



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

Importance of Your Decisions

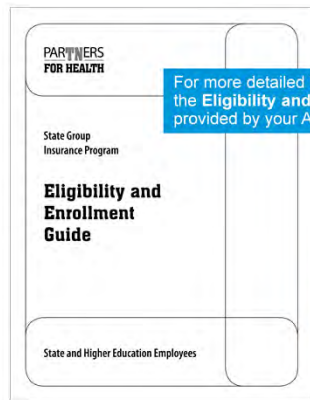
- The decisions you make **now** as a new employee will have lasting effects on your benefits
- **Please note: Some decisions can only be made during the new hire period**
- Be aware of all the options available to you and make informed decisions
- Submit questions to your **Agency Benefits Coordinator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

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

Resource Materials



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

The image shows an 'EMPLOYEE INSURANCE CHECKLIST' form from the 'STATE OF TENNESSEE GROUP INSURANCE PROGRAM'. It includes sections for 'EMPLOYEE INFORMATION', 'COBRA/RETIREMENT', 'HEALTH INSURANCE', 'LIFE INSURANCE', and 'DISABILITY INSURANCE'. There are checkboxes for various insurance options and a section for 'EMPLOYEE SIGNATURE' and 'ABC SIGNATURE'.

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

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

Resource Materials

The screenshot shows the website tn.gov/finance/fa-benefits. The page header includes the Tennessee Department of Finance & Administration logo and a search bar. The main content area is titled "Insurance & Benefits" and contains a sidebar with a list of links. A blue callout box on the left contains the text: "The Summary of Benefits and Coverage (SBC) describes your health coverage options. You can print a copy on the Benefits Administration website, or ask your ABC for a copy." A blue arrow points from this box to the "Summary of Benefits" link in the sidebar. The sidebar links include: Partners for health website, Insurance Products, Other Benefits, Publications & forms, Quicklinks, Annual Enrollment, For New Employees, For Retirement, Customer Service, Premiums, Report Fraud, Summary of Benefits (circled), and Agency Benefits Coordinators. The main content area also has a "Summary of Benefits" section with a brief description of the program and a "Print SBC" button. At the bottom of the page, the website address www.partnersforhealthtn.gov and the phone number 800-253-9981 are displayed, along with the "PARTNERS FOR HEALTH" logo.

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

Need More Help?

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

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

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

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

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4

There are additional resources to help you:

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

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

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

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

About the Plan

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

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

Who is Eligible for Coverage?

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

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

Adding Coverage

Three times you may add health coverage:

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

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

Annual Enrollment

- During Annual Enrollment you may:
 - Enroll in or cancel **health insurance** for yourself or your eligible dependents
 - Change your health insurance option
 - Choose your health insurance **network (doctors and facilities)**
 - Enroll in, cancel or transfer between **dental** and **vision** insurance
 - Enroll in, cancel or transfer between **Short Term and Long Term Disability Insurance** options (**state employees**)
 - Enroll in, cancel or transfer between **Short Term Disability Insurance** options (**higher education employees**)
 - Enroll in **flexible spending accounts**
 - Enroll in or cancel **voluntary accidental death & dismemberment**
 - Apply for, cancel, increase or decrease **voluntary term life insurance** amounts (if eligible)
- **Changes are effective January 1 of the following year**

Annual Enrollment occurs during the fall

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

- You can enroll in and change your health insurance, network of doctors and facilities, and make changes to your voluntary benefits, which include disability, dental, vision, voluntary AD&D coverage and voluntary term life insurance. You can also enroll in flexible spending accounts, which are called FSAs.
- The Annual Enrollment period occurs during the fall and changes are effective the January 1 of the following year.

Choosing Your Premium Level

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

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

Canceling Coverage

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

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

Health Insurance

You get the choice of a health plan and a network

Three health options — you choose one.

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

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

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11

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

There are three health options — you choose one.

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

Here are your options in more detail (PPO stands for Preferred Provider Organization):

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

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

Health Insurance

CDHP/HSA benefits

- The state contributes to your HSA (**\$250 employee only/\$500 family tiers***), and you can contribute to this account with pre-tax dollars from each paycheck.
- Instead of paying a high premium, you could take the money you save in premiums for this plan versus a PPO and put it in your HSA. You can use your HSA money to pay for your deductible and other healthcare costs or save it.
- And the account rolls over — you keep your money in your HSA at the end of the year!

***If your insurance coverage starts on or after Sept. 2, 2018, through the end of 2018, the state will not contribute funds to your HSA in 2018.**

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12

CDHP/HSA benefits

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- And the account rolls over — you keep your money in your HSA at the end of the year!

***If your insurance coverage starts on or after Sept. 2, 2018, through the end of 2018, the state will not contribute funds to your HSA in 2018. COBRA participants and retirees are not eligible for state HSA funds.**

Health Insurance

How does the CDHP/HSA work?

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

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

Note: For the CDHP plan, the deductible and out-of-pocket maximum can be met by one or more family members. The total deductible must be met before coinsurance applies for any family member unless otherwise noted in the Eligibility and Enrollment Guide.

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13

How does the CDHP/HSA work?

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

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Please note: For the CDHP plan, the deductible and out-of-pocket maximum can be met by one or more family members. The total deductible must be met before coinsurance applies for any family member unless otherwise noted in the Eligibility and Enrollment Guide.

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

Health Insurance

How does the CDHP/HSA work?

You get a HSA to save! The state will put money into your account, and you can contribute too. For example, you can put the difference in premiums between the CDHP and PPO (premium savings) into your account each month.

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

- When you turn 65, you can use money in your HSA for non-medical expenses (before age 65 non-medical expenses are both taxed and subject to a 20% penalty. After age 65, non-medical expenses are taxed, but the 20% penalty does not apply).
- **2018 maximum HSA contribution amounts (includes employer contributions):**
 - \$3,450 for employee only (includes \$250 state HSA contribution)
 - \$6,900 for all other tiers (includes \$500 state HSA contribution)
 - Members 55 or older can save an extra \$1,000 in a catch up contribution during the plan year

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14

How does the CDHP/HSA work?

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

- When you turn 65, you can use money in your HSA for non-medical expenses (before age 65 non-medical expenses are both taxed and subject to a 20% penalty. After age 65, non-medical expenses are taxed, but the 20% penalty does not apply).
- There is a limit on how much money you can put in your HSA each year (includes employer contributions):
- 2018 maximum HSA contribution amounts:
 - \$3,450 for employee only (includes the \$250 state HSA contribution)
 - \$6,900 for all other tiers (includes the \$500 state HSA contribution)
 - Members 55 or older can save an extra \$1,000 in a catch up contribution during the plan year
- Higher Ed employees: If you want to contribute to your HSA by payroll deduction, talk to your ABC.

Health Insurance

How does the CDHP/HSA work?

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

How does the CDHP/HSA work?

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

Health Insurance

CDHP restrictions:

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

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

However, members may be eligible if the following applies:

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

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

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16

CDHP restrictions:

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

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

However, members may be eligible if the following applies:

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

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

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

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

Network Options

You choose one of three networks of doctors and facilities:

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

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

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17

You choose one of three networks of doctors and facilities.

- **BlueCross BlueShield Network S:** There is no additional cost for this network. In 2018 in the Memphis market, Methodist facilities will be out-of-network, and Baptist facilities will be in-network. All Methodist provider groups will be in-network.
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- **Cigna OAP:** This is a large network, with a choice of more doctors and facilities, but you will pay more. In 2018 in the Memphis market, Baptist facilities will be out-of-network, but Methodist facilities will be in-network.
 - Monthly surcharges will apply:
 - \$40 more for employee only and employee+child(ren) coverage
 - \$80 more for employee+spouse and employee+spouse+child(ren) coverage
- Each network has providers (doctors and facilities) across Tennessee and the country. Providers can move in and out of networks. It's important to check the networks carefully for the doctor(s) or hospital you want when making your choice.
 - Note: If you use providers outside of the network, you will be charged out-of-network rates.
- Your network vendor's (BlueCross BlueShield or Cigna) website may have tools and resources to help you find out how much a procedure or test could cost.

Pharmacy benefits

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

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

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

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

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18

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

On the screen are the in-network pharmacy costs. This same information is found in your Eligibility and Enrollment Guide. Generally, you will pay less out of your pocket in copays with the Premier PPO.

If you use out-of-network pharmacy benefits, they are different and will cost you more.

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

Pharmacy benefits

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

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

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

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

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

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

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19

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

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

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

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

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

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

Pharmacy benefits

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

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

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

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**PARTNERS
FOR HEALTH**

20

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

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

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

Pharmacy benefits

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

The following quit aids are FREE under the pharmacy benefit:

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

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

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**PARTNERS
FOR HEALTH**

21

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

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Telehealth

24/7 Care — When You Need It

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

When to use Telehealth

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

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

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PARTNERS
FOR HEALTH

22

24/7 Care — When You Need It

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

When to use Telehealth

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

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

Telehealth

Cost:

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

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

BlueCross BlueShield of Tennessee Members

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

Cigna Members

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

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**PARTNERS
FOR HEALTH**

23

Here are the costs for members:

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

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

Network vendor information is below:

BlueCross BlueShield of Tennessee Members

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

Cigna Members

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

Behavioral Health & Substance Use Services

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

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

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

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

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**PARTNERS
FOR HEALTH**

24

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

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

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

Employee Assistance Program (EAP) — HERE4TN.com

Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all benefits-eligible employees and eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

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

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

Take Charge at Work: Access to a telephonic program that helps you identify your triggers, and recognize and manage symptoms of stress and depression. Go to HERE4TN.com for more information.

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**PARTNERS
FOR HEALTH**

25

Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all benefits-eligible employees and eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

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

Wellness Voluntary Rewards Program

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

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**PARTNERS
FOR HEALTH**

26

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

Preventive Screenings

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

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

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

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FOR HEALTH

27

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

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

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

Premiums for 2018: State and Higher Education

Employee Share of Monthly Premiums

Premium Level	Premier PPO	Standard PPO	CDHP/HSA
Employee Only	\$150	\$102	\$66
Employee + Child(ren)	\$225	\$153	\$98
Employee + Spouse	\$314	\$215	\$138
Employee + Spouse + Child(ren)	\$389	\$266	\$170

- Premiums shown are for the employee share for **active employees**.
- A complete chart is available in the Eligibility Guide and on the ParTners for Health website
- Premiums are for the BCBS Network S or Cigna LocalPlus network
- Premiums do NOT include the cost for the larger Cigna Open Access Plus network – which would add \$40 to \$80 more EACH MONTH depending on your tier

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28

- Here are the health insurance premiums for **active state plan employees**.
 - A complete chart for all coverage tiers is available in the Eligibility and Enrollment Guide and at www.partnersforhealthtn.gov
 - Important to note – premiums do not include the cost for the Cigna Open Access Plus network which would add \$40 to \$80 more **per month** to your premium depending on your coverage tier.

2018 Deductibles and Out-of-Pocket Maximums

	Premier PPO	Standard PPO	CDHP/HSA
	In-Network	In-Network	In-Network
Deductibles			
Employee only	\$500	\$1,000	\$1,500
Employee + Child(ren)	\$750	\$1,500	\$3,000
Employee + Spouse	\$1,000	\$2,000	\$3,000
Employee + Spouse + Child(ren)	\$1,250	\$2,500	\$3,000
Out-of-Pocket Max (medical and pharmacy combined)			
Employee only	\$3,600	\$4,000	\$2,500
Employee + Child(ren)	\$5,400	\$6,000	\$5,000
Employee + Spouse	\$7,200	\$8,000	\$5,000
Employee + Spouse + Child(ren)	\$9,000	\$10,000	\$5,000

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29

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

Note: For the CDHP plan, the deductible and out-of-pocket maximum can be met by one or more family members. The total deductible must be met before coinsurance applies for any family member unless otherwise noted in the Eligibility and Enrollment Guide.

Take Note!

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

Example: Employee Only Coverage - Premier PPO

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

	Deductible	Out-of-Pocket Max
In-Network	\$500	\$3,600

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

	Deductible	Out-of-Pocket Max
Out-of-Network	\$1,250	\$9,000

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

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

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

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FOR HEALTH

- You will probably hear about an employee initiative called *Working for a Healthier Tennessee*.
- The *Working for a Healthier Tennessee* initiative was implemented under the leadership of Governor Bill Haslam and is supported by the ParTNers for Health Wellness Program and the ParTNers Employee Assistance Program.
- It expands wellness resources to employees regardless of whether or not they are enrolled in health coverage.
- Its goal is to encourage and enable employees to lead happier, healthier lives. Most departments have a Wellness Council to help employees improve in three key areas: physical activity, healthy eating and tobacco cessation.

Employee Sick Leave Bank State only

Employee Sick Leave Bank – State Only

- Administered by Tennessee Department of Human Resources
- Provides sick leave to qualifying members
- A member may receive a maximum of 90 days from the Bank
- Open enrollment is August 1 – October 31 each year
- Must be a full-time state employee for 12 consecutive months and have at least six days of sick leave by October 31 of your enrollment year
- Must contribute four sick leave days to enroll
- One day of sick leave thereafter assessed each Oct 1 to maintain membership
- New members are eligible to apply for grants of sick leave on Feb. 1 after enrollment

For more information or to enroll, go to the Department of Human Resources website.

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FOR HEALTH**

The Tennessee Department of Human Resources administers the Employee Sick Leave Bank (SLB).

- **Higher Ed employees:** You have access to your own sick leave program.
- The SLB provides sick leave to qualifying members who are medically certified as unable to perform the duties of their jobs.
- A member may receive a maximum of 90 days from the Bank as a result of a personal illness, injury, accident, disability, medical condition, or quarantine or a condition related to, resulting from, or recurring from a previously diagnosed condition for which the Bank granted sick leave.
- You must be a full-time State employee for 12 consecutive months and have at least six days of sick leave by October 31 of your enrollment year.
- Open enrollment is August 1 through October 31 each year.
- New members must contribute four sick leave days to enroll. The member must also be employed full time and in leave accruing status. Thereafter, one day of sick leave per year will be assessed each October 1 to maintain membership in the Bank.
- Existing members contribute one day annually.
- You are not required to re-enroll every year if you are already a member of the Bank. You maintain your membership in the Bank as long as you meet the annual assessment requirement.
- New members are eligible to apply for grants of sick leave on February 1 following enrollment.
- See the SLB Guidelines, eligibility requirements, FAQs and enroll online on the SLB website found at the Department of Human Resources website.

Hybrid Pension Plan State only

- New hires with the State will be enrolled in the Hybrid Pension Plan
- Employees originally hired prior to 7/1/14 transferring from the State, Higher Education or a Local Education Agency as a K-12 teacher will be grandfathered into the legacy plan
 - Employees transferring from local government will be treated as a new hire
- The Hybrid Pension Plan contains both a Defined Benefit and a Defined contribution component
 - Defined benefit component is administered by TCRS
 - Defined contribution component is administered by **Empower Retirement**
- Shared risk by Employer and Employee
- Employees are required to contribute to the plan

PARTNERS
FOR HEALTH

- The state offers a Hybrid Pension plan.
- New hires with the State will be enrolled in this plan.
 - Someone is also considered a new hire if he/she has ever lost membership in TCRS (i.e., the employee terminated or refunded contributions in the legacy plan or the employee terminated and refunded contributions in the former legacy plan or the employee terminated, was not vested, and was not employed for a period of seven years or more).
- The Hybrid Pension Plan contains both a Defined Benefit and a Defined contribution component.
 - Defined benefit component is administered by TCRS
 - Defined contribution component is administered by Empower Retirement
- The risk for this plan is shared by the Employer and the Employee.
- Employees are required to contribute to the plan.
- For more information about the defined benefit and the defined contribution including employee and State contribution percentages; employee rights regarding the account; auto-enrollment for defined contribution, go to the Treasury website.

Enrolling in Benefits

- You must enroll using Edison Employee Self Service (ESS) for health, dental and vision coverage and voluntary accidental death & dismemberment insurance
- 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 and a Marriage License for a spouse
 - Birth certificate for a child

To enroll in voluntary benefit products such as voluntary term life insurance, use the separate enrollment forms provided by your ABC.

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FOR HEALTH

- You must use Edison Employee Self Service (ESS) to enroll in your benefits.
- **Enrollment must be completed within 31 days of your hire date.** If you want to cover your spouse or children, you will also need to provide documentation during this time to verify their relationship to you.
 - Examples of dependent verification can include a marriage license and Federal Income Tax Return for a spouse or a birth certificate for a child. A complete list of required documentation for dependent verification can be found on the BA website (www.tn.gov/finance/fa-benefits) under the **Forms** tab in the **Health and Dental** box.
- If you choose to enroll in any of the voluntary products we've discussed in this presentation, please consult their individual enrollment forms for submission deadlines. All enrollment forms will be provided by your ABC.
- **Please note:** Voluntary term life enrollment is available through Minnesota Life's website or through a paper enrollment form.

Online Enrollment through ESS

To enroll in your health insurance and other benefit options:

- Log on to Edison
 - » www.edison.tn.gov
 - » Use username and temporary password provided by your Human Resource office
 - » Go to Self Service > Employee Work Center > My Benefits > Benefits Enrollment
 - » Click **SELECT**
 - » Follow the prompts
- If covering dependents, submit dependent verification by:
 - » Uploading electronic documentation
 - » Faxing documentation to Benefits Administration service center

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FOR HEALTH**

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

When Will Coverage Begin?

- Health, dental, vision, disability and basic term life/AD&D coverage will begin on the first day of the month after one full calendar month of employment from your hire date.
- If you are hired on Sept. 15, coverage would begin on Nov. 1
- Voluntary term life insurance begins after three full calendar months from employment/eligibility
- Ask your ABC if you have questions about when your coverage begins

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FOR HEALTH

- Once you enroll, your health, vision, dental, disability, basic term life insurance and AD&D coverage will begin on the first day of the month after one full calendar month of employment from your hire date.
- For example, if you are hired September 15th, your coverage will begin on November 1st. Your ABC can help if you have questions about when your coverage begins.

Voluntary term life insurance begins on the first of the month after three full calendar months from employment.

When Are Premiums Paid?

- Your ABC will tell you when your premiums will be deducted from your paycheck
- Enter your benefit selections in ESS or submit your enrollment forms to your ABC as soon as possible.
 - If you do not enter your benefit selections early, in some instances you could end up with a double deduction from your paycheck the first month of enrollment.

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FOR HEALTH

- Your ABC will tell you when your premiums will be deducted from your paycheck.
- We do recommend entering your benefit selections in ESS or submitting your enrollment forms to your ABC as soon as possible.
- If you do not enter your benefit selections early, in some instances, you could end up with a double deduction from your paycheck.
 - For example, double deductions will occur in the following scenario:
 - The employee's hire date is July 31 (the employee has until August 31 to enroll).
 - If the employee enters their enrollment in ESS after mid-August (i.e., after payroll "runs") the employee will have two months of premiums deducted.
 - In this instance, if the employee enters his or her elections NO LATER than the first week of August, they WILL NOT be double deducted.

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

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

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FOR HEALTH

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

Retiree Insurance

- Retiree health insurance coverage (pre-65 retirees) is not available to employees whose employment first began on or after July 1, 2015.
- The Tennessee Plan (Supplemental Medical Insurance for retirees with Medicare) will not be available to any employee whose first employment is on or after July 1, 2015.
- Any senator, representative or governor if first elected to office after July 1, 2015, is not eligible to continue coverage after retirement from office.
- Any employee whose first state employment began before July 1, 2015, and who returns to state service after July 1, 2015, will not be prohibited from retiree coverage if the employee did not accept a lump sum payment from TCRS before July 1, 2015. Employees must also meet all other retiree insurance eligibility requirements.

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- A new law regarding retiree insurance was approved by the legislature in April of 2015.
- As of July 1, 2015, retiree health insurance coverage for pre-65 retirees will not be available to any employee whose employment with the state first began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
- The Tennessee Plan (Supplemental Medical Insurance for retirees with Medicare) will not be available to any employees whose first employment with the state began on or after July 1, 2015. Employees hired before July 1, 2015, will be grandfathered in.
- Likewise, any senator, representative, governor if first elected to office after July 1, 2015, is not eligible to continue coverage after retirement from office.
 - But any employee whose first state employment began before July 1, 2015, and who returns to state service after July 1, 2015, may participate in retiree coverage if the employee did not accept a lump sum payment from TCRS before July 1, 2015, and if the employee meets eligibility requirements for retiree insurance.
- If you have questions about eligibility for retirement insurance, please contact Benefits Administration.
- If you have questions about your insurance options as an employee, talk to your ABC.

Your Privacy

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

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

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FOR HEALTH

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

Insurance Carrier Websites

- BlueCross BlueShield, Cigna and CVS/caremark each offer member websites that allow you to:

- View detailed information about your claims
- Print temporary ID cards
- Access other helpful member services

➤ **BlueCross BlueShield**

www.bcbst.com/members/tn_state/

➤ **Cigna**

www.cigna.com/site/stateoftn

➤ **CVS/caremark**

www.info.caremark.com/stateoftn

www.partnersforhealthtn.gov 800-253-9981

**PARTNERS
FOR HEALTH**

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

Who to Contact

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

- **ParTNers for Health**
www.partnersforhealthtn.gov

- **Benefits Administration**
www.tn.gov/finance/fa-benefits

www.partnersforhealthtn.gov 800-253-9981

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



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

More information is available at
[www. tn.gov/finance/fa-benefits](http://www.tn.gov/finance/fa-benefits)

Have questions? Please ask your ABC at this time.

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