State of Tennessee Group Insurance Program
Summary of Plan Changes

January 1, 2011

New Benefit Design

- Contracts for the Point of Service (POS) and Health Maintenance Organization (HMO) options have ended
- Current options sponsored by the State Group Insurance Program include the Partnership PPO, the Standard PPO, and (for the Local Government population) the Limited PPO
- All options have deductibles, copays, coinsurance and out-of-pocket maximums
- Member cost sharing is based on a combination of co-payments and co-insurance
- Preventive Services do not require a member payment and are not subject to a deductible or out-of-pocket maximum

Partnership Promise

- Applicable to The Partnership PPO option
- Upon enrollment, members commit to take an active role in their health
- Members should receive the appropriate preventive and routine healthcare services
- Members who fail to complete a health questionnaire and take a health screening by June 30, 2011 will not be eligible to enroll in the Partnership PPO option for 2012
- Specific results from the Partnership Promise Programs are strictly confidential; the plan's Health and Wellness contractor maintains compliance with the Partnership Promise.

ParTNers for Health Wellness Program

- Free to all eligible plan members and their covered dependents
- Benefits include 24/7 Nurse Advice Line, Health coaching, Health Screenings, Online Resources, Wellness Report, and Weekly Health Tips

Eligibility And Enrollment

Eligibility Date and Effective Date of Coverage Modified –

- For new hires only
- Eligibility date is the hire date
- Effective date of coverage is the first day of the month following the employee's eligibility date (hire date)

Expansion of Dependent Child Definition –

- Coverage of eligible child dependents up to age 26
- Eligibility based on relationship between child and covered participants
- Determination of eligibility based on other factors such as student status, whether or not the child is married, child's employment, whether or not the child is receiving financial support from, or is dependent on, the parents, whether or not the child is considered a dependent under IRS rules, whether or not the child is residing with the parents, and eligibility for other coverage, no longer allowed

Pre-existing Condition Clause Amended –

- Waiting period increased from 6 months to 12 months
- Applies to all adults who are enrolling or re-enrolling
- Does not apply to dependent children under the age of 26
- Waiver continues for adults who can demonstrate prior creditable coverage

Voluntary Cancellation Policy Amended –

- Not permitted outside of the Enrollment/Transfer period
- Exceptions made for Covered Persons experiencing a special qualifying event, family status change, or other qualifying event as approved by Benefits Administration

Late Applicant Process and Related Fees –

- Option to enroll through Medical Underwriting ended 9/15/2010
- Open enrollment conducted during 2010 Annual Enrollment Transfer Period
- Open to active employees
- Closed to retirees
- Active employees and eligible spouses could request enrollment as late applicants
- Eligible dependent children under the age of 26 not subject to late applicant fee
- Members joining through Open Enrollment subject to late applicant fee every month they are enrolled through December 31, 2013

Premiums

Additional Premium Tiers –

- Two tiers (single and family) previously
- Four premium tiers now:
  (1) Employee only
  (2) Employee plus spouse
  (3) Employee plus child(ren)
  (4) Employee, spouse, and child(ren)

Premium Deferral Policy Amended –

- Plan will no longer permit a 30-day deferral of premium

- Premiums are due by the end of the current month to certify coverage for the next month
- Coverage will be cancelled immediately if premiums are not paid in full by the last working day of the current month
- Policy not applicable where deferral is required by law

Benefits

Medical –

- Previous criteria for bariatric surgery deleted from the Plan Document; updated criteria detailed in 2011 Member Handbooks
- Exclusion for obesity screening, counseling, and treatment deleted
- Pharmacists recognized as eligible providers
- Pharmacist – administered vaccines permitted
- Coverage allowed for prescription vitamins
- Coverage of evidence-based preventive services at no cost to members in compliance with the Affordable Care Act and based on recommendations from the U.S. Preventive Services Task Force
- Coverage for generic and preferred brands of oral diabetic medications, insulin and supplies from in-network pharmacies continues with no member co-pay
- Initial diabetes outpatient self-management training and education services (including medical nutrition counseling) $500 limit per plan year replaced with a limit of six (6) visits per plan year
- Healthy diet counseling for other medical conditions limited to three (3) visits per plan year
- Six (6) mastectomy bras per plan year – number limit replaced with “as medically necessary
- Treatment by a licensed doctor of chiropractic – visits subject to medical necessity but no visit limit; co-pay increase beyond 20 visits
- Coverage for rehabilitation therapies enhanced – outpatient therapy limit of 45 visits per condition, per plan year replaced with limit of 90 days for speech, physical, and occupational therapies combined; claims administrator retains the authority to exceed limit where medically appropriate

Pharmacy –

- Claims administration resides with a Pharmacy Benefits Manager
- Days supply limit: Up to a 30 day supply (retail pharmacy) or up to a 90-day supply (mail service pharmacy and 90 day at retail); specialty medications have 30-day supply limit

Mental Health and Substance Abuse –

- Implementation of Mental Health Parity
- Separate deductible eliminated
- Limitations on inpatient stays and outpatient therapy visits eliminated

Subrogation

- Covered Persons must answer any and all documentation requests
- Failure to respond to requests for information and to pay any owed subrogation expenses to the plan, result in Covered Person's disenrollment from the plan, extending to Covered Person's dependents
- Employees disenrolled due to failure to comply with the subrogation policy are ineligible to rejoin the plan for three (3) years

Appeals

Administrative Appeals –

- Regarding an administrative process or decision (such as, transferring between health plans, effective dates of coverage, or timely filing issues)
- Members should contact their agency benefits coordinator

Benefit or Service Appeals –

- Internal and External Procedures to help resolve complaints
- Initial levels of appeal (the internal appeal procedure) should be directed to the appropriate claims administrator: medical – BCBS or Cigna, pharmacy – Caremark, mental health and substance abuse - Magellan
- Decision letters will advise members of further appeal rights including the option for review by an Independent Review Organization, where applicable
- Expedited consideration may be requested for denials made prior to services being received if the denial can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services

Resources And Contact Information

www.tn.gov/finance/ins - provides direct links to information about insurance products offered, related programs, publications and forms, premiums, and customer service.

www.tn.gov/finance/ins/publications.html - provides direct links to Member Handbooks, Insurance Comparison Charts, Retirement Brochures, and Plan Documents. Note: The Plan Documents are under revision and may not yet reflect the changes summarized here. An updated document will be posted when all changes have been incorporated.

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