PARTNERS FOR HEALTH

Group Health Insurance Program For ORS Employees

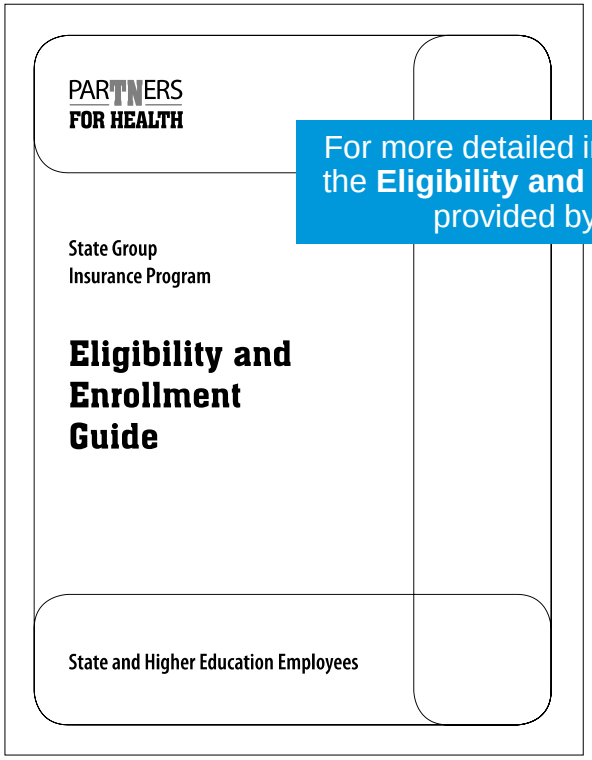
New Employee Benefits Orientation

January 1 – December 31, 2016

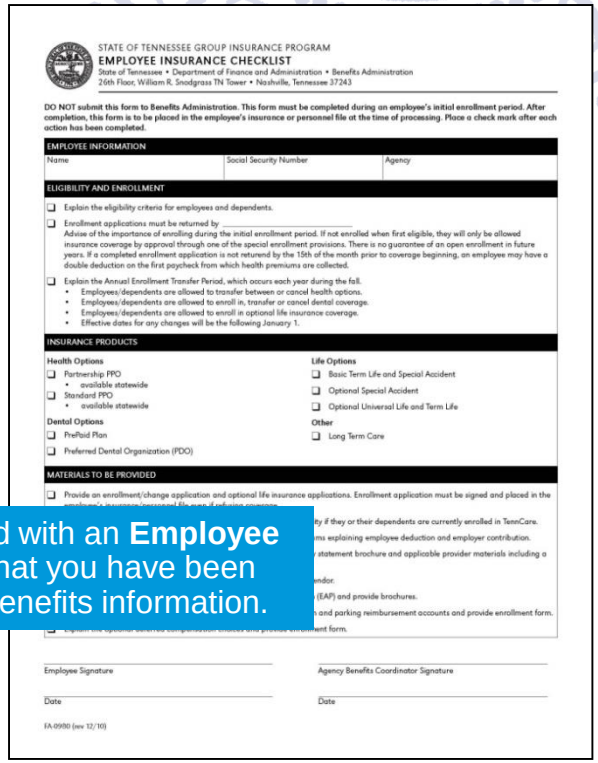
Importance of Your Decisions

- The decisions you make **now** as a new employee will have lasting effects on your benefits
- **Please note:** Some decisions can only be made during the new hire period
- Be aware of all the options available to you and make an informed decision
- Submit questions to Human Resources

Resource Materials



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



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

EMPLOYEE INSURANCE CHECKLIST

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

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

EMPLOYEE INFORMATION

Name | Social Security Number | Agency

ELIGIBILITY AND ENROLLMENT

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

INSURANCE PRODUCTS

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

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

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

Other
- ☐ Long Term Care

MATERIALS TO BE PROVIDED

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

ity if they or their dependents are currently enrolled in TennCare.
ms explaining employee deduction and employer contribution.
statement brochure and applicable provider materials including a
endor.
(EAP) and provide brochures.
and parking reimbursement accounts and provide enrollment form.
ment form.

Employee Signature | Agency Benefits Coordinator Signature

Date | Date

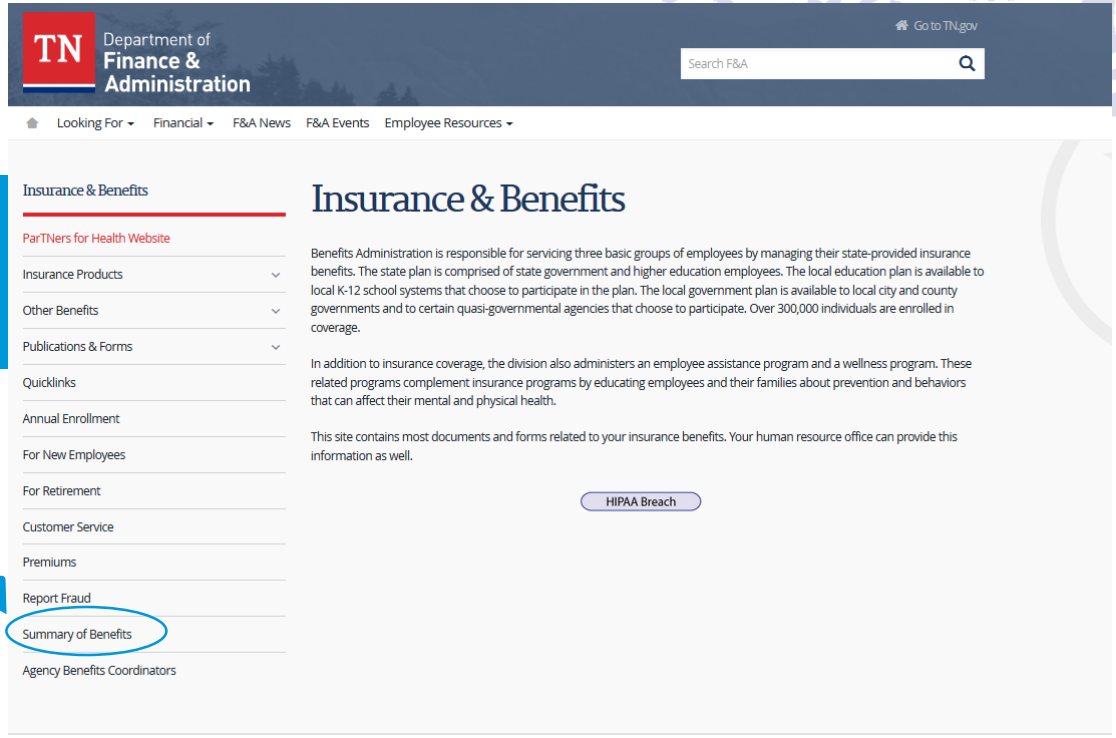
FA-0980 (rev 12/10)

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

Resource Materials

tn.gov/finance/section/fa-benefits

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



About the Plan

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

Who is Eligible for Coverage?

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

Adding Coverage

Three times you may add health coverage:

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

Annual Enrollment

- During Annual Enrollment you may:
  - Enroll, cancel or make changes to health insurance
  - Select or change your health insurance carrier
  - Choose or switch CDHP/PPOs (subject to eligibility)

- Changes are effective January 1 of the following year

Annual Enrollment occurs each year during the fall

Canceling Coverage

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

Definitions

- **Premiums** - amount you pay each month for your coverage regardless of whether or not you receive health services
- **Copay** - flat amount you pay for services and products (office visits. Prescriptions etc.)
- **Deductible** - set amount you must pay each year for services
- **Coinsurance** - % of cost for a service after you meet deductible

Definitions

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

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

What is ALEX?

ALEX is a smart, funny benefits expert who explains benefits options and may help members choose what's best for them.

Go to www.partnersforhealthtn.gov

Choosing Your Health Insurance Options

1 Plan Options

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

2 Two Insurance Carriers

- BlueCross BlueShield of Tennessee
- Cigna

3 Four Premium Levels (tiers)

- Employee
- Employee + child(ren)
- Employee + spouse
- Employee + spouse + child(ren)

Health Benefits

Preferred Provider Organizations (PPOs)

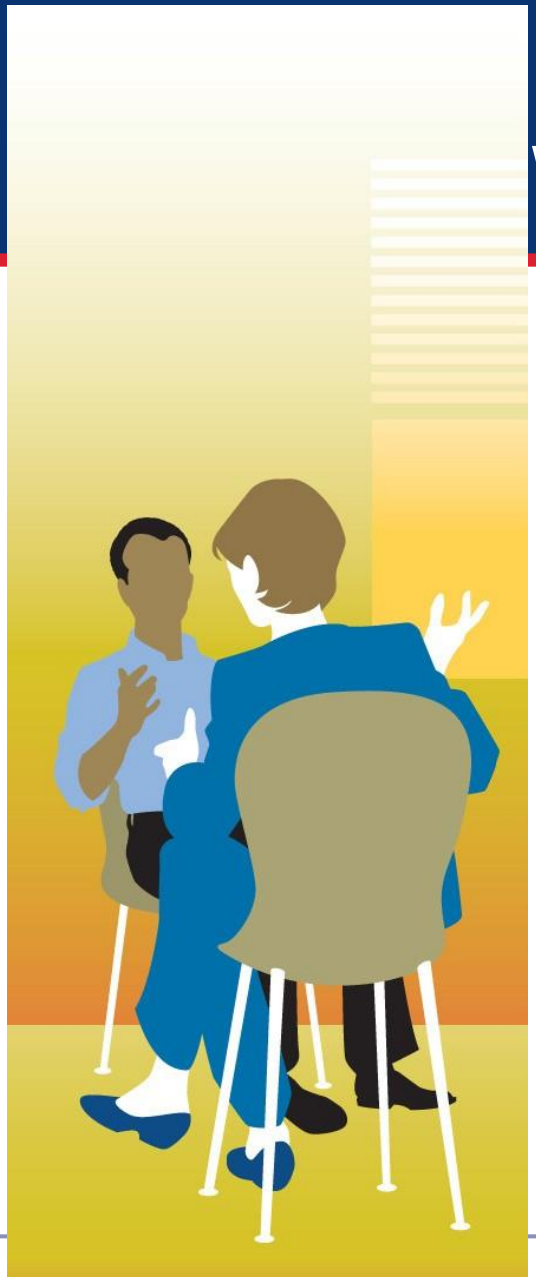
- **Partnership PPO, Standard PPO and Limited PPO**
  - Offer same services and treatments
  - Pay less in copays and coinsurance with the Partnership PPO versus the Standard PPO
  - Pay deductible first before coinsurance applies
  - Separate out-of-pocket maximums for medical and pharmacy
  - Pay for prescriptions with copays
  - When out-of-pocket maximum is reached the plan pays 100% for in-network services

Standard and Limited PPOs

- The Standard and Limited PPOs offer the same services as the Partnership PPO
- With the Standard PPO, you will pay **more** for monthly premiums, annual deductibles, copays, medical care co-insurance and out-of-pocket maximums
- With the Limited PPO, you will pay **less** for monthly premiums but have higher out-of-pocket costs
- Members enrolled in the Standard and Limited PPOs are not required to fulfill the Partnership Promise – but do have access to the ParTNers for Health Wellness Program and other tools, information and resources

ORS also offers
Supplemental Gap Insurance
provided by
Beazley Insurance as a
benefit

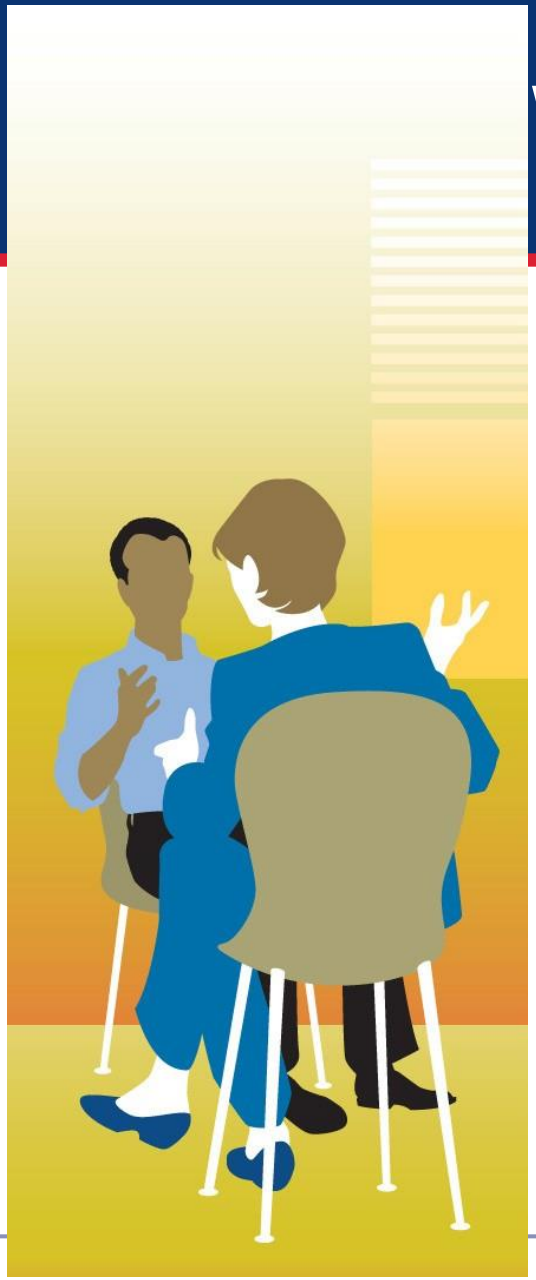
What is Gap Insurance?



- Medicare Gap supplement plans are a good example of Gap Insurance plans
- Medicare doesn't pay for everything, so people buy a Medicare Gap plan that helps pay their out-of-pocket costs
- Like a Medicare Gap plan the Beazley Gap plan is designed to help pay out of pocket costs

PARTNERS FOR HEALTH

What is Gap Insurance?



- Limited PPO
  - Employees who pick Limited PPO plan will be eligible for our Beazley Gap Plan
  - The Gap plan will cover family members who are covered on the Limited PPO
- Partnership/Standard PPO's
  - If you pick the Partnership or Standard PPO plans you have the option of purchasing a Gap plan on a voluntary basis
  - This option is 100% paid by the employee
- There is not a Gap plan available for the CDHP

PARTNERS FOR HEALTH

Limited PPO Gap Insurance

If you pick the Limited PPO plan the district will pay toward the cost of our Beazley Supplemental Gap plan

Gap Coverage Type	District Pays	You Pay
Employee (EE)	100%	0%
EE + Child(ren)	100%	0%
EE + Spouse	100%	0%
EE + Spouse + Child(ren)	100%	0%

PARTNERS FOR HEALTH

Partnership/Standard PPO Gap Insurance

If you pick the Partnership or Standard PPO plan the district will pay toward the cost of our Beazley Supplemental Gap plan

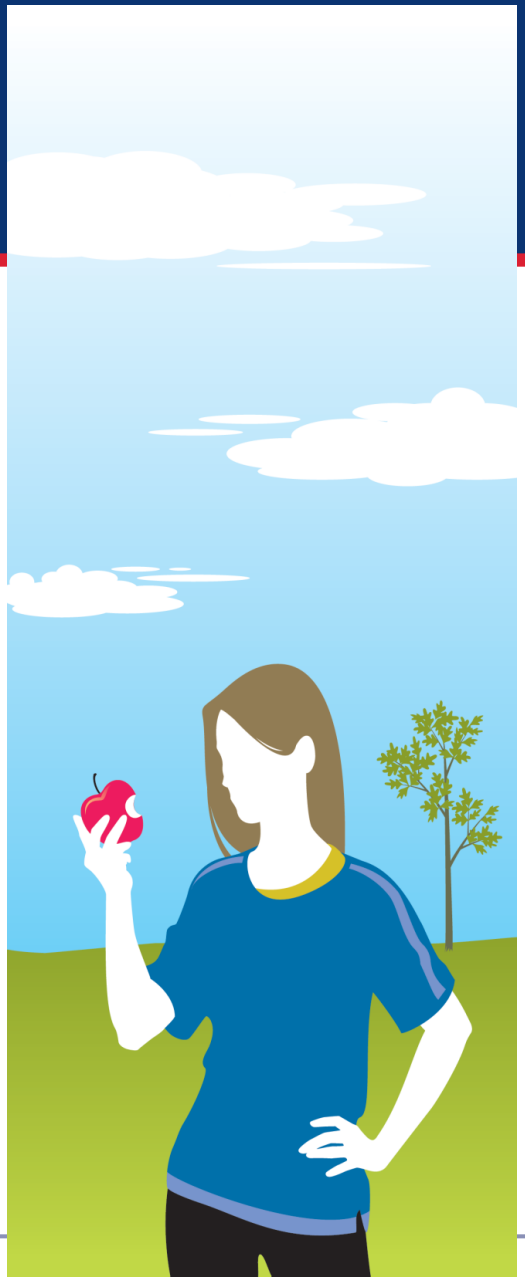
Gap Coverage Type	District Pays	You Pay
Employee (EE)	$0	$38.50
EE + Child(ren)	$0	$63.00
EE + Spouse	$0	$83.00
EE + Spouse + Child(ren)	$0	$114.00

PARTNERS FOR HEALTH

Gap Plan Highlights

- The Beazley Gap plans are guaranteed issue with no health questions asked!
- There are no pre-existing conditions limitations other than what the state health plans requires (if any)
- The Gap plan pays qualified claims for both In and Out of Network providers
- The Gap plan reimburses qualified out of pocket expenses beginning first dollar!
- For example, you owe $500 in deductible expense the Gap plan will pay the $500
- Claims must be qualified expenses

PARTNERS FOR HEALTH



When do I Use the Gap Insurance?

- The Gap Plan will reimburse you for eligible expenses to reduce two key areas:
  1. Deductibles
  2. Co-insurance costs
- Gap insurance is typically used to reimburse out-of-pocket costs associated with:
  - Hospitalizations
  - Certain “Out-Patient” procedures
  - And, major medical tests like MRI’s

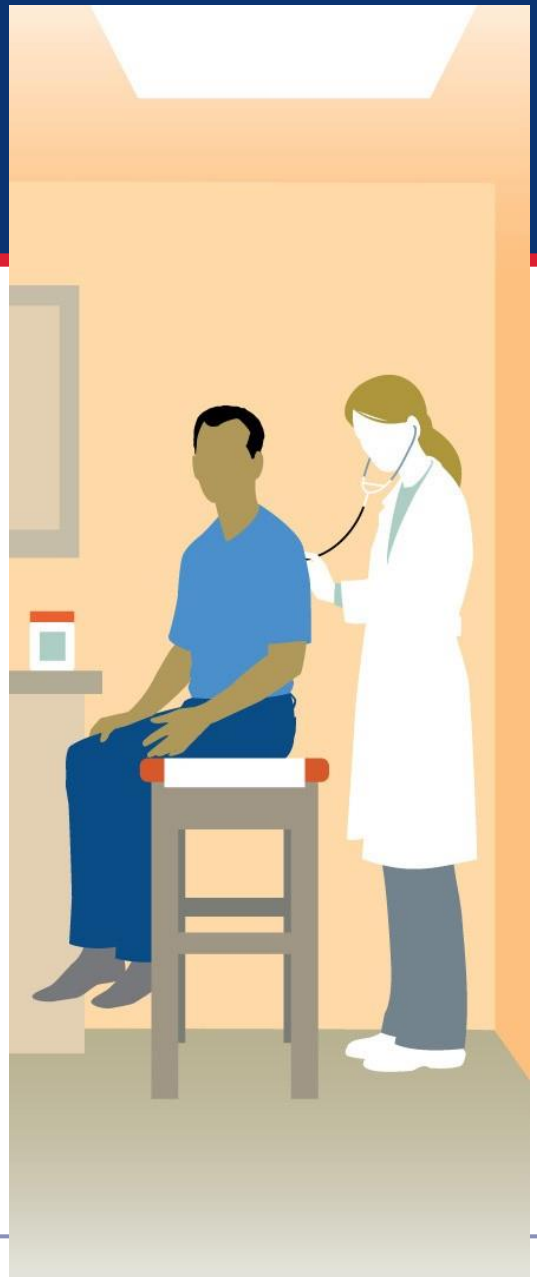
PARTNERS FOR HEALTH

Annual Maximum Beazley Gap Benefits for Limited PPO

Type Coverage	In Patient Annual Maximum	Out Patient Annual Maximum
Employee only	$6,000	$4,000
EE + Child(ren)	$6,000 per person $12,000 max	$4,000 per person $8,000 max
EE + Spouse	$6,000 per person $12,000 max	$4,000 per person $8,000 max
EE + Sp + Child(ren)	$6,000 per person $12,000 max	$4,000 per person $8,000 max

Annual Maximum Beazley Gap Benefits Partnership or Standard PPO's

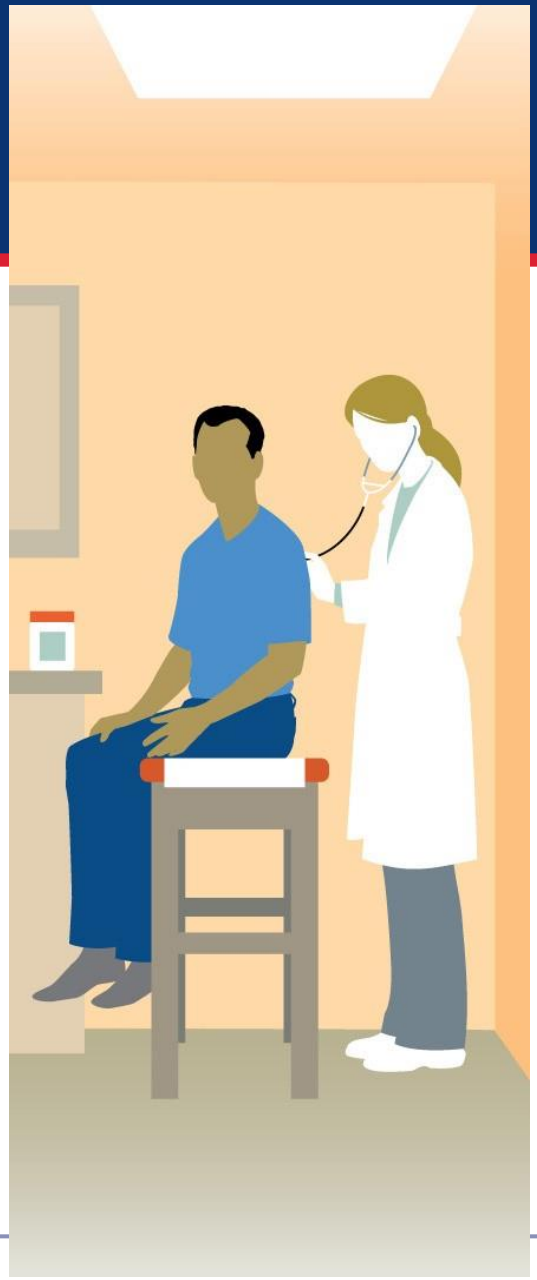
Type Coverage	In Patient Annual Maximum	Out Patient Annual Maximum
Employee only	$2,500	$1,000
EE + Child(ren)	$2,500 per person $5,000 max	$1,000 per person $2,000 max
EE + Spouse	$2,500 per person $5,000 max	$1,000 per person $2,000 max
EE + Sp + Child(ren)	$2,500 per person $5,000 max	$1,000 per person $2,000 max



Gap Inpatient Benefits

- Covered inpatient services included are:
  - Hospital room and board charges
  - Hospital ancillary charges
  - Surgery - surgeons fees, etc.
  - Chemotherapy, Radiation, Dialysis
  - Radiological Imaging (X-ray, CRT, MRI)
- See your Beazley policy for more details

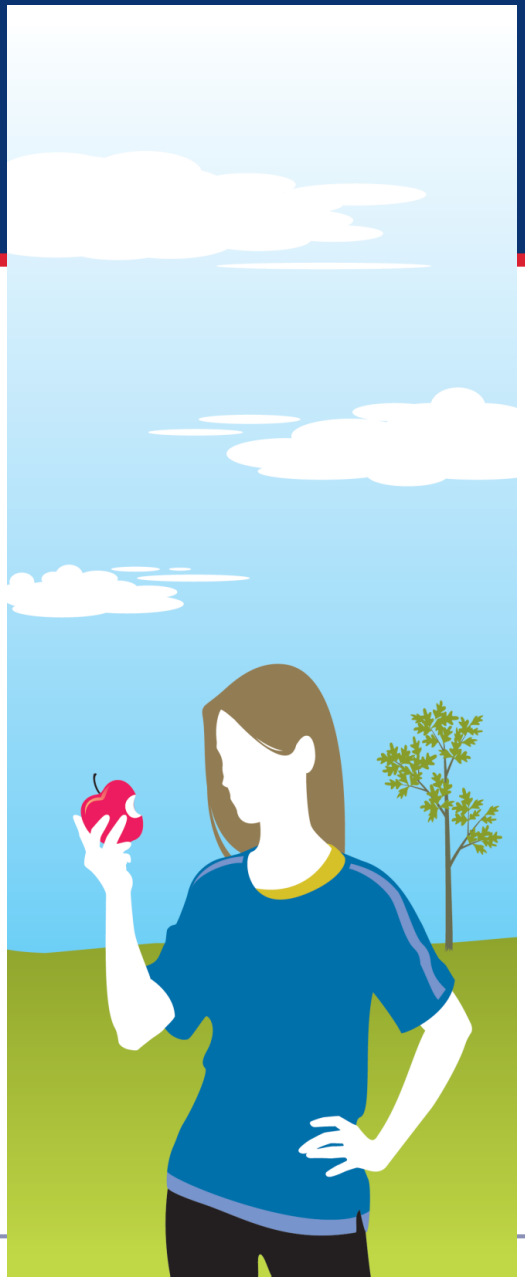
PARTNERS FOR HEALTH



Gap Out Patient Benefits

- Covered outpatient services included are:
  - Treatment in a Hospital Emergency Room, but not admitted to inpatient
  - Surgery in a Hospital Outpatient Facility or Freestanding Surgery Center
  - Radiological diagnostic testing in a Hospital Outpatient or MRI facility
  - Outpatient Radiation and Chemotherapy
- See your Beazley policy for more details

PARTNERS FOR HEALTH

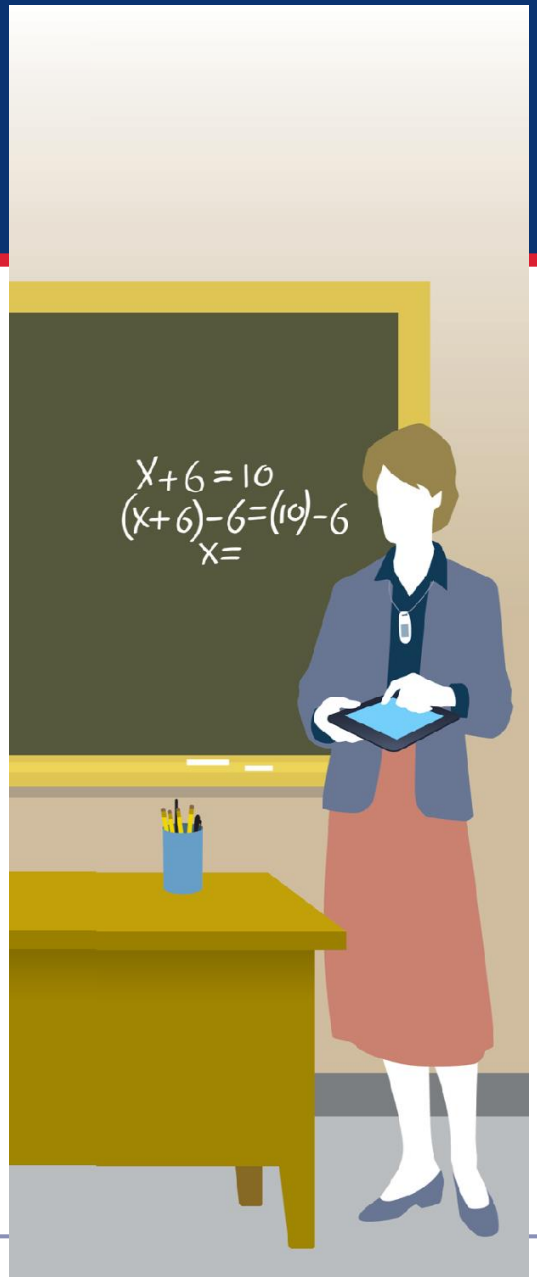


When Does Gap Not Pay?

- These are some services that are not covered by Gap and are not reimbursed:
  - Doctor office visits, urgent care centers, preventative exams, chiropractic visits
  - Prescription drugs
  - Ambulance
  - Durable medical equipment (DME)
  - Out Patient kidney dialysis, or therapies like speech, occupational, rehab
  - Dental and Vision, unless injury or congenital anomaly of newborn
- See your Beazley policy for more details

PARTNERS FOR HEALTH

Exclusions and Limitations



- Like all insurance plans the Beazley Gap plans have exclusions and limitations
- Examples of exclusions would be:
  - Out of pocket expenses incurred as a result of the insured committing a crime, or as a result of being legally intoxicated
  - Dental and vision services other than for accidents or birth defects
  - Injuries as a result of hazardous activities like hang gliding, etc.
  - Drug or alcohol treatment is not covered
  - Sleep Studies

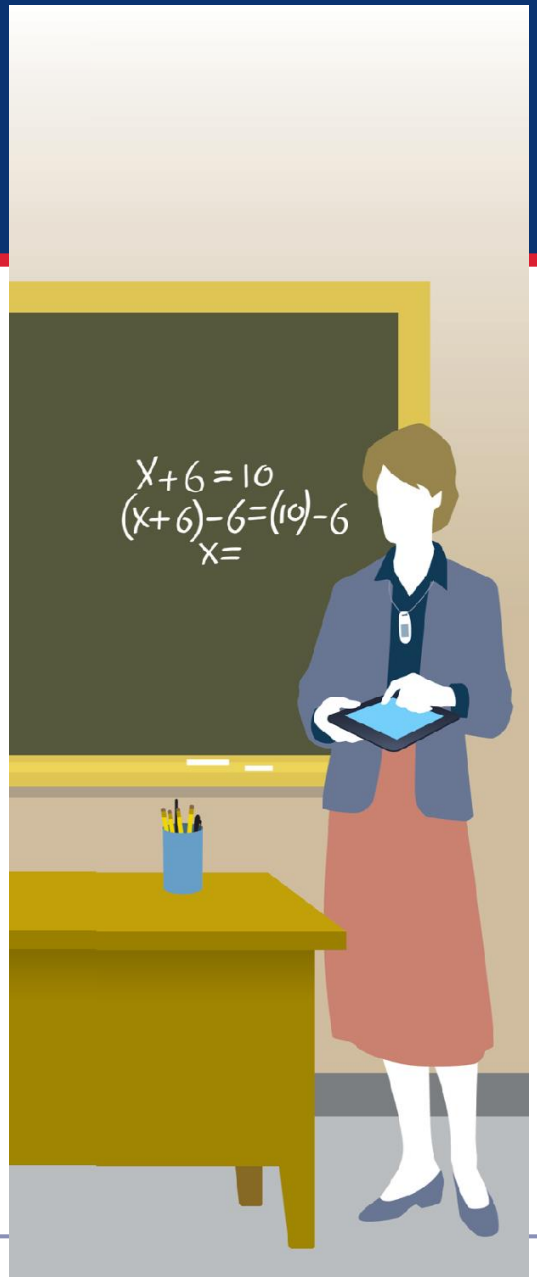
PARTNERS FOR HEALTH

Let's Review…

Type of Service	Limited, Partnership, & Standard PPO Benefits	Gap Benefits
In-Patient Hospital Care	Subject to Ded / Coinsur	Gap Pays
Surgery In Hospital	Subject to Ded / Coinsur	Gap Pays
Out-Patient Surgery in Hospital or Clinic	Subject to Ded / Coinsur	Gap Pays
Diagnostic Tests in Hospital & Out-patient Center	Subject to Ded / Coinsur	Gap Pays
In and / or Out-Patient Radiation & Chemotherapy	Subject to Ded / Coinsur	Gap Pays
In and/ or Out-Patient Drug & Alcohol Treatment	Subject to Ded / Coinsur	Not Reimbursed
Ambulance Services	Subject to Ded / Coinsur	Not Reimbursed
Doctors Office, Specialist, & Urgent Care Center	Subject to Copay	Not Reimbursed
Prescriptions	Subject to Copay	Not Reimbursed
Out-Patient Physical, Speech, Rehab Therapy	Subject to Copay or Ded / Coinsur	Not Reimbursed
Durable Medical Equipment (DME)	Subject to Ded / Coinsur	Not Reimbursed
Out-Patient Kidney Dialysis	Subject to Ded / Coinsur	Not Reimbursed

*** Review the state health plan and Gap plan benefit summaries for complete details, exclusions, and limitations. The above information is a brief summary and is for illustrative purposes only.**

Exclusions and Limitations

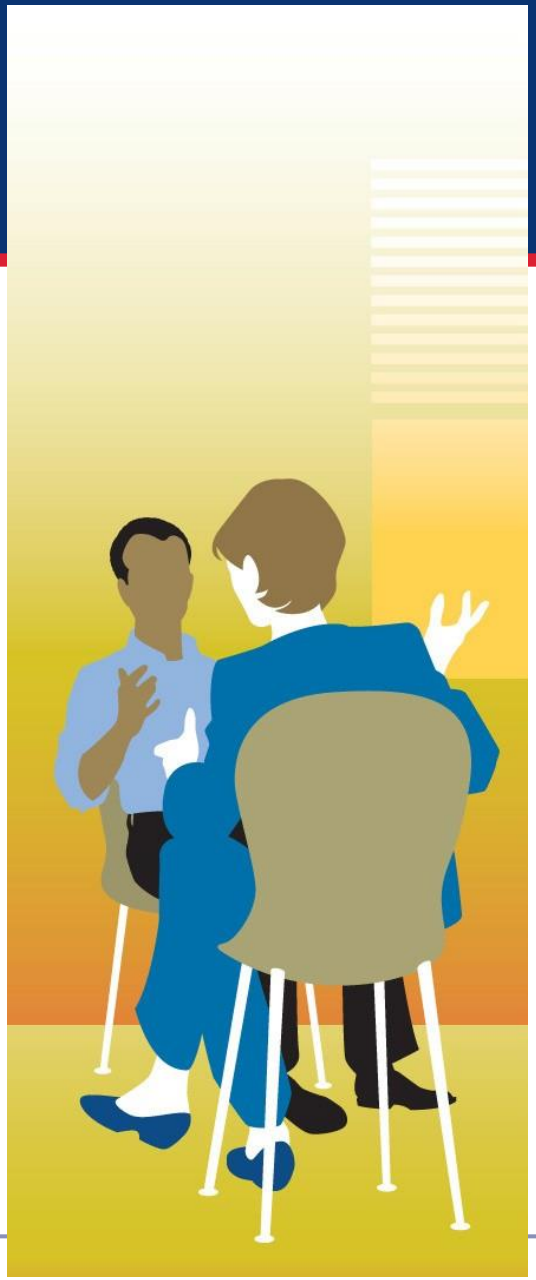


- The Partnership, Standard, Limited, and CDHP plans also have exclusions and limitations
- Review the benefit summaries to learn more about what's covered and non-covered, exclusions, and limitations

PARTNERS FOR HEALTH

How Does the Limited PPO and Gap Plan Work Together?

How Gap Plans Save You Money



- Employees who pick the Limited PPO + Gap plan can save money:
  - Per paycheck with lower premiums
  - Can have significantly lower Out of Pocket (OOP) costs because the Gap plan can pay all or most of OOP's
- The combined savings of lower OOP's and lower premiums can be significant

PARTNERS FOR HEALTH

2016 Monthly Employee Cost

	Limited PPO + Gap Plan	Partnership PPO	Standard PPO	CDHP
Employee (EE)	$51.91	$81.11	$84.86	$48.16
EE + Child(ren)	$171.30	$267.65	$275.15	$158.93
EE + Spouse	$202.44	$316.32	$331.32	$187.82
EE + Sp. + Child(ren)	$269.93	$421.76	$436.76	$250.43

Monthly and Annual Savings Example

BCBST	2015 Partnership PPO Cost	2016 Limited + Gap Cost	2016 Limited + Gap Savings	2016 Limited + Gap Annual Savings
Employee (EE)	$81.11	$51.91	$29.20	$350.40
EE + Child(ren)	$267.65	$171.30	$96.35	$1,156.20
EE + Spouse	$316.32	$202.44	$113.88	$1,366.56
EE + Sp. + Child(ren)	$421.76	$269.93	$151.83	$1,821.96

Health Benefits

HealthSavings CDHP

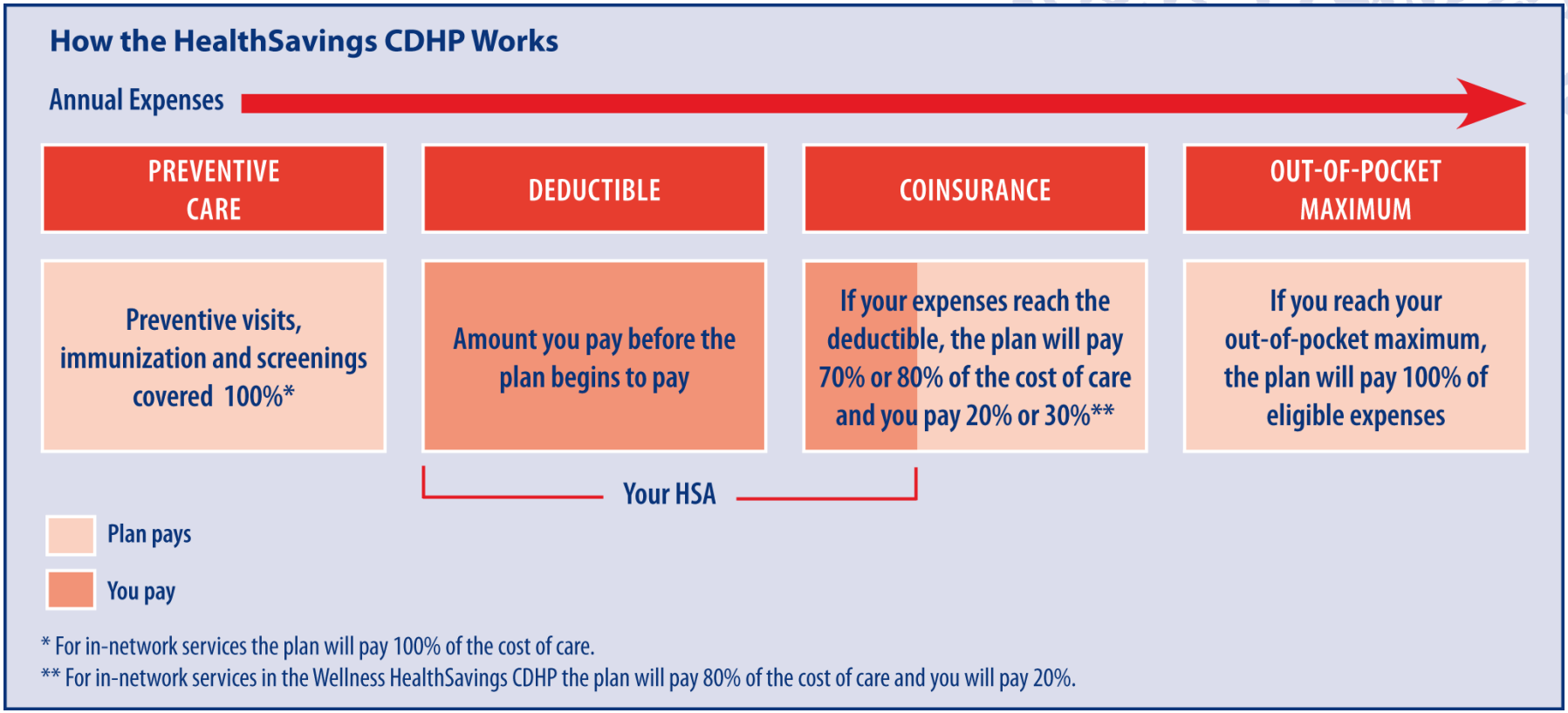
- **HealthSavings CDHP** – does not include the Partnership Promise. Employees may fund the HSA

Health Benefits

With the HealthSavings CDHP option you have:

- Comprehensive health insurance coverage
- Lower monthly premiums but a higher deductible
  - A tax-free HSA – which you own
  - To meet your deductible before the plan starts paying for covered expenses
  - No separate deductible or out-of-pocket maximum for pharmacy
  - Coinsurance after you meet your deductible
  - Lower total out-of-pocket maximum compared to PPOs

Health Benefits



Health Benefits

Difference Between PPOs and HealthSavings CDHP:

IN-NETWORK COMPARISON	PARTNERSHIP PPO	STANDARD PPO	LIMITED PPO	HEALTHSAVINGS CDHP
DEDUCTIBLE	$450 individual $1,150 family	$800 individual $2,050 family	$1,200 individual $2,600 family $100 per member for pharmacy	$1,500 individual $3,000 family
MEDICAL OUT-OF-POCKET MAX	$2,300 individual 4,600 family	$2,600 individual $5,200 family	$6,600 individual $13,200 family	$3,800 individual $7,600 family
PHARMACY OUT-OF-POCKET MAX	$2,500 individual $5,000 family	$3,000 individual $6,000 family	included with medical	included with medical
HSA CONTRIBUTIONS	N/A	N/A	N/A	member and employer option

Health Benefits

CDHP Enrollment Restrictions

- **You cannot be enrolled in another plan, including a PPO, spouse's plan or any government plan (Medicare, Medicaid, TRICARE).**
- **Eligible for VA medical benefits but you did not receive benefits during the preceding three months, you can enroll in and make contributions to your HSA.**
  - If you receive VA benefits in the future, then you are NOT entitled to contribute to your account for another three months.
- **You can't be claimed as a dependent by someone else.**
- **For other restrictions go to IRS.gov.**

Health Benefits

What are the benefits of a HSA?

- The money in your HSA **rolls over each year**
- Use money in your account to pay deductible and qualified expenses including some **not covered by the CDHP (i.e., vision and dental, hearing aids, acupuncture, etc.)**
- The money is yours! Take it with you if you leave, retire or change plans
- The HSA offers tax advantages on money in your account:
  1. Both employer and employee contributions are tax free.
  2. Withdrawals for qualified medical expenses are tax free.
  3. Interest earned is tax free
- HSA is a retirement savings account option.

Health Benefits

How does the HSA work?

- You can contribute pre-tax money into your account and then use the funds for qualified medical expenses or save for future expenses.
- You cannot fund or use your HSA if you or your spouse have funds in a medical FSA the same year.

Allowable maximum contribution:

You can contribute to your HSA up to the annual IRS allowable maximums:

- In 2016, IRS guidelines allow total tax-free contributions up to $3,350 for individuals and $6,750 for families annually.
- At age 55 and older, you can make an additional $1,000/year contribution ($4,350 for individuals or $ 7,750 for families).
- If your agency contributes money to your account, it counts toward the maximum.

Health Benefits

PayFlex – Health Savings Account

- **If you choose to enroll in the HealthSavings CDHP, a health savings account is automatically opened for you.**
  - PayFlex will send you a letter asking for additional information
  - Then, you will receive a debit card from PayFlex.
  - Register and access your PayFlex HSA online at www.stateoftn.payflexdirect.com

Health Benefits

PayFlex – Health Savings Account

- **Use the PayFlex Card**
  - Convenient way to pay for eligible expenses
  - Expenses paid automatically
  - Keep your receipts for audit purposes
- **Pay yourself back**
  - Pay for eligible expenses with cash, check or personal credit card
  - Withdraw funds for your HSA to pay yourself back
  - Or have payment deposited directly to checking or savings account
- **Pay your provider**
  - Use PayFlex's online feature to pay provider
- **Contribute post-tax dollars** from your bank account online

Health Benefits

PayFlex – Health Savings Account

- **PayFlex free mobile app**
  - Manage and access your account 24/7
  - Available for most mobile digital devices
  - Upload photos of receipts for tax purposes

- **Earn interest and invest your money**
  - Earn tax free interest on your HSA
  - When account reaches $1,000 – can invest the funds over this amount

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

2016 Partnership Promise

What is the Partnership Promise?

- Employees who enroll in the Partnership PPO pay lower premiums and costs by agreeing to complete simple steps for better health. There steps are called the Partnership Promise.

- The Partnership Promise is an annual commitment, but you are not required to sign a new promise each year.

- You and all eligible family members must enroll in the same healthcare option. Your dependent spouse must also agree to the Partnership Promise.

- Children are not required to complete the steps.

- Healthways administers the Partnership Promise.

- Requirements may change each year.

Goal of the Partnership Promise

Offers tools and health coaches to help you get and stay healthy:

- Lose weight
- Eat healthy
- Increase exercise
- Quit tobacco.

Members who participate in the Partnership Promise are also rewarded with lower rates and lower costs for service.

Partnership Promise – 2016 New Members

2016 new members and covered spouses must:

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

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

2 Choosing an Insurance Carrier

- Once you select your plan, select either:
  - BlueCross BlueShield of Tennessee Network S
  - Cigna LocalPlus Network

- Check the networks carefully to make sure your preferred doctors and hospitals are in the network you choose

3 Choosing Your Premium Level

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

Remember: Partnership PPO premiums are lower than the premiums for the Standard PPO.

Premiums:

Total of Monthly Premiums*

Premium Level	Partnership PPO	Standard PPO	Limited PPO	HealthSavings CDHP
Employee Only	**$81.11**	**$84.86**	**$51.91**	**$48.16**
Employee + Child(ren)	**$267.65**	**$275.15**	**$171.30**	**$158.93**
Employee + Spouse	**$316.32**	**$331.32**	**$202.44**	**$187.82**
Employee + Spouse + Child(ren)	**$421.76**	**$436.76**	**$269.93**	**$250.43**

In-Network Deductibles and Out-of-Pocket Maximums

IN-NETWORK COMPARISON	PARTNERSHIP PPO	STANDARD PPO	LIMITED PPO	HEALTHSAVINGS CDHP
DEDUCTIBLE	$450 individual $1,150 family	$800 individual $2,050 family	$1,200 individual $2,600 family $100 per member for pharmacy	$1,500 individual $3,000 family
MEDICAL OUT-OF-POCKET MAX	$2,300 individual 4,600 family	$2,600 individual $5,200 family	$6,600 individual $13,200 family	$3,800 individual $7,600 family
PHARMACY OUT-OF-POCKET MAX	$2,500 individual $5,000 family	$3,000 individual $6,000 family	included with medical	included with medical
HSA CONTRIBUTIONS	N/A	N/A	N/A	member and employer option

***See eligibility guide for more detail on out-of-network costs.**

Free In-Network Preventive Care

If provided in-network, free preventive care includes:

- Flu and pneumococcal vaccinations
- Annual physical exam
- Annual well-woman visit
- Osteoporosis screening for women
- Screenings for colon, breast or cervical cancer

Regular preventive care is one of the most important things you can do to stay healthy.

Take Note!

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

Example – Partnership PPO

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

	Deductible	Out-of-Pocket Max
In-Network	$450	$2,300

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

	Deductible	Out-of-Pocket Max
Out-of-Network	$800	$3,500

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

Pharmacy Benefits

CVS/Caremark is the pharmacy benefits manager for all plan members

- Covered drug list is the same for both the PPOs and CDHP
- More than 67,000 independent and chain pharmacies throughout the U.S.
- 90-day supply of approved maintenance drugs is available at discounted rates
  - About 916 Tennessee pharmacies fill 90-day prescriptions in the Retail 90 Network

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

Prescription Drug Copays

	Partnership PPO		Standard PPO		Limited PPO		HealthSavings CDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
30-Day Supply (only from pharmacies in the 30-day network)	$5 copay generic $35 copay preferred brand $85 copay non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay for generic $45 copay for preferred brand $95 copay for non-preferred brand	Copay, plus any amount exceeding MAC	$10 copay generic $55 copay preferred brand $105 copay non-preferred	Copay plus amount exceeding MAC	30% coinsurance	50% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic $65 copay preferred brand $165 copay non-preferred brand	N/A – no network	$20 copay for generic $85 copay for preferred brand $185 copay for non-preferred brand	N/A – no network	$20 copay generic $105 copay preferred brand $205 copay non-preferred	N/A – no network	30% coinsurance	N/A – no network
90-Day Supply (certain maintenance medications from 90-day pharmacy or mail order)	$5 copay generic $30 copay preferred brand $160 copay non-preferred brand	N/A – no network	$10 copay generic $40 copay preferred brand $180 copay non-preferred	N/A – no network	$10 copay generic $50 copay preferred $200 copay non-preferred	N/A – no network	20% coinsurance without first having to meet deductible	N/A – no network

Employee Assistance Program (EAP) – Free

Included for every employee enrolled in medical benefits. EAP can help with:

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

- **Services are free, confidential and available to members 24/7**
- You and your eligible dependents - get up to five, free counseling sessions per problem episode, per year
  - Toll Free 24/7 at **1.855.HERE4TN** (1.855.437.3486)
  - Or at **www.Here4TN.com**

Behavioral Health and Substance Abuse Treatment

All members of state health plans have behavioral health and substance abuse treatment benefits through Magellan Health

- Call 1.855.HERE.4.TN (1.855.437.3486) or www.HERE4TN.com
- Services include:
  - Outpatient assessment and treatment
  - Inpatient assessment and treatment
  - Alternative care (partial hospitalization, residential or intensive outpatient treatment)
  - Treatment follow-up and aftercare
- Prior authorization is required for some services

ParTNers for Health Wellness Program

- The ParTNers for Health Wellness Program is FREE to all health insurance plan members, eligible spouses and dependents

- Wellness Resources:
  - Coaching
  - Well-Being Assessment (WBA)
  - Nurse Advice Line
  - Wellness Challenges
  - Weight Watchers at Work discounts and Fitness Center discounts
  - Weekly health e-tips

Visit wellness webpage on the ParTNers for Health website to access

Working for a Healthier Tennessee

- Expands wellness resources to all employees
- Encourages state employees to lead healthier lives by focusing on
  1. Physical Activity
  2. Healthy Eating
  3. Tobacco Cessation

Enrolling in Benefits

- **Employees must enroll using the Enrollment Change Application provided by Human Resources.**
- Enrollment must be completed within **31 days** of your hire date
- Any required dependent verification must also be submitted during this timeframe
  - Example dependent verification documents include:
    - Federal Income Tax Return for a spouse
    - Birth certificate for a child

When Will Coverage Begin?

- Health coverage begin on the first day of the month
- If you are hired on Sept. 15, coverage would begin on Oct. 1 or Nov. 1*
- Ask Human Resources if you have questions about when your coverage begins

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

When Are Premiums Paid?

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

When Will My ID Cards Arrive?

- Within three weeks of the date your application is processed

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

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

Your Privacy

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

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

Retiree Insurance

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

Insurance Carrier Websites

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

➢ **BlueCross BlueShield**

www.bcbst.com/members/tn_state/

➢ **Cigna**

www.cigna.com/site/stateoftn

➢ **CVS/caremark**

www.info.caremark.com/stateoftn

Who to Contact

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

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