visits happen often, this approach for dialysis benefits the member the most.

**9. How are maternity benefits covered?**

It is important to note that ALL OB/GYN doctors are considered primary care doctors. If enrolled in a PPO plan, you will pay the primary care copay. You only have to pay a copay for your first visit to confirm your pregnancy. You will then pay for the delivery, which is subject to the deductible, coinsurance and out-of-pocket maximum. If enrolled in a HealthSavings CDHP, your doctor's office may charge the cost of the office visit or you may pay the coinsurance rate, depending on if your deductible has been met.

If you have any difficulties and need to see a specialist other than your OB/GYN or need extra time in the hospital, those services will have either a copay or coinsurance and the deductible will apply.

**10. How is chemotherapy covered?**

If enrolled in a PPO plan, the member pays a copay if the therapy is done in a doctor's office, but he or she would have to pay coinsurance if the therapy is done in an outpatient facility or hospital. If enrolled in a HealthSavings CDHP, you may be charged the negotiated rate of the service or the coinsurance rate, depending on if your deductible has been met.

**11. How is durable medical equipment (DME) covered?**

Durable medical equipment is subject to the deductible and coinsurance. For in-network services, members are responsible for the following after the deductible has been met.

<b>Partnership PPO</b>	<b>10%</b>
<b>Standard PPO</b>	<b>20%</b>
<b>Limited PPO</b>	<b>30%</b>
<b>Wellness HealthSavings CDHP</b>	<b>20%</b>
<b>HealthSavings CDHP</b>	<b>30%</b>

## **12. What happens if I have a high medical bill? Will I have to pay coinsurance for the whole amount?**

No. Our health plans have what is known as an “out-of-pocket maximum.” Once you pay this amount, your health plan will pay 100 percent of the coinsurance for your covered expenses. This protects members who have very high medical bills.

## **BlueCross BlueShield & Cigna**

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**For general information about carrier information including provider directories and premiums costs, visit the [Carrier Information](#) page.**

### **1. Do all plan members have the same health insurance choices?**

State and higher education employees are eligible for the Partnership PPO, Standard PPO, Wellness HealthSavings CDHP and the HealthSavings CDHP. Local education and local government employees are eligible for the PPO plans (Partnership, Standard and Limited) and the HealthSavings CDHP.

### **2. Does everyone have a choice of insurance carriers?**

Yes. Every eligible member can chose between two insurance carriers – BlueCross BlueShield and Cigna. Both carriers offer all of the health plan options.

### **3. What do I do if I have a question regarding my insurance claims?**

Members should always carefully review their explanation of benefits (EOB) and contact their insurance carrier if they have any questions. Contact information for your carrier is printed on the back of your insurance card.

### **4. If I live in the east region, does that mean I can only go to doctors in that region?**

No. The regions just show where our members live and work. This does not mean that you can only go to doctors and hospitals in your area. In both BlueCross BlueShield and Cigna plans, you will always have access to doctors and medical facilities across Tennessee and across the country.

### **5. What is the Informed Choice Outreach Program offered by Cigna?**

Cigna’s MedSolutions national program features a support and outreach program called Informed Choice. The goal of the program is to educate members undergoing an MRI, CT or PET scan about their options for geographically convenient and cost-effective facilities as they and their doctors choose where to have the tests done.

After a physician contacts MedSolutions for precertification of coverage of an MRI, CT or PET scan, a specially trained representative may contact the member by phone and provide information about conveniently located credentialed participating facilities (hospitals or free-standing facilities) and offer appointment options. MedSolutions representatives can also provide cost comparison information, so that members are aware of the financial impact of their choices.

MedSolutions can assist members in scheduling an appointment at the individual’s facility of choice and complete the referral for the services that have been authorized for coverage. In addition, if the member has additional questions about benefits, account-based balances (e.g., HRA or HSA), or other plan details, the MedSolutions representative can connect directly with Cigna's customer service team.

This proactive outreach occurs only when true opportunities for choice exist, such as when the ordering physician has requested a higher cost radiology center or hospital for services and other participating credentialed centers offer the same services at a lower cost.

**6. Is the plan design any different for the Cigna LocalPlus network or the BlueCross Network S?**

No. The health plans all cover the same general benefits. Members will only see a difference in the network of doctors and facilities available to them at in-network rates.

**7. What happens when I go to a provider outside LocalPlus but within other Cigna networks?**

When a customer visits a non-LocalPlus provider within the LocalPlus area, coverage will be at the out-of-network rate. When a customer is **outside of the LocalPlus service area, but the provider is within the Cigna OAP network, coverage will be at OAP in-network rates.** As a reminder, if the provider is out-of-network, coverage will be at the out-of-network rate.

**8. What network options will be offered by the State of Tennessee?**

The State of Tennessee offers BlueCross BlueShield Network S and Cigna LocalPlus.

BlueCross BlueShield offers a national and international network. Cigna offers the LocalPlus Network in certain areas nationally and where LocalPlus is not available members have access to the Open Access Plus network. It is best to contact the carriers directly for more information on specific providers.

## **ParTNers Employee Assistance Program (EAP)**

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For general information about EAP including services and Behavioral Health information, visit the [EAP](#) page or [www.Here4TN.com](http://www.Here4TN.com).

**1. How many sessions do I have through the EAP?**

You receive up to five, no cost to you, sessions per separate incident. Your EAP is available 24/7 every day of the year. Preauthorization is required to use the EAP but can easily be obtained by either going to [HERE4TN.com](http://HERE4TN.com) or calling 855.437.3486.

**2. What happens if I utilize all of my available EAP sessions, but would like to continue seeing my provider?**

If you are a member of the state group health insurance program, you may continue to receive services under your behavioral health benefit. The majority of EAP providers are also behavioral health providers, so many times you are able to continue to see the same provider if that relationship is working well for you.

**3. Is preauthorization required for outpatient behavioral health?**

You do not need to obtain preauthorization for most outpatient behavioral health services. Preauthorization is required for some treatments including psychological testing, electroconvulsive therapy, applied behavioral analysis and transcranial magnetic stimulation.

#### **4. If I am contacted by Magellan for case management, what do I need to do to fulfill my Partnership Promise?**

If you are contacted by Magellan Health Services and asked to participate in their case management program, you are required to engage to continue in the Partnership PPO.

## **Voluntary (Optional) Vision**

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**For general information about vision including benefits and provider information, visit the [Vision](#) page.**

**For information about vision insurance at retirement, visit the [Continuing Insurance at Retirement](#) page.**

#### **1. How often can I get an eye exam and materials?**

On either plan (basic or expanded), you can have an eye exam once every calendar year. You can get standard plastic/glass lenses or contacts once every calendar year and frames once every two calendar years.

#### **2. How does the frame allowance work?**

If you choose the basic plan and use a network provider, you will not have to pay anything for your frames if they cost \$50 or less. If the frames are over \$50, you will get a 20 percent discount on the balance of the monies you owe.

If you choose the expanded plan and use a network provider, you will not have to pay anything for your frames if they cost \$115 or less. If the frames are over \$115, you will get a 20 percent discount on the balance of the monies you owe.

#### **3. My doctor is not listed in the EyeMed network? Can I still get some reimbursement if I continue to see him?**

You can get an eye exam at your non-network provider but your benefit will be much less than if you used a network provider. You might want to consider filling your vision prescription at one of EyeMed's network providers in order to save money. If you are seeing the doctor for a medical reason (other than a routine eye exam) the charges will have to be submitted to your medical plan.

#### **4. Do I need to file a claim?**

No, you do not file claims if you use an in-network provider. However, if you do not use a network provider you will need to file an out-of-network claim form, which is located on the EyeMed [website](#). If you have an issue with a claim, contact the EyeMed Customer Care Center at 855.779.5046 with any questions pertaining to your claim.

#### **5. Do I need my ID card in order to use my benefit or discount?**

No, you do not need your ID card in order to use your EyeMed plan. Once you have your card, we recommend taking it with you because it saves time and helps the provider correctly apply your benefit. However, if you have lost your card, simply let the provider's office staff know that you are an EyeMed member and they will have to verify your eligibility and plan details for you. To request a replacement ID card, log on to the secure member area of the EyeMed website and print a new one.

**6. How do I print or request additional or replacement ID cards?**

If you need more ID cards or a replacement for a lost or damaged card, you can print a card once you register or log onto the EyeMed [website](#) or by calling their customer care center at 855.779.5046.

**7. How can I request that my provider be added to the EyeMed network?**

If your provider is not currently participating in the EyeMed network, you can recommend them by submitting a provider nomination form. The form, including instructions, can be found on the EyeMed [website](#).

**8. What if I need to see a provider outside of Tennessee?**

The EyeMed network is national. You can locate an in-network provider throughout the United States and they will submit all claims for you.

**9. Who should I contact if I have trouble logging into the EyeMed member website?**

Call the EyeMed Customer Care Center at 855.779.5046 for assistance with logging into the website.

**10. Can I get a discount on additional replacement contact lenses?**

After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member's home.

**11. Can I use a portion of my allowance during the calendar year and then use the remaining balance during that same calendar year?**

Benefit allowances provide no remaining balance for future use within the same benefit frequency.

**12. Who is eligible to enroll in the state EyeMed vision plan?**

All state and higher education employees and their qualified dependents are eligible. Employees and their qualified dependents of local education and local government agencies are eligible if their agency has added the vision insurance program to their benefits. The following retiree groups are eligible for vision coverage if enrolled in the medical plan:

- Retirees receiving TCRS benefit
- Retirees who participated in a higher education optional retirement plan
- Dependents of a currently enrolled retiree

**VSP Questions for TBR employees only**

**The Tennessee Board of Regents (TBR) also has a separate vision plan for employees. See [tbrvision.com](http://tbrvision.com) for more information.**

**13. If I work for a Tennessee Board of Regents (TBR) institution can I enroll in the state EyeMed Vision Program?**

Yes, you may choose to enroll in the EyeMed plan offered by the state or the VSP plan offered by the TBR or both plans.



#### **14. Are the state vision plan and the TBR vision plan just alike?**

No, while the plans are very similar, there are differences. You can find more specific information about the state's plan on our website [partnersforhealthtn.gov](http://partnersforhealthtn.gov).

#### **15. Will there be coordination of benefits between the state and the TBR vision plans.**

No.

## **Voluntary (Optional) Dental**

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**For general information about dental including benefits and provider information, visit the [Dental](#) page.**

#### **1. Why are there waiting periods for some dental services?**

Unlike our health insurance options, which are self-insured, our dental products are fully insured. This means that the insurance carriers, not the state, are the ones that assume the risk of premium payment versus claims cost.

The Cigna Prepaid Dental (DHMO) plan does not require any waiting periods before services will be covered. This is due to the fact that the prepaid plan pays a fee each month to the participating dentists for each enrolled member and in turn the dentists have agreed to deep discounts in their fees.

The MetLife Dental Preferred Provider Organization (DPPO) plan does require a waiting period before certain more expensive services will be covered. A six-month waiting period applies for implants, bridges, partial dentures, full dentures, crowns and cast restorations. This discourages members from joining for one year just to receive expensive major services while only paying premiums for one year. Waiting periods cannot be appealed through the state; please direct any questions to MetLife at 855.700.8001.

#### **2. What happens if my dentist leaves Cigna dental's network?**

When a dentist leaves the network, he/she must provide Cigna with a 90-day notice. Cigna will mail a letter to all members who selected the terminating dentist 30 days prior to him/her leaving the network. The letter will also ask affected members to select a new general dentist.

#### **3. Do I have to select a primary dentist in the Cigna Prepaid Dental plan? Can I change my dentist?**

Yes, you will need to select a primary dentist from the list of general dentists. Each family member can select a different primary dentist. Your dentist selection and/or change to your dentist selection should be made by the 15th of the month for the change to be effective by the 1st of the following month.

#### **4. How do I find a Cigna Prepaid Dental network dentist?**

1. Online at [cigna.com](http://cigna.com) and use the [Find a Doctor tool](#).

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**5. What if I am out of the area and need emergency care? Will Cigna Prepaid Dental cover some or all of the services?**

In the case of an emergency and you cannot see your selected dentist, you can file a claim for a reimbursement. You will need to provide documentation to Cigna within 30 days of the actual treatment. The out-of-area emergency care is limited to emergency care up to \$25 per occurrence.

**6. How do I find a network dentist in the MetLife network?**

Your dentist must be in the MetLife PDP network to receive the in-network benefit. Members can receive services from a dentist not in MetLife's network, but these dentists are considered out-of-network and you will have to pay the out-of-network rates.

To find a dentist:

- Go to [mybenefits.metlife.com/StateOfTennessee](https://mybenefits.metlife.com/StateOfTennessee)
- Call MetLife at 855.700.8001

**7. How can I find out how much a procedure will cost under my MetLife DPPO plan?**

Ask your dentist to request a pre-treatment estimate, which will tell you if a service is covered, how much it may cost, and what your share may be. Pre-treatment estimates are not required but are highly recommended for procedures with significant costs such as crowns. Pre-treatment estimates are not a guarantee of benefits or costs.

## **Voluntary (Optional) Long-Term Care Insurance**

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For general information about long-term care insurance, visit the [Long-Term Care Insurance](#) page.

**1. Who is eligible to enroll in the state's long-term care insurance plan?**

Employees of state and higher education agencies plus employees of local education and local government agencies that have submitted notice to Benefits Administration that the long-term care insurance program will be offered are eligible. The employee's qualified dependents (spouses and dependent children ages 18 through 25), their parents and parents-in-law are also eligible.

**2. What are the eligibility requirements for a retiree to enroll in long-term care insurance?**

You are eligible for long-term care insurance if you are a retiree receiving a TCRS pension or participated in an optional retirement program.

**3. When can I enroll in the long-term care insurance plan?**

You may apply for enrollment in the long-term care insurance plan at any time. Eligible new hires may enroll within 90 days of their hire date and not have to answer health underwriting questions. Employees who did not enroll during their initial 90-day guarantee issue period may still apply at any time by submitting an application with answers to specific health questions.

**4. How do I get more information on enrolling in long-term care insurance?**

Contact MedAmerica at 866.615.5824 or visit [ltc-tn.com](https://ltc-tn.com)

## Life Insurance - STATE AND HIGHER EDUCATION ONLY

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For general information about life insurance, visit the [Life Insurance](#) page.

### Basic Term Life Insurance/Basic AD&D Insurance

**1. Does coverage reduce as I age?**

The face amount of coverage declines when an employee reaches age 65, 70 and 75.

**2. Can I take my coverage with me when I leave?**

You are able to convert basic term life coverage to an individual life insurance policy without answering any health related questions. Premiums may be higher for the individual life policy than those paid for the group term policy.

### Voluntary (Optional) Universal Life Insurance

**The plan is closed to new enrollments.**

**3. Can I decrease the amount of coverage I have?**

You may ask to decrease the face amount on your policy as long as your request is submitted in writing to Unum at least 45 days prior to the anniversary date, which is January 1 of each year. If your decrease is approved, it will take effect on the January 1 following your request for the decrease.

Please note: decreases cannot reduce the face amount to less than the minimum of \$5,000. Unum reserves the right to decline to make any change that Unum determines will cause the coverage to fail to qualify as life insurance under applicable tax law.

**4. Can I increase the amount of coverage I have?**

No, the plan is closed to increases in coverage.

**5. How can I find out who is the beneficiary I designated?**

Unum maintains the beneficiary information for each certificate holder. You can contact their customer service center at 866.298.7636 Monday through Friday 7 a.m. to 7 p.m. CST. It's always a good idea to check the beneficiary information periodically to be sure the designation is current.

### Voluntary (Optional) Term Life Insurance

**6. Can I increase the amount of coverage I have?**

You may increase your coverage by the annual guaranteed issue amount of \$5,000 during the fall annual enrollment period if you receive a letter or postcard from Minnesota Life notifying you that you are qualified for the increase based upon your salary and current level of coverage.

You may submit an evidence of insurability application (required answers to specific health questions) to increase your coverage amount above the guaranteed issue amount up to the overall maximum amount during the fall annual enrollment period.

**7. Can I decrease the amount of coverage I have?**

Yes, you may decrease your coverage amount during annual enrollment (to a minimum of \$5,000). While changing your coverage amount can only be done during annual enrollment, you may cancel your coverage at any time. The decrease in coverage will be effective on the following January 1.

**8. How can I find out who is the beneficiary I designated?**

Minnesota Life has the beneficiary information for each certificate holder. You can review your designated beneficiary information by logging on to your account on the Minnesota Life website [lifebenefits.com/stateoftn](http://lifebenefits.com/stateoftn) or you may contact their customer service center at 866.881.0631 Monday through Friday from 7 a.m. to 6 p.m. CT. It's always a good idea to check the beneficiary information periodically to be sure the designation is current.

**9. May a spouse, who is also a state or higher education employee, enroll as an employee and as a dependent of the other spouse?**

No, both spouses must enroll as employees.

**10. What option do I have for voluntary (optional) term life if I am rehired?**

Coverage lost upon employment termination will be automatically reinstated if rehired within 90 days. Payment of premiums for past periods will be withheld from your paycheck upon your return to active employment.

**Voluntary (Optional) Accidental Death and Dismemberment (AD&D) Insurance**

**11. May two employees cover the same dependent children?**

No, one employee should select single coverage while the other employee selects family coverage.

**12. If I did not enroll when I was first hired, may I enroll later?**

Yes, you may enroll with no health questions asked during the fall annual enrollment period.

**13. How much coverage will I have?**

Coverage is based upon the employee's salary with the maximum amount of coverage being \$60,000.

**Affordable Care Act (ACA)**

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**1. What is required of me?**

If someone does not have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee. Employer sponsored coverage (such as the state group health insurance program) is considered minimum essential coverage.

**2. The new health care law states that employees must now have health insurance coverage. Does that mean I have to sign up now if I do not have coverage?**

To meet the requirements, you need to enroll in the state group insurance program during open enrollment or purchase your own health insurance through the Marketplace ([www.Healthcare.gov](http://www.Healthcare.gov)).

**3. What if I already have coverage through my spouse's employer?**

As long as you have minimum essential coverage (through the state group insurance program or elsewhere) you have satisfied the requirements of the health care law.

**4. Do the ParTNers for Health plans meet the healthcare reform law's minimum value requirements?**

Yes, all ParTNers for Health plans meet this requirement.

**5. If I drop my health coverage, am I subject to the healthcare reform law's penalty?**

Yes, to avoid the fee you need insurance that qualifies as minimum essential coverage which simply means that your plan will pay at least 60 percent of the total cost of medical services.

**6. What is the Health Insurance Marketplace?**

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Ask your employer for information about the Marketplace or log on to [Healthcare.gov](http://Healthcare.gov).

**7. Can I get insurance through the Marketplace?**

If you have a special qualifying event, you may sign up for the Marketplace. If not, the Marketplace open enrollment is from November 1, 2015 to January 31, 2016.