Questions and Answers
(updated September 5, 2014)

Enrollment & Eligibility

1. Do local government and local education plan members have the option of enrolling in the Limited PPO?
   Yes, both local government and local education employees have the option to enroll in the Limited PPO as a new hire or during the annual enrollment period in the fall.

2. What is the Limited PPO?
   The Limited PPO offers the same services, treatments and products as the other PPO plans. The Limited PPO has low monthly premiums but higher deductibles and out-of-pocket maximums. Be sure to look at the benefit grid for additional information including cost structure, copays and deductible amounts. In addition, be sure to look at the in-network and out-of-network deductibles and out-of-pocket maximums for all tiers (employee only, employee + children, employee + spouse and employee + spouse + children).

3. Will my doctor change if I select the Limited PPO?
   No, selecting the Limited PPO does not affect network selections. By choosing the Limited PPO, you are selecting the type of PPO you would like. You will then have the option to select either BlueCross BlueShield of Tennessee or Cigna for your insurance carrier. Be sure to check the networks for both insurance carriers to make sure the physicians and hospitals you want to use are in them.

4. 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.

5. 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.

6. 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 the BCBST and Cigna plans, you will always have access to doctors and medical facilities across Tennessee and across the country.
7. 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).

8. 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.

9. Do the preexisting condition exclusions apply to anyone over age 19? What about spouses and children?

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

**Partnership Promise**

1. What is required for the 2015 Partnership Promise?

Employees and their covered spouses enrolled in the Partnership PPO must do the following:

- Complete the online Healthways Well-Being Assessment (health questionnaire) between January 1 and March 15, 2015.

- If you receive a call from Healthways in 2015, you must complete a biometric health screening and fully participate in health coaching (which could include a Healthways tobacco cessation program).

- Participate in case management if identified by BlueCross BlueShield, Cigna or Magellan.

- Update your contact information with your employer if it changes. Your spouse, if also covered under your insurance, must keep his/her contact information up to date in Well-Being Connect or by calling Healthways at 888.741.3390. (Retirees must keep their contact information up to date with Benefits Administration.)

**New employees and newly covered members** are required to complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date.

Note: The benefits of the ParTNers for Health Wellness Program are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 888.741.3390, and they will work with you and/or your physician, if you wish, to find an alternative way for you to meet the Promise.

2. 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, regardless of age, **do not** have to fulfill the Partnership Promise.
3. Are adult children (age 19 and up) required to fulfill the Partnership Promise?
   No. The Partnership Promise does not apply to dependent children of any age. Adult children age
   18 and older have access to all of the wellness services, but are not required to participate.
   Please note, if your child ages off your coverage and enrolls in COBRA, he/she would need to fulfill
   the Partnership Promise at that time if he/she enrolls in the Partnership PPO.

4. Are new hires and newly covered members required to complete the online Well-Being
   Assessment (WBA) and get a biometric screening?
   Yes. All new plan members (employees and their covered spouse) who enroll in the Partnership
   PPO must complete the online Well-Being Assessment and get a biometric screening within 120
   days of their insurance coverage effective date.
   Please note: If you enroll in the Partnership PPO during annual enrollment in the fall of 2014 you
   are not considered a new plan member.

5. 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.

6. If I do not fulfill the Partnership Promise, will my claims still be paid?
   Yes. The plans will continue to pay eligible claims for the calendar year, even if you do not meet the
   Partnership Promise. However, you will not be able to stay in the Partnership PPO for the following
   year if you do not fulfill your Partnership Promise. The Standard PPO (or Limited PPO for local
   government and local education) will still be available to you.

7. 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.

8. 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 dependent 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 they 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)

9. Do I have to complete an online questionnaire?
   Yes. All members and covered spouses must complete the online Healthways Well-Being Assessment (WBA) between January 1 and March 15, 2015. Other health questionnaires (ex: Cigna or BlueCross assessments) will not count toward fulfilling the Partnership Promise.

10. Can I complete my Well-Being Assessment (WBA) over the phone?
    Yes, however, 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.

11. 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.

12. What information do I need to create an online Well-Being Account?
    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.

13. 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.

Biometric Screening

14. What is a biometric screening?
    In 2015, a biometric screening is required of all new members of the Partnership PPO (employees and covered spouses) as well as those members contacted by Healthways for health coaching.
    The screening includes height, weight, blood pressure and waist circumference. A sample of your blood is also collected to determine blood sugar, cholesterol levels and other factors that can lead to lifestyle-related health complications. The biometric screening is not a part of the Well-Being Assessment (WBA).

15. How can I complete a biometric screening?
    At a doctor’s office or walk-in medical clinic: (Healthways will accept screening results from a doctor’s visit [annual physical] between July 16, 2014, and July 15, 2015).
    Visit the Onsite Health Diagnostics (OHD) website where you can download your Physician Screening Form (PSF) to take to your doctor. Or you can go to the QuickLinks box on the ParTNers
for Health homepage and click on “Complete Your Biometric Screening.” This will take you directly to the OHD website.

**NOTE:**

- You must download and print your Physician Screening Form from the OHD website; your PSF will not be emailed.
- Make sure you measure and write your waist circumference on your PSF.
- The doctor will need to complete your form. If the form is not complete, your form will not be processed.
- Both you and your physician must sign and date the form.
- **You or your doctor must fax (or mail) it to OHD by the July 15, 2015, deadline.**

16. **If I don’t have access to the internet, 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.

17. **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.

19. **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 copay.

20. **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.

21. **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.

**Health Coaching**

22. **What is health coaching?**
   A health coach is your personal resource to improve your health through behavior change. Coaches work with you to set personal goals, provide tools, track progress and offer information to help you make better choices and manage your health.
   Your conversations with your health coach are confidential and are not shared the State of Tennessee or your employer. Information is shared with your doctor only with your permission.
23. What is case management?

Case management is administered by BlueCross, 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 BCBST, Cigna or Magellan and asked to participate in case management.

24. What does behavioral health case management by Magellan involve?

Situations that would cause someone to 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.

25. Who do the health coaches work for and what are their credentials?

All health coaches are employees of Healthways, the company that the state has contracted with to manage the wellness program. The ParTNers for Health Wellness Program health coaches have wide expertise. They include licensed registered nurses and licensed dieticians, 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.

26. How will Healthways decide who will be contacted for coaching?

Healthways will decide who will be contacted for health coaching based on your answers on the Well-Being Assessment (WBA), biometric screening results and health insurance claims. If you are contacted for health coaching, which could include a tobacco cessation program if you are a tobacco user, you will need to continue coaching unless you are notified differently by Healthways.

27. How often, when and how do I have to communicate with my health coach?

A health coach may contact you at any time during the plan year (January 1 – December 31, 2015). 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. Health coaches will work with you to create a plan of care that is best suited for your health needs.

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

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

If a health 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 health coach. If you do not follow up with your health coach within the timeframe specified in the letter, you will not be eligible for the Partnership PPO the next year.

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.
29. If I am able to meet my goals for better health, will I still be required to work with a health 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 Program until your health goals are met. If you are able to improve your health, lower your health risk behaviors and complete your plan of care with a 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.

30. What happens if I don’t meet the goals I initially set with my health coach?

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

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

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

32. Will the health 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.

The health coach’s role is to provide information and support—not a prescriptive plan that a member must follow. Members can work with both their health coach and doctor to develop a plan that is clinically appropriate.

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

Yes, but your spouse will have to speak to the coach first to give permission. If your spouse cannot speak to the coach, then a release form will need to be signed to allow you to speak to a Healthways coach on his/her behalf. You can obtain a release form by calling Healthways at 888.741.3390, Monday through Friday from 8:00 a.m. to 8:00 p.m.

34. If I was identified for coaching in 2014, will I automatically continue coaching in 2015?

Yes, you will need to continue coaching until you are notified differently by your Healthways health coach.
35. How will my spouse be contacted if identified for coaching?

A health 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 spouses to keep their contact information up-to-date with Healthways.

Spouses can create and log in to their online Well-Being Account to enter their contact phone number. If spouses don’t have access to the internet, they can also call Healthways at 888.741.3390 to update their information. This will ensure that Healthways can reach the spouse if he/she is identified for coaching.

36. Can I work with a health coach even if I am not contacted by Healthways to coach?

Absolutely. All members in the Partnership, Standard and Limited PPOs have access to health 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

37. 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, 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 is a better option for you.

38. 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 quit program. 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.

39. Is there a charge for the tobacco cessation programs?

No, there is no charge for the tobacco cessation coaching offered by the ParTNers for Health Wellness Program. You also have access to free quit aids offered by the state’s health plan. These include Chantix, Bupropion (generic Zyban) and over-the-counter generic nicotine replacement products (with a prescription), including gum, patches and lozenges.
40. 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, cigars or smokeless tobacco, as well as any non-FDA approved tobacco cessation device such as e-cigarettes. 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).

41. A tobacco cessation program sounds scary. What if I am not ready to quit, 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 2015, 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 is a better option for you.

Updating Contact Information

42. 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.

43. 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.

44. 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).
1. **What security information will health 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. 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 the ParTNers for Health Wellness Program employee when he or she calls?**

   If you are concerned about the identity of your health 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. **How does the spouse of an employee create an online account to complete the online Well-Being Assessment or check his or her status in the Partnership Promise?**

   Covered spouses will have access to set up their 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, or
   - Signing into their online Well-Being Account and view completion status under the “Rewards Center.”

4. **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 2014 included True Colors (healthy eating), Step It Up! (physical activity), Go for 10 (physical activity), and Make the Cut (weight management).

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

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

6. **Does the state offer wellness incentives or discounts for fitness centers?**

   Fitness center discounts are available to all state group insurance program members. Certain fitness centers have agreed to offer a discount on their regular member price and/or initiation fees. See the fitness center page (under Wellness Program) for more information and a list of participating fitness centers.

   Additional wellness and fitness discounts are available through the ParTNers for Health Wellness Program, ParTNers for Health Employee Assistance Program (EAP) services and our health insurance carriers, BlueCross BlueShield and Cigna.

   You can go to the Wellness Program tab to learn more.
7. I've heard that the state offers discounts for employees to join weight loss groups such as Weight Watchers. Where can I find out how to apply for these discounts?

The state partners with Weight Watchers to offer Weight Watchers at Work and other weight management programs. Weight Watchers offers all health plan members a discount for these programs. See the Weight Watchers page for information. BlueCross and Cigna also offer discounts for weight management programs. Check with their customer service center for more information.

8. Can Standard and Limited PPO participants use the ParTNers for Health Wellness Program services without additional cost?

Yes. All members may use resources such as health coaching, 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.

Pharmacy

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.

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)

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.

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

This benefit is changing effect 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). From now until January 1, 2015, both Accu-Chek and OneTouch products are available to you at the reduced preferred “90-day maintenance” cost.

Beginning January 1, OneTouch test strips and lancets will be 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. **Are flu and pneumococcal shots free?**

Yes. Members can get a free flu shot and/or pneumococcal vaccine at a participating vaccine network pharmacy or at an in-network doctor’s office. To get a flu shot at a vaccine network pharmacy, use your Caremark prescription card. To find a participating pharmacy, go to [info.caremark.com/stateoftn](http://info.caremark.com/stateoftn), and in the Network Lists section, click on “Nationwide Vaccine Network.” If you get a flu shot from an in-network doctor’s office, use your medical insurance card. You will not have to pay a copay unless you are treated for another illness or discuss another condition at the same visit.

8. **Are tobacco cessation drugs and quit aids covered by our insurance?**

Yes. Currently our prescription benefit covers Chantix and Bupropion (generic Zyban) as the "medications" used for tobacco cessation – up to two, 12-week courses of treatment each year (168 days of therapy) with no lifetime limits. The quantity limit is two cycles annually, and the quantity limit resets every calendar year. These medications are covered at $0 copay to the member.

Over-the-counter quit aids are also covered with an annual limit of a 168-day supply (two, 12-week courses of treatment). These include [generic](#) Nicotine replacement products such as nicotine
patch, gum and lozenges and are covered at $0 copay to the member. (Nicotine inhalers are not included or covered in this benefit.)

A written prescription by a licensed clinician is required to receive any or all tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your Caremark card at the pharmacy to have those filled for a $0 copay.

Smoking cessation counseling is available from health coaches through our ParTNers for Health Wellness Program. To speak to a health coach call 888.741.3390.

9. **Does a deductible or out-of-pocket maximum apply for pharmacy benefits?**

   Only the Limited PPO has an additional deductible ($100) for pharmacy benefits. The Partnership and Standard PPOs do not have an additional deductible for pharmacy. For 2015, the maximum out-of-pocket that a plan member will pay in prescription copayments is as follows:

   - Partnership PPO  $2,500 employee only coverage; $5,000 all other coverage levels
   - Standard PPO  $3,000 employee only coverage; $6,000 all other coverage levels
   - Limited PPO  $6,600 employee only coverage; $13,200 all other coverage levels (integrated with medical)

10. **Where can I find the drug list for Caremark?**

    For a complete list you can contact Caremark at 877.522.TNRX (8679) or visit info.caremark.com/stateoftn and click on "Preferred Drug List" in the Drug Lists section.

11. **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.

12. **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.

13. **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.
14. 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.

15. 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

1. What is considered preventive care? What preventive services are covered?

Preventive care refers to services or tests that help identify health risks and are 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 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 each PPO, 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 a copay 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/recommendations.htm.

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 is 100 percent including reading, interpretation and results AFTER any applicable office visit copay.

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 by a copay?**

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.

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 so 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. Keep in mind, this is for a normal pregnancy. 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.

10. **How is chemotherapy covered? Is it a copay or is it subject to deductible and coinsurance?**

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.

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 10 percent coinsurance in the Partnership PPO, 20 percent coinsurance in the Standard PPO and 30 percent coinsurance in the Limited PPO, after meeting their deductible.
12. What happens if I have a high medical bill? Will I have to pay coinsurance for the whole amount?

No. Our PPOs 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**

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

   All members are eligible for both the Partnership PPO and the Standard PPO. In addition, the Limited PPO option is available to local education and local government employees. The Cigna LocalPlus network is available for middle Tennessee members as well. See below for more information.

2. Does everyone have a choice of insurance carriers?

   Yes. Every eligible member can choose between two insurance carriers – BlueCross BlueShield of Tennessee and Cigna. Both carriers offer the Partnership, Standard and Limited PPO options.

3. Why are the monthly premiums different among regions?

   Depending on where you live, BlueCross BlueShield and Cigna have a $20/$40 network carrier surcharge because the providers have different costs in each region.

   If you’re in east or middle Tennessee, the Cigna plan costs $20 more per month for employee only coverage and $40 more per month for all other premium levels. If you’re in west Tennessee, the BlueCross BlueShield of Tennessee plan costs $20 more per month for employee only coverage and $40 more per month for all other premium levels.

4. 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.

5. Are the network providers the same for both carriers?

   No. Each carrier has its own network of preferred doctors, hospitals and other healthcare providers. You can find out if your providers are in the networks, as follows:

   1. Call the carriers’ customer service staff:
      a. BlueCross BlueShield of Tennessee at 800.558.6213
      b. Cigna at 800.997.1617

   2. Search for your providers online through the carriers’ websites:
      c. BlueCross BlueShield of Tennessee ([bcbst.com/tools/findadoctor](http://bcbst.com/tools/findadoctor)) and look for Network S; out of state look for the BlueCard Program
      d. Cigna ([cigna.com](http://cigna.com)) and look for OpenAccess Plus or LocalPlus

   3. View a PDF of the provider directory:
      e. [BlueCross BlueShield of Tennessee](http://bcbst.com/tools/findadoctor) (3.4 MB)
      f. [Cigna Open Access Plus](http://cigna.com) (4.4 MB)
6. **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.

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7. **What is Cigna LocalPlus?**

Cigna offers two network options for members in middle Tennessee. In addition to Cigna’s current broad network called Open Access Plus (OAP), they offer a high-performance LocalPlus network. The LocalPlus network is limited to a smaller group of network hospitals and physicians, and provides the same quality care at a lower cost.

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8. **What hospitals and physicians are in the LocalPlus network?**

Cigna’s LocalPlus network includes many of the hospitals and doctors you are currently accustomed to seeing, including the HCA and Vanderbilt facilities and related physicians. Many of the local hospitals outside of the metro Nashville area are also included. However, Saint Thomas and its hospitals, including Baptist, Middle Tennessee Medical Center (MTMC) and Williamson County are NOT in this network. For information about providers in the LocalPlus network visit [Cigna.com](http://Cigna.com) or [myCigna.com](http://myCigna.com) or call 800.997.1617 to speak with a customer service associate.
9. What counties are in middle Tennessee?

10. If I live in middle Tennessee and choose LocalPlus, how do I find LocalPlus providers if I travel outside of middle Tennessee for services or have a child attending college outside of Tennessee?
Cigna’s LocalPlus network covers the entire state of Tennessee. Regardless of where you seek services in Tennessee, Cigna has a full complement of LocalPlus providers to meet your needs.
If you are visiting an area with a LocalPlus network, you should see a doctor in the LocalPlus network to receive the most benefit. If there is no LocalPlus network in the area you are visiting, you can visit any doctor who participates in Cigna’s nationwide Open Access Plus (OAP) network.
To find local Cigna providers, simply call the number on your ID card or check the LocalPlus provider listing on Cigna.com or myCigna.com.

11. If I am an east or west Tennessee member, can I sign up for Cigna’s LocalPlus network?
No. At this time, only middle Tennessee members can choose the LocalPlus network option.

12. Is the plan design any different for the LocalPlus network?
No. The Partnership, Standard and Limited PPOs 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.

13. How is it possible to have the same services while paying lower premiums?
Only a select group of high-performance physicians and hospitals will participate in the LocalPlus network. Cigna has a long-standing relationship with these providers and/or Cigna can negotiate better rates. Most of these physicians and hospitals agree to provide the same covered services at a negotiated “discount” rate for all LocalPlus network customers.

14. What happens when a customer goes to a provider outside the LocalPlus network 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.
For more information regarding the Cigna Local Plus option, see the LocalPlus FAQ.
ParTNers Employee Assistance Program (EAP)

1. What is the ParTNers EAP?
   The ParTNers Employee Assistance Program or EAP is an employer paid benefit that exists to help employees and their eligible family members with no cost emotional, financial and legal counseling. In addition, your EAP provides other supportive services such as assistance in researching child and elder care options, adoption, as well as providing many other benefits such as screening for depression and substance abuse. Visit HERE4TN.com to learn more or call 855.HERE4TN (855.437.3486)

2. How many sessions do I have through the EAP?
   You receive up to five, no cost to you, sessions per separate incident. We know that issues and challenges often come in waves and we want you to be able to access services when you need them most. 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 or calling 855.437.3486.

3. 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 plan. 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.

4. 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.

5. If I’m in the Partnership PPO, is there anything specific I need to know about my behavioral health benefit?
   If you are contacted by Magellan Health Services and asked to participate in their case management program, you are required to engage if you would like to maintain your membership in the Partnership PPO.

Vision

1. How can I find a network provider?
   You can locate a provider that is part of the EyeMed Network by logging on to eyemedvisioncare.com/stoftn. Under “Locate a Provider,” click on “Find a Provider Now.” Then enter your ZIP code and click on “Search.” You can also call EyeMed at 866.299.1358 and ask for customer service.

2. 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.
3. 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% 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% discount on the balance of the monies you owe.

4. 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.

5. 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.

6. 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.

7. 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.

8. How will my provider know if I have used all of my benefits?

   An in-network provider will locate the member in the EyeMed system and verify that benefits are available prior to the appointment.

9. 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.

10. 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.
11. 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.

12. Does a deductible or out-of-pocket maximum apply for vision benefits?

No deductible or out-of-pocket maximum applies to the vision benefit. There are specific allowances and copays for materials as specified in your plan.

13. Who do I contact with questions about my claim and how it was paid?

You can contact the EyeMed Customer Care Center at 855.779.5046 with any questions pertaining to your claim.

14. What are the hours for the EyeMed Customer Care Center?

The EyeMed Customer Care Center is open Monday through Saturday, 6:30 a.m. to 10:00 p.m. CT and Sunday 10:00 a.m.-7:00 p.m. CT.

15. Can I get a discount on additional contact lenses I purchase after I have used my lens benefit?

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

16. 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.

17. 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.

18. What are the eligibility requirements for a retiree to enroll in vision insurance?

You are eligible for vision insurance if you are a retiree currently enrolled in health coverage and you receive a TCRS pension or participate in a higher education optional retirement program.

19. Are Medicare supplement plan members eligible for our vision insurance?

No, Medicare supplement plan members are NOT eligible for our vision insurance.

20. Are local government and local education non-TCRS retirees eligible for retiree vision insurance?

No, local government and local education retirees who do not receive a TCRS pension are NOT eligible to enroll in retiree vision insurance.
21. If an employee does not have vision coverage at the time of retirement, can he or she enroll in vision as a retiree?
   Yes, as long as the retiree meets the eligibility criteria, he or she can enroll in vision insurance at the time of retirement.

22. If my agency does not offer vision coverage, can our retirees enroll in vision coverage?
   Eligible retirees will be able to take vision at retirement even if their agency does not offer the vision product.

23. When a retiree turns 65, will he/she be removed from vision coverage? And, do the same rules apply for dental?
   Retirees will be removed from vision coverage when they become Medicare eligible by virtue of age. Because of a specific state law, he/she will be able to remain enrolled in dental coverage.

24. When a retiree turns 65 and is removed from vision coverage, can the dependents enrolled in vision coverage keep the vision plan?
   Yes, the spouse may retain the vision coverage until reaching age 65, and a dependent child may retain the vision coverage until reaching age 26 as long as they remain enrolled in the state’s health coverage.

25. Can dependents of active employees who are 65 or older have vision coverage?
   Active employees can remain enrolled in vision coverage past age 65. Their spouses (and dependent children under the age of 26) are also eligible.

26. Are dependents of covered retirees allowed to enroll in vision if the retiree has single medical insurance?
   No. In order to be eligible to enroll in retiree vision, a dependent must also be enrolled in the state health insurance plan.

VSP Questions for TBR employees only

27. 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.

28. 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 and by logging into eyemedvisioncare.com/stoftn. Under “Locate a Provider/Find a Provider Now” enter your ZIP code. (You can also call EyeMed at 855.779.5046 and ask for customer service.)

29. Will there be coordination of benefits between the state and the TBR vision plans.
   No.
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 and not the state are the ones that assume the risk of premium payment versus claims cost.

The Assurant prepaid 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 Delta Dental preferred dental organization (PDO) does require a waiting period before certain more expensive services will be covered. A 12-month waiting period applies for implants, bridges, partial dentures, full dentures, crowns and cast restorations and orthodontic services. 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 Delta Dental at 800.223.3104.

2. **What happens if my dentist leaves Assurant’s network?**

When a dentist leaves the network, he/she must provide Assurant with a 90-day notice. Assurant 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 Assurant 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. You can change your primary dentist as frequently as every month with a simple call to customer service at 800.443.2995 or by using their website assurantemployeebenefits.com/stoftn. Your dentist selection and/or change to your dentist selection should be made by the 10th of the month for the change to be effective by the 1st of the following month.

4. **How does the Assurant prepaid plan work?**

You choose a primary dentist from the list of participating general dentists. Each general dentist will have a unique facility number. Be sure to complete the dentist selection form and send the form to Assurant Employee Benefits. The form is available in the back of the member booklet or on the website assurantemployeebenefits.com/stoftn.

Once you have selected a primary dentist and notified Assurant of your dentist selection, you will be listed on his/her roster (the roster is a list of eligible members that is provided to the dentist each month) and you can contact the office for your dental appointments. You will also receive your ID card and a list of covered services and the amount that you will pay to the dentist when you receive the service (referred to as your copayment). All covered services have a copay based on the dental procedure code. You must use your selected general dentist, not just any dentist, to receive benefits.
5. **How do I find an Assurant network dentist?**
   
   There are four ways to find a network dentist:
   1. Online at assurantemployeebenefits.com/stofrn
   2. Call customer service at 800.443.2995
   3. Consult a printed directory
   4. On your smart device using Assurant’s mobile app
      - To download, search for “Assurant” in the apps store/market, then select the app called “Benefits Tools.”
      - Use “Find a Dentist” and select Denticare as the dental provider.

6. **What if I am out of the area and need emergency care? Will Assurant 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 Assurant within 30 days of the actual treatment. The out-of-area emergency care is limited to emergency care up to $25 per occurrence (not to exceed $50 per member per year).

7. **How do I find a network dentist in the Delta Dental network?**
   
   Members in the PDO have access to Delta Dental’s PPO network. Your dentist must be in this network to receive the in-network benefit. Members can receive services from a dentist in Delta Dental’s Premier network, but these dentists are considered out-of-network and you will have to pay the out-of-network rates.

   There are three ways to find a dentist:
   - Visit deltadentaltn.com/statetn/ to search for a dentist or access the consumer toolkit.
   - Request a booklet by calling customer service at 800.223.3104.
   - Access the Delta Dental TN mobile application on a smart device (download the mobile application by visiting the App Store or Play Store and search for “Delta Dental”).

8. **How can I find out how much a procedure will cost under my Delta Dental plan?**
   
   Ask your dentist to request a predetermination, which will tell you if a service is covered, how much it may cost, and what your share may be. Predeterminations are not required and are not a guarantee of benefits.

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**Long-Term Care Insurance**

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 participate 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

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**Life Insurance - STATE AND HIGHER EDUCATION ONLY**

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

1. **Do I have to enroll for basic term life insurance?**

   The state provides $20,000 of basic term life and $40,000 of basic accidental death coverage at no cost to state employees. For employees who elect health coverage, the amount of coverage increases as the employee's salary increases, with premiums for coverage above $20,000/$40,000 deducted from the employee's paycheck. The maximum amount of coverage is $50,000 for term life and $100,000 for accidental death and dismemberment.

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

   The face amount of coverage declines when an employee reaches age 65.

3. **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.

**Optional Universal Life Insurance**

4. **Can I enroll in the optional universal life insurance plan if I am not already enrolled?**

   No, the plan is closed to new enrollments.

5. **Can I decrease the amount of coverage I have under the optional universal life insurance plan?**

   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.

6. **Can I increase the amount of coverage I have under the optional universal life insurance plan?**

   You may increase your coverage by the annual guaranteed issue amount of $5,000 during the fall enrollment period in 2014 if you receive a letter from Unum notifying you that you are qualified for the increase based upon your salary and current level of coverage.

   You may submit a supplemental 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 enrollment period in 2014.

7. **How does universal life insurance work?**

   The premiums you pay to maintain universal life coverage support the cost of insurance and administrative charges. Any amount left over goes toward cash value that accumulates and earns interest.

   When an individual retires (or otherwise stops working for the state) they can elect to continue paying the premium for the universal life insurance. If no premium is paid, the cash value is used to pay the monthly cost of insurance and administrative charges.

   However, several circumstances can affect the policy’s value, including the cost of supporting the coverage, the accumulated cash value and any loans taken against the policy. These variables mean the premium or accumulated cash value may not remain adequate to keep the policy in force until maturity.

   Your annual statement will provide information on the amount of your policy’s cash value or loan balances, the cost of insurance, and the interest credited. **Please carefully review your annual statement every year.**

   The cost of insurance rate (an amount per $1,000 of coverage) is determined by the individual’s current age on January 1 (attained age); that rate multiplied by the amount of coverage determines one of the monthly charges you pay.

   The schedule of the cost of insurance rates will not change under the initial contract extension. If certain conditions are met, Unum may request an increase in the cost of insurance rates. It is unlikely that these conditions will occur anytime soon. However, an increase in the cost of insurance rates will not mean an increase in the total premium that you pay, but it can affect how long the coverage remains in force.

8. **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 8 a.m. to 8 p.m. EST. It’s always a good idea to check the beneficiary information periodically to be sure the designation is current.

Optional Term Life Insurance

9. **Will there be an open enrollment for the optional term life insurance plan during the fall enrollment period?**

   No, only the changes noted below may be made.
10. Can I increase the amount of coverage I have under the optional term life insurance plan?

You may increase your coverage by the annual guaranteed issue amount of $5,000 during the fall enrollment period if you receive a letter 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 enrollment period.

11. Can I decrease the amount of coverage I have under the optional term life insurance plan?

You may ask to decrease the face amount on your policy as long as your request is submitted to Minnesota Life 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. Minnesota Life reserves the right to decline to make any change that Minnesota Life determines will cause coverage to fail to qualify as life insurance under applicable tax law.

12. 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/stateofmn 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.

Optional Accident and Dismemberment (AD&D) Insurance

13. Will there be an open enrollment for the optional AD&D life insurance plan during the fall annual enrollment period?

Yes, employees and their qualified dependents may enroll or cancel coverage. The options are single or family coverage.

14. 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.

15. May two employees cover the same dependent children?

No, one employee should select single coverage while the other employee selects family coverage.
Affordable Care Act (ACA)

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 currently?**
   If you want to satisfy the requirements of the new healthcare law you can enroll in the state group insurance program during open enrollment.

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. A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population.

5. **If I drop my health coverage, am I subject to the healthcare reform law’s penalty for not having coverage?**
   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% 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.

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 15, 2014, until February 15, 2015.

   If you purchase health coverage through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. In addition, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

   If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.