Enrollment & Eligibility

1. If a member wants to make a change to his or her benefits during the Annual Enrollment Transfer Period will he or she have to use ESS?

   All members who want to update or change or add benefits must use Employee Self Service (ESS) in order to make changes.

   The only exceptions to this policy are retirees and Local Government plan members who work for an agency that has less than 100 eligible employees who will fill out a paper application.

2. How do I find my User ID and password for ESS?

   Higher Education, Local Education and Local Government plan members will receive a letter in late September with their User ID and temporary password. This information will be given to your designated Agency Benefit Coordinator (ABC) as well. Instructions on how to use ESS are in the 2013 Decision Guides which each member will receive in the mail in mid-September. If you are having trouble logging on, contact Benefits Administration at 1-800-253-9981, and select option 3.

   State employees will use their current Edison User ID and password. If you have trouble logging on, please call the Edison Help Desk at 1-866-376-0104.

3. When is the Annual Enrollment Transfer Period/Open Enrollment?

   The Annual Enrollment Transfer Period and open enrollment is October 1 – November 1, 2012. This means you can make changes online until 11:59 p.m. on November 1, 2012.

   If you are a retiree you will fill out a paper application. If you are a local government member and are filling out a paper application, we will need to receive that application from your ABC by the deadline of November 1, 2012.

4. Will the Annual Enrollment Transfer Period be an Open Enrollment this year?

   Yes. Employees or their eligible dependents who did not join the health plan when they were initially eligible, or who were previously enrolled and dropped coverage, will be allowed to enroll in benefits during AETP if they agree to pay the monthly late applicant fee while they are enrolled through December 31, 2013.

5. Will the 2014 transfer period be an Open Enrollment?

   Yes. As the health reform law currently stands, we are on track to have an Open Enrollment in 2014. There will not be a late applicant fee after 2013.

6. Will I receive new health insurance cards for 2013?

   Yes. Members will receive new health insurance cards before January 1, 2013, to reflect co-pay changes for 2013.
7. Why can’t members, other than Local Government, be offered or allowed to enroll in the Limited PPO?

The Limited PPO is a high deductible, catastrophic coverage health option available only to Local Government Plan members. It was put in place at the request of the Local Government Insurance Committee and was not approved by the State or Local Education Insurance Committees.

8. 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.

9. 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.

10. Will the late applicant fee amount remain the same this year or will it increase?

It will remain the same in 2013 as it was in 2012.

11. Is the late applicant fee for the same in 2013 for the members who joined the plan in 2011?

Yes, the late fee for 2013 is the same for all members including those who enrolled in 2011 and 2012.

12. How long will I have to pay the late applicant fee?

You must pay the late applicant fee each month as long as you are covered through December 31, 2013. At that time, the late fee will stop for all members.

13. Does the late applicant fee apply to children?

No. Dependent children are not subject to the late applicant fee.

14. If an employee or eligible dependent spouse joins the plan subject to the monthly late applicant fee and later has a special enrollment qualifying event, will he/she still have to pay the late fee?

No. An event that would normally make a member eligible for coverage will cancel the late fee, and the fee will no longer have to be paid.

15. If an employee joined the plan during the Annual Enrollment Transfer Period and later retires, will he/she have to pay the late fee?

No. Although retirement is not a special qualifying event, Benefits Administration will recognize termination of employment (including final termination of employment for retirement) as a qualifying reason to drop late applicant fees.

16. 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; it does not mean that you can only go to doctors and hospitals in your area. You will always have access to doctors across Tennessee and across the country.
17. 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?

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

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

Coverage can only be dropped during the Annual Enrollment Period or if a member has a qualifying family status change. A list of events is on the cancel request form.

19. Do the pre-existing condition exclusions apply to anyone over age 19? What about spouses and children?

The 12-month pre-existing condition exclusion applies to any employee or employee’s spouse who cannot show proof of prior creditable coverage. However, this pre-existing condition exclusion does not apply to pregnancy, newborns or covered children of any age.

20. Are there any exceptions to the pre-existing condition exclusion?

Pre-existing does not apply to services that are truly preventive (like an annual physical or well-woman exam or screening mammogram) as long as the claim is coded as preventive. If claims are coded with a medical diagnosis, however, it can trigger the pre-existing condition clause. The service really isn’t considered preventive when that happens.

21. I am a retiree; can I enroll in the state’s health insurance plan during Open Enrollment? What about my dependents?

A retiree, who did not continue coverage at retirement, cannot join the plan during Open Enrollment. However, a retiree who is already on the health plan can add an eligible dependent during open enrollment. The late applicant fee will apply to dependent spouses.

As a reminder, a retiree who is age eligible for Medicare is not eligible to enroll in the state-sponsored health Plan. Retirees who have lost eligibility due to becoming age-eligible for Medicare may not enroll dependents in the health Plan.

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**Partnership Promise**

1. **What is required for the 2013 Partnership Promise?**

Members and covered spouses must do the following things in 2013:

- Complete the online Healthways Well-Being Assessment™ (health questionnaire) by March 15, 2013.
- **NEW this year!** Engage in one ParTNers for Health wellness activity by July 15, 2013.
- Keep your address, phone number and email, if you have one, current with your employer. (Retirees must keep their contact information up to date with Benefits Administration.)
- **NEW this year!** If you are a tobacco user, you must engage in a tobacco cessation program. Members and covered spouses identified as at risk must also do the following things in 2013:
- Complete a biometric screening at your health care provider’s office between July 15, 2012 and July 15, 2013.
• Participate in health coaching and/or case management.

New employees (as of 1/1/13) will be required to complete the online Well-Being Assessment and screening within 120 days of their insurance coverage effective date.

Note: If it is unreasonably difficult because of a medical or mental health condition for you to achieve the standards to fulfill the Partnership Promise, or if it is medically inadvisable for you to attempt to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 1.888.741.3390, and they will work with you to develop an alternate way to fulfill the Promise.

2. What is different this year?

In 2013, we are asking you to take a more active role in learning about and managing your health. All members and covered spouses are required to complete the online Well-Being Assessment (health questionnaire) and one ParTNers for Health wellness activity.

Members with certain health conditions or risk behaviors who are identified as at risk will need to work with a health coach to establish goals to improve their health and reduce identified health risk behaviors and complete a biometric screening at your physician’s office.

If you are a tobacco user, you must engage in a tobacco cessation program. If you are a new hire (as of 1/1/13) you must complete the WBA and a biometric screening within 120 days of your insurance coverage effective date.

3. If my spouse and children are covered by my insurance, do they have to fulfill the 2013 Partnership Promise too?

Both you and your covered spouse will have to meet the 2013 Partnership Promise in order to remain in the Partnership PPO in 2014. Children, regardless of age, do not have to fulfill the Partnership Promise.

4. 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.

Please note, if your child ages off of your coverage and enrolls in COBRA, he/she would need to fulfill the Partnership Promise at that time.

5. Do I have to create a new online account?

Yes, you will have to create a new online well-being account this year. Beginning January 1, 2013, you can create one at any time by clicking on the “My Wellness Login” link on the ParTNers for Health homepage. You must create an account before you can complete the Well-Being Assessment, create a Well-Being Plan, participate in the wellness challenges and access the tools, trackers and resources.

6. What information will I need to create a new online account?

In order to create an online account, you will be asked to provide your legal first and last name, date of birth, mailing zip code and email address. If you do not have an email address, you can create an email account for free at websites such as www.gmail.com or www.yahoo.com.
7. How can I check the status of my Partnership Promise?

This year members can check the status of their Partnership Promise through their online well-being account. This is the account you will create when you complete the Well-Being Assessment in 2013. Beginning January 1, 2013, you can create one at any time by clicking on the "My Wellness Login" link on the ParTNers for Health homepage.

When you log in, you can view your Partnership Promise status in the Rewards Center. Be sure to check your status often as it can change throughout the year depending on your participation.

If you do not have internet access, you can also check your Promise status by calling the ParTNers for Health Wellness Program at 1.888.741.3390.

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 line or other health and wellness services. Coaching and other services will be provided with no additional charge for members in each PPO option.

9. Are new members required to get a biometric screening and complete the online Well-Being Assessment (health questionnaire)?

Yes, new hires (as of 1/1/13) are required to complete the online Well-Being Assessment and screening with their health care provider within 120 days of their insurance coverage effective date.

10. I do not remember signing the Partnership Promise again for 2013. Was I supposed to sign a new document?

No, if you choose to stay in the Partnership PPO for 2013, the Promise you signed in 2011 or 2012 will do.

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

When you sign the enrollment form or click “OK” in Edison employee self-service to enroll in the Partnership PPO, you are agreeing to fulfill the 2013 Partnership Promise.

12. If I break 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 will still be available to you.

13. 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 year before you are eligible to enroll in the Partnership PPO again.

14. If my spouse does not meet his or her Partnership Promise for 2013 and I drop him or her from my coverage, can I re-enroll in the Partnership PPO for 2014?

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 the following year ONLY if the non-compliant spouse is dropped from coverage.
15. What do you mean when you say “unreasonably difficult due to a medical or mental health condition” when talking about fulfilling the Partnership Promise?

If you cannot fulfill the Partnership Promise because of a physical or mental health condition, your health coach will work with you to come up with a different way to keep your Promise.

Well-Being Assessment (WBA)

16. Do I have to complete an online questionnaire in 2013?

Yes, all members and covered spouses must complete the online Well-Being Assessment (health questionnaire) in 2013. You will create a new online well-being account to complete the assessment. See questions #5 and #6 for more information.

17. Can I complete my Well-Being Assessment over the phone?

Yes; however, it is recommended that you complete the WBA online. The online WBA offers a better member experience with instant results and access to a personalized Well-Being Plan.

ParTNers for Health Wellness Activities

18. Which preventive services count toward fulfilling the Partnership Promise?

You should choose a preventive service that is age and gender appropriate. This can include an annual physical, well-woman visit or a flu shot, just to name a few. A complete list of covered preventive services is available at www.uspreventiveservicestaskforce.org/uspstf/uspsabreecs.htm.

19. Do I only have to choose one of the preventive services from the list?

Yes. If you choose an age-appropriate preventive service to fulfill your wellness activity, only one is required. Many members receive more than one preventive service a year. We encourage you to receive the preventive services you need, but only one is required.

20. How will Healthways know that I have completed an age-appropriate preventive service? Does my doctor have to submit a form?

You must report your age-appropriate preventive service by calling Healthways or by reporting your activity in your online well-being account. Once logged in, you will find a link to the form in the yellow post it note message. Your doctor is not required to submit documentation – it is strictly self-reported.

21. What is a wellness challenge?

Wellness challenges are offered online and focus on topics such as fitness, nutrition, weight management and tobacco cessation. They offer fun ways to help members develop healthier lifestyles while providing group support. Past challenges included What Do You Have to Lose, Tennessee? (weight loss) and Step into Spring (fitness).

Though challenges in 2013 will differ somewhat, they will offer new and exciting ways to focus on similar healthy goals.
22. Can I complete a wellness challenge at any time?
Wellness challenges are available once every quarter. If you choose a wellness challenge as your wellness activity, you must complete one of the first two quarterly challenges in 2013 to meet the July 15 deadline.

23. 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, 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. You will be required to complete three action items.

24. What types of action items are required? Can I choose which action items I want to complete?
Action items are personalized steps to improve your well-being in each of your Focus Areas. They are specific activities or suggestions for things you can write, try, learn or consider. Action items can include tracking your exercise, completing a journal entry or reading an article in the Resources Center, to name a few.

You can find your action items under each Focus Area of your Well-Being Plan. Once you finish your action item, click the “Complete” button.

25. How do I update my contact information? Who collects this 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 1.800.253.9981 and selecting option 6.
- **Retirees:** You can change your contact information by contacting the Benefits Administration service center at 1.800.253.9981 and selecting option 2.

26. 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 note: your phone number listed as the preferred number is the phone number the health coach will use to reach you. If you would like for a health coach to contact you at home or on your cell, list that number as your preferred phone number.

27. 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 an email account for free at websites such as www.gmail.com or www.yahoo.com.
Tobacco Cessation Program

28. Am I going to be charged more for being a tobacco user?
   No. There is no surcharge for tobacco use in 2013. However, if you are a tobacco user, you must engage in a tobacco cessation program and work towards quitting as part of the Partnership Promise.

29. What types of tobacco cessation programs are available?
   Healthways will offer two types of tobacco cessation programs with 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 to help you work towards becoming tobacco free. The second option is QuitNet, a more intensive program for those ready to set a quit date. The QuitNet program involves more frequent calls and online support.
   While the goal is always to quit using tobacco products, you are not required to quit in 2013.

30. Is there a charge for the tobacco cessation programs?
   No, there is no charge for the tobacco cessation programs offered by the 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.

31. Does the tobacco cessation program have to be a Healthways tobacco cessation program to fulfill the Promise?
   Yes. The State also offers quit aids at no cost, but you must participate in a Healthways tobacco cessation program to satisfy the Partnership Promise requirement for tobacco users.

32. 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. However, there is one exception. Someone who smokes an occasional cigar (up to one a month) will not be considered a tobacco user (based on similar guidelines from life insurance companies that allow for occasional cigar use).

33. 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 programs are designed to create a positive experience for the member. Their 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, if you enroll in the Partnership PPO, you will be required to complete a tobacco cessation program, but you will not be required to quit tobacco.
   If you are not willing to participate in the tobacco cessation program in 2013, the Standard PPO is a better option for you.
At-Risk Members

34. How will Healthways decide if I am at risk?

ParTNers for Health coaching staff will decide who should participate based on medical conditions and behaviors that may negatively affect your health and/or cause long term health issues. We are still working with Healthways on what specifically would make someone at risk. Generally, one high risk or three moderate risks could cause someone to be identified.

Opportunities to improve health and habits are based on national standards and guidelines scientifically proven to help a person’s health or prevent the chance of chronic health conditions.

35. If I was identified for coaching in 2012, will I automatically be considered at risk in 2013?

We cannot say for certain. The past wellness vendor and Healthways have different methods for identifying members. It is likely there will be a larger group that will be identified as “at risk” this year.

36. When will I be notified if I am identified as at risk? Will I be notified in time to complete the required biometric screening by July 15, 2013?

If you are identified as at risk, Healthways will typically contact you by phone within one week of completing your Well-Being Assessment to let you know that you are at risk and need to complete the biometric screening and participate in health coaching and/or case management.

When you talk to the coach, he/she will help you find the physician screening form online so you can print a copy. If you don’t have access to the internet, the coach can mail the form to you.

We recommend completing your WBA early to allow plenty of time to get a biometric screening if you need one. If a health coach cannot reach you after five attempted phone calls, he/she will mail you a letter to notify you that you are at risk.

37. How will my spouse be contacted if identified as at risk?

If your spouse is identified as at risk, a health coach will contact him/her using the phone number for the spouse on file with the ParTNers for Health wellness vendor. If there is not a number on file for the spouse, the head of contract will receive a letter and the spouse will have 14 days to respond. If the spouse does not respond in time, the head of contract and covered spouse will be defaulted to the Standard PPO in 2014.

Spouses can create and log in to their online well-being account to enter a contact phone number. If spouses don’t have access to the internet, they can also call Healthways to update their information. This will ensure that the ParTNers for Health wellness vendor can reach the spouse if he/she is identified for coaching.

38. Can I work with a health coach even if I am not at risk?

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 identified for coaching but choose to opt in, you are not required to complete a coaching program to meet your Partnership Promise.
Biometric Screening

39. Do I have to get a biometric screening in 2013?
No, it is not required for all members and their covered spouses to get a biometric screening in 2013. However, if you are identified as at risk or if you are hired in 2013, you must get a biometric screening.

40. What is a biometric screening? Will it be the same as the screenings required in 2011?
Typically, during a biometric screening a health professional will collect measurements, including height and weight. A sample of your blood will be collected to determine your cholesterol and glucose levels, triglycerides and other factors that can lead to lifestyle-related health complications.
Biometric screening requirements will be included on the physician screening form. The form will be updated for 2013 and posted online.
The biometric screening requirement will be the same as the 2011 screenings; however, onsite screenings will not be offered in 2013. You must fulfill this requirement by visiting your doctor’s office and submitting a physician screening form.

41. Will I have to pay a co-pay 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.

42. Can I submit the physician screening form or should it come from my doctor?
Anyone can submit the form to Healthways as long as it is signed or stamped by your doctor.

43. If my doctor charges a fee to submit the physician screening form to Healthways, am I responsible for paying that fee?
Yes. The State cannot control what a doctor’s office charges to complete a form.

Health Coaching

44. What is health coaching?
A health coach is a trained health care professional who is here to help you reach your health goals. Coaches will work with you to set goals, provide tools, track progress and offer information to help you make better choices and manage your health.
What you talk about with your health coach is confidential and cannot be shared with your employer, BlueCross BlueShield or Cigna (your health insurance carrier), or the State of Tennessee Group Insurance Program (your insurance company). Information is shared with your doctor only with your permission.

There are two types of health coaching programs:
- **Lifestyle Management programs** can help you form better health habits. Coaches can help if you have issues such as high blood pressure, high cholesterol, tobacco cessation and weight management.
- **Disease Management programs** are for people with chronic health conditions such as diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease (COPD) or coronary artery disease. The health coach works with you and your doctor to help you with self-
management skills to make sure that you are taking your medicines and are getting the right care.

Members identified for Case Management by BlueCross BlueShield of Tennessee, Cigna or Magellan must participate to fulfill the Partnership Promise.

45. What is case management?
Case management is a program administered by BlueCross, Cigna and Magellan that promotes quality and cost effective coordination of care for those with complicated medical needs, chronic conditions and/or catastrophic illnesses or injuries. If you are identified for case management, you will be contacted by BlueCross, Cigna or Magellan.

46. 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 sessions offered by the Employee Assistance Program (EAP), which are not tied to the Partnership Promise.

47. How is participation in health coaching defined?
To be considered an active participant, you need to:

- Work with a health coach to improve or maintain your health. The health coach will assess your health and lifestyle, work with you to set long- and short-term goals, and help you avoid barriers to achieving good health.
- Work with a health coach to create a plan of care specific to your needs. Your plan can include talking with your doctor about needed preventive care for your age and gender.
- Communicate (via phone) with a health coach as needed.
- Work toward making improvement and meeting the goals on your plan.

Failure to participate in health coaching will make you ineligible for the Partnership PPO and transfers you to the Standard PPO in 2014 with a higher premium, deductible and out-of-pocket costs.

48. When will someone contact me for health coaching?
A ParTNers for Health coach may contact you at any time during the plan year (January 1 – December 31, 2013). 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. Coaches are available Monday – Friday from 7:30 a.m. – 9:30 p.m. and Saturday from 8 a.m. – 6:30 p.m. (Central Time).

49. Who do the health coaches work for and what are their credentials?
All health coaches are employees of Healthways. This is 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 registered nurses and licensed dieticians, clinical social workers, certified health educators and those with degrees in exercise physiology, exercise science and
health promotion. This vast experience allows you access to speak with coaches based on your needs and personal health goals.

50. How does Healthways decide who will be contacted for coaching if the biometric screening is not required for everyone in 2013?
   The ParTNers for Health coaches will decide who will be contacted for health coaching based on your answers to the Well-Being Assessment in 2013.

51. If I have a personality conflict with my coach, can I request another coach?
   Yes, you can call the Customer Service Department at 1.888.741.3390 and your request will be honored.

52. If I am able to meet my goals for better health, will I still be required to work with a health coach? For how long?
   If you are identified as at risk, 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 will 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 change in your health 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 2014.

53. 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.

54. If I talk to my doctor instead, does that satisfy the health coaching requirement?
   No. Talking to your doctor does not take the place of participation in the program. Health coaching is not intended to replace your doctor but instead should be in addition to the care you receive from your doctor.

55. 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 health care 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.

56. How often, when and how do I have to communicate with my health coach? What if I miss a call?
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 7:30 a.m. – 9:30 p.m. and Saturday from 8:00 a.m. – 6:30 p.m. (Central Time). If you miss a call, the coach will try to call you back or you can contact him/her. You will need to talk with a health coach more often if you have significant health concerns and less frequently if you have less severe health concerns.

57. If I am currently in a health coaching program with APS Healthcare, will I be transferred to a new Healthways coach?

Yes, you will receive a letter from Healthways as well as a follow up call from a health coach.

However, if you are currently enrolled in the depression disease management program, that program is ending at the end of this year. Our behavioral health provider, Magellan, has a number of support programs available for depression. Please contact them at 1.855.437.3486 to learn more about all of behavioral health benefits, including your Employee Assistance Program which offers five, no-cost counseling sessions per episode.

58. If my spouse gave me permission to speak to a health coach on his/her behalf, will I still be able to do that?

Yes, but your spouse will have to sign a new release form to allow you to speak to a Healthways coach on his/her behalf. Release forms will be available in January 2013.

59. What happens if my health coach is unable to reach me?

If the ParTNers for Health Wellness Program health coach cannot reach you after five tries, he or she will send a letter to your home address and 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.

ParTNers for Health Wellness Program

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 my health coach 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 check his or her status in the Partnership Promise or complete the online Well-Being Assessment?

This year all members and their spouses enrolled in the Partnership PPO can check their status in the Partnership Promise by logging into their online well-being account.
4. **Will 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. A list of participating fitness centers is available at www.partnersforhealthtn.gov/your_other_benefits/fitness.aspx.

5. **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 employees a discount for these programs. To find out more, visit www.partnersforhealthtn.gov/your_other_benefits/weight_watch.aspx.

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**Pharmacy**

1. **What happens if I ask for a generic medication when my doctor writes a prescription indicating that the brand may be substituted for generic?**

   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?**

   Yes, 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 and up. There are no anticipated changes in regards to the Shingles vaccine at this time. Current guidelines can be found under the CDC schedules at www.cdc.gov/vaccines.

3. **Under the new health care law, birth control medication and women’s preventative services are supposed to be at zero copay for plans when the new plan year starts on or after August 1st but I am still paying for my prescriptions and services. When will this change go into effect?**

   The State of TN-sponsored health insurance plans run on a calendar year, and this benefit will begin on January 1st, 2013. Until then, your prescription benefits will continue as-is. There will be more information listed in the 2013 Decision Guide that you will receive prior to your annual enrollment period.

4. **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 new drug tier, we are making 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 will see 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 new drug tier will help these members by lowering their out-of-pocket costs.
5. **What is the maintenance tier?**

To utilize the maintenance tier and to receive the lower co-pays 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, insulins 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 co-pay are: Metformin, Glimepiride, Actos, Januvia, Novolog, Simvastatin, Crestor, Atorvastatin, Pravastatin, Lovastatin, Lisinopril, Hydrochlorothiazide, Amlodipine and Atenolol.

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

You can call CVS Caremark at 1.877.522.TNRX (8679) to find out if your drug may qualify.

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, log in to www.Caremark.com, click on Important Message under the Home tab, then select “visit your forms to print.” The link for participating vaccine network pharmacies is listed at the bottom of the page under Additional Information.

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 co-pay 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 co-pay 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 co-pay 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.

Smoking cessation counseling is available from health coaches through our ParTNers for Health Wellness Program. To speak to a health coach call 1.888.741.3390.
9. Does a deductible or out-of-pocket maximum apply for pharmacy benefits?

Only the Limited PPO has an additional deductible for pharmacy benefits. The Partnership and Standard PPOs do not have an additional deductible for pharmacy.

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

For a complete list you can contact Caremark at 1.877.522.TNRX (8679) or visit www.caremark.com and click on the Understand My Plan and Benefits tab. The drug list is also posted on the pharmacy page of the Partners for Health website (www.partnersforhealthtn.gov/your_other_benefits/pharmacy_benefits.aspx).

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

You need to contact CVS Caremark about your options if the drug you are taking is not covered under the new 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 CVS Caremark and provide clinical information to request an amount over the plan limit. As the plan’s pharmacy benefits manager, CVS 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 CVS Caremark, our pharmacy benefits manager. Call Caremark at 1.877.522.8679 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 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 co-pay 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 co-pay 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 both the Partnership and Standard PPOs, 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 every 1-2 years for women age 40 and older or when prescribed by a physician and determined to be medically necessary. This benefit is based on recommendations by the United States Preventive Services Task Force (USPSTF). Benefits Administration added “or when prescribed by a physician and determined to be medically necessary” to acknowledge that there might be instances where screenings should begin at an earlier age and/or occur more frequently.

   Our benefit language as written doesn't mean that we are limiting women to a screening mammogram every two years. The intent is that our female members who are age 40 or older take preventive measures by having screenings no less frequently than every two years. If you go annually, that is equivalent to every one year and should be covered since the USPSTF recommended range is every 1-2 years.

   Mammogram screenings that fall outside the general guidelines (those occurring more than once a year or earlier than age 40) will only be covered if prescribed by a physician and determined to be medically necessary.

   **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 co-pay.

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 who had a preventive screening colonoscopy after June 1, 2012, believes that his or her claim should have been billed as a preventive screening instead of a diagnostic exam, 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 co-pay?**

There is no co-pay 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 on top of the allergy shot.

7. **Do advanced imaging and outpatient surgery require a co-pay or co-insurance?**

Advanced imaging and outpatient surgery are subject to the deductible, co-insurance and the out-of-pocket maximum will apply.

8. **Does dialysis require a co-pay or co-insurance?**

Members will pay co-insurance 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 co-pay. You only have to pay a co-pay 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 co-pay or co-insurance.

10. **How is chemotherapy covered? Is it a co-pay or is it subject to deductible and co-insurance?**

The member pays a co-pay if the therapy is done in a doctor’s office, but he or she would have to pay co-insurance 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 co-insurance. Members are responsible for 10 percent coinsurance in-network in the Partnership PPO and 20 percent coinsurance in-network in the Standard PPO after meeting their deductible.
12. What happens if I have a high medical bill? Will I have to pay co-insurance 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 co-insurance 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?

Yes. All members are eligible for both the Partnership PPO and the Standard PPO. In addition, the Limited PPO option is available to local government employees.

2. Does everyone have a choice of insurance carriers?

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

3. Why are the monthly premiums different among regions?

Depending on where you live, BlueCross BlueShield of Tennessee and Cigna have variations in premiums because the networks have different costs in each region. If the State pays less, you pay less.

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 health care 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 1.800.558.6213
   b. Cigna at 1.800.997.1617

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

3. View a PDF of the provider directory:
6. Are the Mountain States Health Alliance hospitals and facilities in Cigna's network in upper east Tennessee?

Cigna advised the State that the agreement between Mountain States Health Alliance (MSHA) and Cigna ended January 1, 2012. This means that the hospitals, facilities and physicians of MSHA are considered out-of-network providers for the State of Tennessee Group Insurance Program.

Please note that networks do change from time to time. Call the BCBST and Cigna service centers to make sure that the facilities and doctors you want to use are in the 2013 provider network.

7. What BCBS network changes will take place in the Memphis area beginning January 1, 2013?

The Baptist Memorial Health Care facilities will no longer be in the network. Methodist LeBonheur Healthcare will join the network beginning January 1, 2013.

8. Which Baptist facilities will this effect?

Baptist facilities in Metro Memphis, including Shelby, Tipton and Desoto counties, will no longer be in BCBS’s network but their facilities in Union City and Huntingdon will remain in the network.

9. Will Tennova still be in the Cigna network for 2013?

Yes, Tennova and Cigna have reached an agreement and Tennova facilities will stay in the Cigna network.

Please note that networks do change from time to time. Call the BCBST and Cigna service centers to make sure that the facilities and doctors you want to use are in the 2013 provider network.

10. Which Tennova hospitals are in the Cigna network?

Tennova hospitals in East Tennessee include Physician Regional Medical Center, North Knoxville Medical Center, Turkey Creek Medical Center, Jefferson Memorial Hospital, Lafollette Medical Center, Newport Medical Center and Baptist Women’s.

11. 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.

**Other Benefits**

1. **What is the Employee Assistance Program (EAP)?**
   The 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 assist in researching child and elder care, adoption, as well as providing many other benefits such as screening for depression as well as substance abuse. Visit [www.HERE4TN.com](http://www.HERE4TN.com) to learn more or call 1.855.HERE4TN (1.855.437.3486)

2. **How many sessions do I have through the Employee Assistance Program?**
   You actually 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 everyday of the year. Preauthorization is required to use the EAP but can easily be obtained by either going to [www.HERE4TN.com](http://www.HERE4TN.com) or calling 1.855.437.3486.

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 relationships is working well for you.

4. **Is preauthorization required for outpatient behavioral health?**
   Beginning January 1, 2013, you no longer need to obtain preauthorization for most outpatient behavioral health services. A preauthorization is still required for some treatments including psychological testing and electroconvulsive therapy.

5. **Do behavioral health services need prior authorization, or can I go to any provider in the network?**
   For all inpatient services and certain outpatient services including psychological testing and electroconvulsive therapy, members must call Magellan Health Services at 1.855.437.3486 for prior authorization of services.

6. **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.
7. How can I find a network provider?

Using the benefit at a network provider is easy. Locate a provider that is part of the EyeMed Network by logging on to www.eyemedvisioncare.com. Under Locate a Provider choose “Select” in the drop down box and then enter your zip code. (You can also call EyeMed, at 866-299-1358 and ask for customer service.

8. How often can I get an eye exam?

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.

9. How does the frame allowance work?

If you choose the Basic plan and if you 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 if you 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.

10. 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.

11. Do I need to file a claim?

No, you will 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 (www.eyemedvisioncare.com).

12. How do I request additional ID cards?

If you need more ID cards, you can request them once you register or log onto the EyeMed website or by calling their customer care center at 866-299-1358.

13. 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 order a new one.
14. How will my provider verify that I am a member?

An ID Card is not required to receive benefits at the provider’s office. The provider will search for a member by name and then verify the member’s address, date of birth and employer.

15. 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 their appointment.

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

If your provider is not currently participating on the EyeMed network, you can recommend them by submitting a provider nomination form. The form, including instructions, can be found on our website under the “forms” tab, www.eyemedvisioncare.com.

17. 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.

18. Who should I contact if I have trouble creating or logging in to the EyeMed member website?

To register as a member on the EyeMed Vision Care website, go to www.eyemedvisioncare.com and click on “Members” in the upper left of the home page.

Follow the instructions to create your account. You can also call the EyeMed Customer Care Center at 866-299-1358 for assistance with logging into the website.

19. 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.

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

You can contact the EyeMed Customer Care Center with any questions pertaining to your claim, 866-299-1358.

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

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

22. 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.

23. 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.
24. Who is eligible to enroll in the State EyeMed Vision Plan?
   All state employees and higher education employees are eligible. Employees of Local Education
   and Local Government Agencies that submitted an Intent to Enroll Form to Benefits Administration
   prior to July 1, 2012 are eligible.

25. How do I sign up for the EyeMed Vision Plan?
   You will need to enroll in the EyeMed Vision Plan using ESS in Edison. The only exceptions to this
   policy are retirees and Local Government plan members who work for an agency that has less than
   100 eligible employees who will fill out a paper application.

26. 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.

VSP Vision Plan for TBR employees only

1. 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 a simple comparison of the
   two on the first two pages of your TBR Decision Guide.

   You can find more specific information about the State Plan in the Decision Guide under the Vision
   Section and by logging into www.eyemedvisioncare.com. Under Locate a Provider choose “Select”
   in the drop down box and then enter your zip code. (You can also call EyeMed, at 866-299-1358
   and ask for customer service.

2. If I want to remain in the VSP Vision Plan in 2013, what do I need to do?
   To remain in the current TBR vision plan requires no action on your part. In the event you are
   making changes to your health and dental plans, you will simply “decline or waive” the State’s vision
   coverage when it appears on your ESS screen as an option.

3. What if I want to enroll in the State’s vision plan?
   To enroll to the State’s vision plan you must use the State’s Employee Self Service (ESS) system.
   Even if you are not making changes to your health or dental plans you will need to access ESS to
   complete your vision enrollment.

4. How do I enroll in the TBR vision plan?
   To enroll in the current TBR vision plan visit www.tbrvision.com and complete the online enrollment
   process.

5. Will there be Coordination of Benefits between the State and the TBR vision plans.
   No.
Dental

1. **If I am not enrolled in one of the state group dental insurance plans, may I enroll during the Annual Enrollment Period?**

   Yes. Eligible employees can choose between two dental options—the Assurant Prepaid Plan and the Delta Preferred Dental Organization (PDO). State and Higher Education employees will enroll using Employee Self Service (ESS). Local Education and Local Government employees in agencies where the dental plans are offered will also use ESS.

   If you are a local government member and are filling out a paper application, we will need to receive that application from your ABC by the deadline of November 1, 2012.

2. **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 carriers and not the state are the ones that assume the risk of premium payment versus claims cost.

   Assurant does not require any waiting periods before services will be covered.

   Delta Dental 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. Waiting periods cannot be appealed through the state; please direct any questions to Delta Dental.

3. **What happens if my dentist leaves Assurant’s Prepaid 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.

4. **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 or by using the Assurant Employee Benefits’ web site. Your dentist selection and/or change to your dentist selection should be made by the 20th of the month for the change to be effective by the 1st of the following month.

5. **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 Dentist Selection Form is available in the back of the Prepaid Plan Member Booklet or on the web site at www.assurantemployeebenefits.com/STofTN.

   Once you have selected a primary dentist and notified Assurant Employee Benefits 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.
6. How do I find an Assurant network dentist?

There are four ways to find a network dentist:

- Online at www.assurantemployeebenefits.com/STofTN
- Call customer service at 1-800-443-2995
- Consult a printed directory
- On your smart phone 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.

7. 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).

8. The Delta Dental plan has a 12-month waiting period for certain services. What are those?

There are 12-month waiting periods for:

- Implants
- Bridges
- Dentures (partial and full)
- Crowns and cast restorations
- Orthodontic services

9. 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 two ways to find a dentist:

- Visit www.deltadentaltn.com to search for a dentist or access the consumer toolkit.
- Request a booklet by calling customer service at 1-800-223-3104.

Other

1. Are there any life insurance plans available in the state group insurance program?

Basic Term Life Insurance & Accidental Death/Dismemberment, Optional Accidental Death/Dismemberment, and Optional Term Life Insurance are part of the state group insurance plan for State and Higher Education employees. There is no life insurance in the state group insurance plan for employees of Local Education or Local Government agencies.
2. May I enroll in the optional state group long term care insurance plan during the Annual Enrollment Period?

You may apply for enrollment in the long term care insurance plan at any time. Enrollment applications are not limited to just the Annual Enrollment Period. 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.

3. How do I get more information on enrolling in Long-Term Care Insurance?

Contact MedAmerica at 1-866-615-5824 or visit www.ltc-tn.com