



State Group
Insurance Program

2011 Eligibility and Enrollment Guide

State and Higher Education Employees

CONTACT INFORMATION

	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	1.800.253.9981	www.tn.gov/finance/ins/ www.partnersforhealthtn.gov
Health Insurance Carriers	BlueCross BlueShield of Tennessee CIGNA	1.800.558.6213 1.800.244.6224	www.bcbst.com/members/tn_state/ www.cigna.com/stateoftn
Pharmacy Benefits	Caremark	1.877.522.TNRX (8679)	www.caremark.com
Dental Insurance Carriers	Assurant Employee Benefits Delta Dental	1.800.443.2995 1.800.223.3104	www.assurantemployeebenefits.com/stoftn/ www.deltadentaltn.com/statetn/
Optional Term and Universal Life	Unum Group	1.866.310.6784	w3.unum.com/enroll/StateofTennessee/index.aspx
Basic Term Life and Accidental Death Optional Special Accidental Death	Dearborn National	1.800.348.4512	n/a
Mental Health, Substance Abuse and Employee Assistance Program	Magellan	1.800.308.4934	www.magellanassist.com
Wellness and Nurse Advice	APS Healthcare	1.888.741.3390	www.partnersforhealthtn.gov
Flex Benefits (state employees only)	TN Department of Treasury	1.615.741.3131	www.treasury.tn.gov/flex
Long-term Care (state employees only)	MedAmerica	1.866.615.5824	www.ltc-tn.com
Sick Leave Bank (state employees only)	TN Department of Human Resources	1.615.741.2958	www.tn.gov/dohr/
Medicare Supplement (retirees only)	The POMCO Group	1.888.477.9307	www.thetennesseeplan.com

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INTRODUCTION

Overview

This guide is to help you understand your insurance options. Read the information in this guide and make sure you know the rules.

Benefits Administration within the Department of Finance and Administration manages the group insurance program. Three separate groups receive benefits. The State Plan includes employees of state government and higher education. The Local Education Plan is available to local K-12 school systems. The Local Government Plan is available to local government agencies that choose to participate.

If you are eligible, you may enroll in health coverage and dental coverage. State and Higher Education employees can also enroll in optional life and long-term care coverage.

There are other handbooks that explain the health, dental and life benefits. You may obtain a copy of those books from your agency benefits coordinator or from the Benefits Administration website.

For More Information

Your agency benefits coordinator is your primary contact. This person is usually located in your human resource office. He or she is available to answer benefit questions and can provide you with forms and insurance booklets.

Authority

The State, Local Education and Local Government Insurance Committees set benefits and premiums. The Committees are authorized to (1) add, change or end any coverage offered through the state group insurance program, (2) change or discontinue benefits, (3) set premiums and (4) change the rules for eligibility at any time, for any reason.

State Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Human Resources
- Two members elected by popular vote of general state employees
- One higher education member selected under procedure established by the Tennessee Higher Education Commission
- One member from the Tennessee State Employees Association selected by its Board of Directors

Local Education Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance

- Commissioner of Education as designated by the Governor
- Three teachers selected by the Tennessee Education Association
- One member selected by the Tennessee School Board Association

Local Government Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- One member appointed by the Tennessee Municipal League
- One member appointed by the Tennessee County Services Association

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

The following employees are eligible to enroll in coverage:

- Full-time employees regularly scheduled to work at least 30 hours per week
- Seasonal or part-time employees with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year, (July–June)
- All other individuals cited in state statute as an exception by the State Insurance Committee

Employees NOT Eligible to Participate in the Plan

- Individuals performing services on a contract basis
- Individuals in positions that are temporary appointments
- Individuals who do not meet the eligibility rules

Dependent Eligibility

If you are enrolling dependents, you must provide proof of eligibility when you fill out your enrollment application. The following dependents are eligible for coverage:

- Your spouse (legally married) — Article XI, Section 18 of the Tennessee Constitution provides that a marriage from another state that does not constitute the marriage of one man and one woman is “void and unenforceable in this state”
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian
- Children for whom the plan has Qualified Medical Child Support Orders

All dependents must be listed by name on the enrollment application. Proof of the dependent’s eligibility is also required. Refer to the dependent definitions and required documents chart included on the enrollment application for the types of proof you must provide. A dependent can only be covered once within the same plan, but can be covered under two separate plans (State, Local Education or Local Government). Dependent children are eligible for coverage through the last day of the month of their 26th birthday. This does not include optional term and universal life coverage, which will cancel at age 24.

Children who are mentally or physically disabled and not able to earn a living may continue health or dental coverage beyond age 26 if they were disabled before their 26th birthday and they were already insured under the state group insurance program. The child must meet the requirements for dependent eligibility listed above. A request for extended coverage must be provided to Benefits Administration within 90 days before the dependent’s 26th birthday. The insurance carrier will decide if a dependent is eligible based on disability. Coverage will end and will not be restored once the child is no longer disabled.

You must notify your agency benefits coordinator to cancel coverage if your dependent loses eligibility.

Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse (with the exception of long-term care)
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation)
- Live-in companions who are not legally married to the employee

Enrollment and Effective Date of Health and Dental Coverage

As a new employee, the rules that apply to your enrollment depend on your hire date.

For persons hired before July 1, 2011, the employing agency may choose between two policies. The policy they choose must be applied to all new employees. Depending on the policy your agency applies to new employees:

- You have from the first day of employment through the last day of the first full calendar month worked to turn in your enrollment application. Coverage starts on the first day of the month after you have been employed one full calendar month or you can choose to have your coverage start on the first of the next month; OR
- You have 31 days to turn in an enrollment application. Coverage starts on the first day of the month after your hire date.

For persons hired on or after July 1, 2011, all agencies will use the following policy:

- You have 31 days to turn in an enrollment application. Coverage starts on the first day of the month after your hire date.

State Plan employees in the 1,450 hour category must apply within one full calendar month after meeting the 24-month requirement.

If you are a part-time employee and gain full-time status, your coverage will start the first day of the month after gaining full-time status. You must complete one full calendar month of employment. You may also choose the next month for coverage to start. Application must be made within one full calendar month after becoming eligible

You must be in a positive pay status on the day your coverage begins. If you do not enroll in health coverage by the end of your enrollment period, you will only be eligible if you have a qualifying event under the special enrollment provisions. Refer to the special enrollment provisions section of this guide for more information.

Positive Pay Status – Being paid even if you are not actually performing the normal duties of your job. This is related to any type of approved leave with pay.

A dependent's coverage starts on the same date as yours unless newly acquired. Newly acquired dependents will start coverage on the date they were acquired if you are in family coverage. You may also choose to have coverage start the first day of the following month. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption.

An insurance card will be mailed to you three to four weeks after your application is processed. You may call the insurance carrier to ask for extra cards or print a temporary card from the carrier's website.

Choosing a Premium Level (Tier)

There are four premium levels for health and dental coverage to choose from depending on the size of your family.

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Employee + Spouse + Child(ren)

Family Coverage – Coverage other than Employee Only is considered family coverage.

If you enroll as a family in the second, third or fourth premium level, all of you must enroll in the same health and dental options. However, if you are married to an employee who is also a member of the State, Local Education or Local Government Plan, you can each enroll in employee only coverage if you are not covering dependent children. If you have children, one of you can choose employee only and the other can choose employee + child(ren). Then you can each choose your own benefit option and carrier.

A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who declined coverage when first eligible. The employee spouse will always have dependent status unless he or she later qualifies under the special enrollment provisions.

If you are in the State Plan and your spouse is also in the State Plan, you both may want to think about choosing “employee only” coverage. State Plan employees can get a higher level of life insurance coverage as the head of contract. Refer to the available benefits section of this guide for more information.

One employee may choose family coverage and cover the spouse as a dependent. Coverage for a dependent child or children cannot be chosen by more than one eligible employee. An employee may not enroll as both head of contract and dependent within the same plan.

Premium Payment

For state and higher education employees, the state pays about 80 percent of the cost of your health insurance premium if you are in a positive pay status or on approved family medical leave. If approved for workers compensation and receiving lost-time pay, the state pays the entire health insurance premium. Insurance premiums are taken from the paycheck you get at the end of each month to pay for the next month’s coverage.

Optional coverages, such as dental, get no state support and you must pay the total premium.

The plan permits a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled back to the date you last paid a premium. There is no provision for restoring your coverage.

Pre-tax Premiums – State employee health and/or dental premiums are paid before income or social security tax is deducted. Pre-tax premiums reduce an employee’s taxable income because they are taken out before taxes are withheld.

Adding New Dependents

An enrollment application must be completed within 60 days of the date a dependent is acquired. The “acquire date” is the date of birth, marriage, or, in case of adoption, when a child is adopted or placed for adoption. Premium changes start on the first day of the month in which the dependent was acquired or, the first of the next month, depending on the coverage start date.

An employee’s child named under a qualified medical support order must be added within 40 days of the court order.

If adding dependents while on single coverage, you must request the correct family coverage tier for the month the dependent was acquired so claims are paid for that month. This change is retroactive and you must pay the premium for the entire month the dependent is insured.

To add a dependent more than 60 days after the acquire date, the following rules apply based on the type of coverage you currently have.

If you have single coverage

- The new dependent can only enroll if they have a qualifying event under the special enrollment provisions

If you have family coverage

- The new dependent can only enroll if they have a qualifying event under the special enrollment provisions, unless;
- The level of family coverage you had on the date the dependent was acquired was sufficient to include that dependent without requiring a premium increase. You must have maintained that same level of family coverage without a break. The dependent’s coverage start date may go back to the acquire date in this case.

More information is provided under the special enrollment provisions section of this guide.

Updating Personal Information

State employees can update information, such as home address, using employee self-service through Edison.

Annual Enrollment Transfer Period

During the fall of each year, benefit information is mailed to you. Review this information carefully to make the best decisions for you and your family members. The enrollment transfer period gives you another chance to enroll in optional coverage products. These include dental, optional term, universal life, and optional special accident. You can also make changes to your existing coverage, like increasing or decreasing term life insurance, transferring between health and dental options, and canceling coverage.

Most changes you request start the following January 1. However, optional term and universal life coverage may start January 1, February 1 or March 1.

Health and dental enrollments remain in effect for a full plan year (January 1 through December 31). You may not cancel health and dental coverage outside of the transfer period unless eligibility is lost or there is a qualifying change or event. For more information, see the section on canceling coverage in this guide.

Cancelling Health or Dental Coverage

Outside of the annual enrollment transfer period, you can only cancel health and/or dental coverage for yourself and/or your covered dependents, IF:

- You lose eligibility for the state group insurance program
- You experience a special qualifying event, family status change, or other qualifying event as approved by Benefits Administration

You must notify your agency benefits coordinator of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for adopted children ends when the legal obligation ends. Insurance continued for a disabled dependent child ends when he/she is no longer disabled, or at the end of the 31-day period after any requested proof is not given. For a divorce or legal separation, you cannot remove your spouse until a final decree is entered, unless your spouse or the court gives permission.

You may cancel coverage for yourself and/or your dependents if you become newly eligible for another plan. There are no exceptions. You have 60 days from the date of the event to turn in an application and proof to your agency benefits coordinator. The required proof is shown on the application. Approved reasons to cancel are:

- Marriage
- Adoption/placement for adoption
- New employment (self or dependents)
- Return from unpaid leave
- Entitlement to Medicare, Medicaid or TRICARE
- Birth
- Divorce or legal separation
- Court decree or order
- Open enrollment
- Change in place of residence or work out of the national service area (i.e., move out of the U.S.)
- From part-time to full-time employment (spouse or dependents)

Once your application and required proof are received, the coverage end date will be either:

- The last day of the month before the eligibility date of other coverage
- The last day of the month that the event occurred
- The last day of the month that documentation is submitted

Transferring Between Plans

Members eligible for coverage under more than one state-sponsored plan may transfer between the State, Local Education and Local Government Plans. You may apply for a transfer during December with a start date of January 1. In no case may you transfer to another state-sponsored plan and remain on your current plan as the head of contract.

If You Don't Apply When First Eligible

If you do not enroll in health coverage when you are first eligible, you can only apply later through special enrollment due to certain life events. You should apply for health insurance when you are first employed. You may not be able to get coverage at a later date.

Special Enrollment Provisions

The Health Insurance Portability Accountability Act (HIPAA) is a federal law. It allows you to enroll in a group health plan due to certain life events. The state group insurance program will only consider special enrollment requests for health and/or dental coverage.

If adding a newly acquired dependent for any of the reasons below, you may also add previously eligible dependents at the same time. Approved reasons are:

- A new dependent spouse is acquired through marriage
- A new dependent newborn is acquired through birth
- A new dependent is acquired through adoption or legal custody

You must make the request within 60 days of acquiring the new dependent. You must also submit proof to show:

- The date of the birth as proved by a birth certificate
- The placement for adoption as proved by adoption documents
- The date of marriage as proved a marriage certificate

The above events are ONLY subject to special enrollment IF you want to add other previously eligible dependents at the same time as the new dependents. If you only want to add a newly acquired dependent, this is treated as a regular enrollment.

Options for coverage start dates due to the events above are:

- Day on which the event occurred
- First of the month or next month after approval by the committee or its representative (when administrative review is required)

Other events allow enrollment based on a loss of coverage under another plan:

- Death of a spouse or ex-spouse
- Divorce
- Legal separation
- Loss of eligibility (excluding loss due to failure to pay premiums or termination of coverage for cause)
- Termination of spouse or ex-spouse's employment
- Employer ends total premium support to the spouse's, ex-spouse's, or dependent's insurance coverage (not partial)
- Spouse's or ex-spouse's work hours reduced
- Spouse maintaining coverage where lifetime maximum has been met
- Loss of TennCare (does not include loss due to non-payment of premiums)

Applications for the above events must be made within 60 days of the loss of the insurance coverage.

You must submit proof to show ALL of the following:

- A qualifying event has occurred, as proved by death certificate, final signed divorce decree or agreed order of legal separation, employment termination notice, or employer's statement regarding date total premium support changed, date loss of eligibility occurred, or date lifetime maximum was reached
- You and/or your dependents were covered under another group health plan at the time of the event
- You and/or your dependents may not continue coverage under the other plan as proved by either a letter from the employer on company letterhead or a certificate of creditable coverage from TennCare. In either case, the documents must provide the names of covered participants, the date coverage ended, and the reason why coverage ended.
- If enrolling due to loss of coverage under another plan, options for coverage start dates are:
 - First of the month in which other coverage was lost, if other coverage was lost in the middle of the month (double coverage)
 - First of the month following loss of other coverage if other coverage was lost at the end of the month
 - First of the month following the 60-day period of the loss of insurance coverage
 - First of the month or next month after approval by the committee or its representative (when application requires administrative review)

Important Reminders

- If enrolling dependents who qualify under the special enrollment provisions, you may choose to change to another health option, if eligible
- If you or your dependents had COBRA continuation coverage under another plan and coverage has since ended, enrollment requirements will be waived if application is received within 60 days of the loss of coverage
- Premiums for coverage type selected must be paid before the coverage can start.
- Loss of eligibility does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause.

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION OF EMPLOYMENT

Extended Periods of Leave

Family and Medical Leave Act (FMLA)

FMLA allows you to take up to 12 weeks of leave during a 12-month period for a serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to get state support of your health insurance premium. Initial approval for family and medical leave is up to each agency head. You must have completed a minimum of 12 months of employment and worked 1,250 hours in the 12 months immediately before the onset of leave. Cancellation due to failure to pay premiums does not apply to FMLA.

Leave Without Pay – Health Insurance Continued

If continuing coverage while on an approved leave of absence you must pay the total monthly health insurance premium once you have been without pay for one full calendar month. You will be billed at home each month for your share and the employer's share. The maximum period for a leave of absence is two continuous years. At the end of the two years, you must immediately report back to work for no less than one full calendar month before you can continue coverage during another leave of absence. If you do not immediately return to work at the end of two years of leave, coverage is canceled and COBRA eligibility will not apply.

Leave Without Pay – Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any optional coverages. You may reinstate coverage when you return to work. If canceled for nonpayment, coverage cannot be restored unless you have a qualifying event under the special enrollment provisions.

To Reinstate Coverage After You Return

You must submit an application to your agency benefits coordinator within 31 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 31 days of your return to work, you can only re-enroll if you have a qualifying event under the special enrollment provisions. The following rules apply::

If returning within six months

- No waiting period, coverage goes into effect the first of the next month after you return to work
- Preexisting condition does not apply

If returning after six months

- Must wait one full calendar month before coverage starts
- Must satisfy the twelve-month preexisting condition clause (waived if you provide a certificate of coverage letter showing other coverage while on leave without a 63-day lapse)

If you and your spouse are both insured with the state group insurance program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract. To transfer coverage, submit an enrollment/change application to suspend your coverage. Your spouse should submit an enrollment/change application to add you as a dependent. Benefits Administration must be contacted to assist with this change and to transfer deductibles and out-of-pocket expenses.

Reinstatement for Military Personnel Returning From Active Service

An employee who returns to work after active military duty may reinstate coverage on the earliest of the following:

- The first day of the month, which includes the date, discharged from active duty
- The first of the month following the date of discharge from active duty
- The date returning to active payroll
- The first of the month following return to the employer's active payroll

If restored before returning to the employer's active payroll, you must pay 100 percent of the total premium. In all instances, you must pay the entire premium for the month.

Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave. No preexisting conditions or waiting period will apply.

Leave Due to a Work-Related Injury

If you have a work-related injury or illness, contact your benefits coordinator about how this will affect your insurance. You must keep insurance premiums current until you receive a notice of lost-time pay from the Division of Claims Administration. You will receive a refund for any health insurance payments you make once you receive notice.

If approved for lost-time pay, only the premium for health insurance is paid by your agency. You must pay the premium for any optional coverages on a monthly basis. You are responsible for 100 percent of the premium when lost-time pay ends if you do not have any paid leave.

All benefits paid on claims due to a work-related injury or illness will be recovered. This means that you are required to repay all claims paid related to a work-related injury.

Lost-time Pay – Payments received due to lost time (without pay) caused by an approved work-related injury. Lost time pay is approved by the Department of Treasury, Division of Claims.

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration. A COBRA notice to continue health and/or dental coverage will be mailed to you. Life insurance conversion notices will also be mailed if applicable. Make sure your correct address is on file with your benefits coordinator and human resource office.

Continuing Health and Dental Coverage through COBRA

You may be able to continue health and/or dental coverage under the Consolidated Omnibus Budget Reconciliation Act. This is a federal law known as COBRA. This law allows employees and dependents whose health or dental insurance would end to continue the same benefits for specific periods of time. Persons may continue health or dental insurance if:

1. Coverage is lost due to a qualifying event (refer to the COBRA brochure for a list of events)
2. You are not insured under another group health plan as an employee or dependent (waived if you or your dependents enroll in another group health plan that has a preexisting condition clause, and a condition exists that is not covered by the other plan.) In this case, you must provide the following to Benefits Administration:
 - A letter from the new employer or claims administrator explaining that plan's preexisting condition clause and how long it applies
 - A letter from your doctor stating your preexisting condition

Benefits Administration will send a COBRA packet to you. It will be sent to the address on file within 7-10 days after your coverage ends. You have 60 days from the date of the COBRA notice to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. Please make sure your correct home address is on file with your agency benefits coordinator. If you do not receive a letter within 30 days after your insurance ends, you should contact Benefits Administration.

Continuing Coverage at Retirement

Members who meet the rules may continue health insurance at retirement for themselves and covered dependents until eligible for Medicare. To continue coverage as a retiree, you must submit an application within one full calendar month of the date active coverage ends. A member cannot have retiree coverage and keep active coverage as an employee in the same plan. After the one full calendar month period, eligible retirees may only continue coverage if qualified for a special enrollment provision or through COBRA.

Limited Coverage for Disability

If you become totally and permanently disabled while enrolled in health coverage, you (as a former employee) may keep health coverage, for that condition only, for one year. Coverage is not provided for any other injury or illness and is in lieu of any other option offered by the state group insurance program. You must request this, in writing, within 30 days of the date your active coverage ends. You will not have to pay a premium, but you must pay your deductible, copay and coinsurance amounts. Pharmacy charges must be paid at the time of service and refunds are subject to the terms and conditions of the plan.

If you have at least five years of service, you may be able to continue health coverage beyond one year. This rule applies if you are totally and permanently disabled as decided by the TCRS medical review panel or by an award letter from the Social Security Administration. You must be covered under the state group insurance program at the time the disabling injury or illness occurs.

If you remain disabled for two years and become eligible for Medicare Part A and B, you must purchase Part B. Medicare will become primary at this time. Your coverage through the state will become secondary. The state coverage will remain primary for 30 months if you are diagnosed with end-stage renal disease. If you continue to be eligible, you may keep the state coverage until you become eligible for Medicare due to age. This applies to state and local education plan members only. Local government plan members lose state-sponsored coverage if Medicare eligible regardless of age.

Coverage for Dependents in the Event of Your Death

If You Are an Active Employee

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage under COBRA for a maximum of 36 months as long as they remain eligible. If your spouse will be receiving your TCRS retirement benefit, he or she may be eligible to continue insurance as a retiree in lieu of COBRA. The surviving spouse should contact the agency benefits coordinator or Benefits Administration to confirm eligibility. Dental insurance will terminate at the end of the month of the death of the employee. However, continuation of dental coverage through COBRA will be available. The dependents may be able to convert life insurance to a direct-pay basis.

If You Are a Covered Retiree

Your covered dependents will get six months of health coverage at no cost. Dependents may continue to be covered as long as they continue to meet eligibility rules.

If You Die in the Line of Duty

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage only at an active employee rate until they become eligible for other insurance coverage or they no longer meet the dependent eligibility rules.

Line-of-duty – An employee on-the-job in a positive pay status; as determined by the State Division of Claims Administration in the Department of Treasury.

If You Are Covered Under COBRA

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage under COBRA if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

AVAILABLE BENEFITS

Health Insurance

You have a choice of two health insurance options:

- Partnership PPO
- Standard PPO

PPO stands for preferred provider organization. With a PPO, you can see any doctor you want. However, the PPO has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. These providers make up a network. You can visit any doctor or facility in the network. These providers have agreed to take lower fees for their services. The cost is higher when using out-of-network providers.

The PPOs cover the same services, treatments and products, including the following:

- In-network preventive care, x-ray, lab and diagnostics at no cost
- Primary and specialist doctor office visits for a fixed copay without having to meet a deductible
- Prescription drugs for a fixed copay without having to meet a deductible, with the exception of the Limited PPO for local government plan members
- Deductibles and coinsurance for certain services such as hospitalization, therapy, durable medical equipment, advanced imaging and ambulance
- Out-of-pocket maximums to limit your coinsurance costs

Partnership Promise

There is one important difference between the Partnership PPO and the Standard PPO. If you choose the Partnership PPO, you must sign a Partnership Promise. The Partnership Promise requires you to take certain steps to get or stay as healthy as you can. In return, you will pay less than you would with the Standard PPO. In general, the Partnership Promise is a commitment to:

- Know your health history
- Know your health risks
- Take actions to get and stay as healthy as you can

The Partnership Promise is an annual commitment. In order to remain in the Partnership PPO, you must meet your commitment each year. You must renew your promise the following fall during the enrollment transfer period.

You and all eligible family members must enroll in the same PPO. If you choose the Partnership PPO, your dependent spouse must also agree to the Partnership Promise. Children are not required to take action. By signing your enrollment form and agreeing to the Partnership Promise in 2011, you make a commitment to:

- Complete a health questionnaire
- Complete a health screening
- Get appropriate preventive and routine healthcare services

All new employees who join the Partnership PPO between January 1 and March 1 must fulfill the Partnership Promise. If you join after March 1 you may, but are not required to, complete the health questionnaire and health screening prior to the next enrollment period. However, you will be required to commit to complete the full Partnership Promise during the next plan year.

The health questionnaire asks about your current health habits, such as what you eat, how much you exercise, work and life stress and whether you use tobacco or alcohol. The health screening measures your height, weight, blood sugar, blood pressure and cholesterol level. You can do the screening with your doctor or at one of the health screening sites offered by the state group insurance program.

In return for committing to the Partnership Promise, you will have lower premiums, copays, coinsurance, deductibles and out-of-pocket maximums than under the Standard PPO. If you sign up for the Partnership PPO, but do not satisfy the Partnership Promise, you will only be eligible for the Standard PPO in the next plan year.

Preexisting Conditions

A preexisting condition is a condition for which you had treatment or advice during the 12-month period immediately prior to coverage with the state group insurance program.

Preexisting conditions do not apply to pregnancy, newborns or dependent children up to age 26. If you are enrolling as a new hire and have had health coverage without a 63-day lapse in coverage, the preexisting condition clause will be waived.

If you or your dependents do not have prior health coverage, or if the prior coverage cancelled for more than 63 days, you must meet the 12-month preexisting condition requirement. Treatments for conditions determined to be preexisting will not be covered until insurance has been in force for 12 months.

You or your dependents must furnish a certificate of coverage letter (letter on former employer or insurance carrier letterhead) stating that you had prior coverage. The letter must include the names of the persons who were enrolled and the date the coverage ended. You must provide this letter to your benefits coordinator in order to be exempt from the preexisting condition rule. There cannot be a lapse of coverage longer than 63 days. If you do not have the letter when you enroll, you may provide it later and Benefits Administration will change the coverage to show that preexisting do not apply.

Dental Insurance

Dental coverage is available to all State Plan participants. You must pay 100 percent of the premium if you elect this coverage. Two options are available—a prepaid plan and a preferred dental organization (PDO) plan.

In the prepaid plan, you must select from a specific group of dentists. Under the PDO plan, you may visit the dentist of your choice; however, members get maximum savings when visiting a PDO network provider. Both dental options have specific rules for benefits such as exams and major procedures, and have a four-tier premium structure just like health insurance.

You can enroll in dental coverage as a new employee or during the annual enrollment transfer period. You may also enroll if you have a special qualifying event. You do not have to be enrolled in health coverage to be eligible for dental insurance.

Prepaid Plan

- Must select a network provider for each covered family member
- Major services at predetermined copayments
- No claim forms
- Preexisting conditions are covered

- No maximum benefit levels
- No deductibles
- No charge for oral exams, routine semiannual cleanings, most x-rays and fluoride treatments; however, an office visit copay will apply

PDO Plan

- Select any dentist
- \$1,500 calendar year benefit maximum per person
- \$0 calendar year deductible per individual in-network, \$100 per individual out-of-network
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of \$1,250 for orthodontia

Employee Assistance Program

The Employee Assistance Program (EAP) is a no cost, confidential support tool that helps you, and those around you, deal with personal issues and situations. Seeking help is not a weakness. The goal is that after you make the decision to ask for help, you will find the program both easy to access and helpful. Sooner or later, all of us will encounter a personal problem of some kind. The EAP can help with issues including:

- | | | |
|--------------------------------|-------------------|------------------|
| • Financial strain or planning | • Family/marital | • Grief and loss |
| • Everyday stress | • Workplace | • Legal |
| • Behavioral health | • Addiction | • Elder care |
| | • Chronic illness | • Parenting |

The EAP offers seminars on various issues of interest at locations across the state. Call 615.253.5190 or 615.741.8643 for more information.

All services are confidential, and available at no cost to members. Prior authorization is required. Services can be easily accessed by calling the carrier who is available 24 hours a day, 365 days a year. You may participate in EAP services on work time with your supervisor's approval.

You and your eligible dependents may get up to six counseling sessions per problem episode at no cost to you. If you need assistance beyond the EAP, you will be referred to your insurance carrier's mental health and substance abuse benefits. For more information, call 615.253.5190. The program is available to all full-time state and higher education employees and their dependents, under-65 retirees and COBRA participants. All local education and local government employees, under-65 retirees and COBRA participants enrolled in a state sponsored health plan are also eligible. Dependents of local education and local government members may get EAP services even if the dependents are not enrolled in health coverage.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is free to all state group insurance program members and eligible spouses and dependents. This program is an optional benefit for Standard and Limited PPO members.

24/7 Nurse Advice Line

The ParTNers for Health Nurse Advice Line gives you information and support, 24 hours a day, 7 days a week, at no cost to you. Call day or night to talk to a nurse about:

- The closest hospital or after-hours clinic
- Understanding what a doctor told you
- Your symptoms or questions about medications

Working with a Health Coach

Health coaches can help you reach your personal health goals, and will schedule calls when it is convenient for you. All calls are confidential.

ParTNers for Health Website

The ParTNers for Health website links you to powerful online tools and health information at your fingertips. Choose from a variety of online health improvement programs and keep track of your progress to reach your personal goals. Registration is easy. Simply follow the links and on screen instructions at www.partnersforhealthtn.gov.

Health Screening

Free health screenings are held in locations all around the state. Visit the ParTNers for Health website to schedule your screening at one of the many convenient locations.

Health Questionnaire

You will find a link to the health questionnaire on the ParTNers for Health website. Just click on the link that says "Questionnaire" to get started. If you do not have access to a computer, call us at 1.888.741.3390 and ask for assistance.

Weekly Health Tips by E-mail

Don't forget to sign up for free weekly health tips by e-mail. Visit our website and click the Weekly Health Tips link to sign up. You will get a short e-mail with each week's healthy living tip.

Fitness Center Discounts

Available to all insurance plan members, discount agreements have been secured from fitness centers throughout the state. Refer to the ParTNers for Health website to view a list of participating fitness centers.

Life Insurance

Basic Group Term Life and Accidental Death and Dismemberment

The state provides, at no cost to the employee, \$20,000 of basic term life and \$40,000 of basic accidental death coverage. If you enroll in health coverage, the amount of coverage increases as your salary increases, with premiums for coverage above \$20,000/\$40,000 deducted from your paycheck. The maximum amount of coverage is \$50,000 for term life and \$100,000 for accidental death and dismemberment. The face amount of coverage declines at ages above 65. For employees who do not enroll in health coverage, the amount of coverage does not increase regardless of salary.

Changes in coverage based upon age or salary take effect on the first day of October based on your age or salary as of September 1.

Eligible dependents (spouse and children) are covered for \$3,000 of basic dependent term life coverage. Dependents (spouse and children) are eligible for basic accidental death insurance, with the amounts of coverage based on salary and family composition. Dependents of employees who do not enroll in health coverage are not eligible for basic term or basic special accident coverage.

Optional Special Accidental Death and Dismemberment

You and your dependents (spouse and children) may enroll in this coverage. It is in addition to the basic accidental death coverage, you must pay a premium. Benefits are paid for dismemberment if the loss occurs within 90 days of the accident, as long as you or your dependent is covered on the date of the accident and meet the criteria.

Optional Term and Universal Life

You and your dependents (spouse and children) may enroll in these coverages whether or not you enroll in health coverage. A premium is required. For guaranteed issue coverage, you must enroll during the first full calendar month of employment with the state. The effective date of coverage is the first of the month after you have completed three full calendar months of employment. If you do not enroll when first eligible, you can apply for coverage during the annual enrollment transfer period by answering health questions.

You may select up to three times your annual base salary (subject to a maximum of \$300,000) if you apply when first eligible. You may apply for up to five times your annual base salary (subject to a maximum of \$300,000), but evidence of good health is required. The minimum coverage level is \$5,000 and you may choose a combination of universal and/or term life.

Your spouse may have \$5,000, \$10,000 or \$15,000 of universal and/or term life at any age. Spouses below age 55 are eligible for up to one times your annual base salary, subject to an overall maximum of \$30,000. To have guaranteed issue coverage, spouses must be performing normal duties of a healthy person of similar age and gender and not be hospitalized within six months prior to the coverage start date. You do not have to enroll in this coverage in order for your spouse to participate.

Children may be covered under either a \$2,500 or a \$5,000 term rider. The rider is added to either your contract or your spouse's contract, but not both. These amounts will cover all eligible dependent children who meet the dependent definition. If a child is determined to be disabled, they may remain covered under the optional life coverage as long as they are eligible.

The optional universal life provides a death benefit, level premiums, a cash value account and a policy loan provision. The optional term life provides a lower cost pure death benefit product, but the premiums increase with age. Both optional life products offer the advance benefit rider, which allows part of the life insurance proceeds if an insured encounters a terminal illness.

Flexible Benefits Spending Reimbursement Accounts

State employees (excludes higher education which have their own flex program, and off-line employees) are eligible for the flexible benefits program, which includes medical, dependent day care, parking and transportation reimbursements accounts. The program is administered by the Department of Treasury. Unless you have an approved family status change, you cannot enroll in or cancel a medical or dependent day care reimbursement account in the middle of a calendar year.

Medical Reimbursement Account

With a medical reimbursement account, you can set aside up to \$7,500 a year to pay for eligible medical expenses with your pre-tax contributions. Over-the-counter medications are not a reimbursable expense unless your doctor writes a prescription.

Dependent Day Care Reimbursement Account

The amount you can set aside for a dependent day care reimbursement account depends on your tax filing status. If you are married and file separately, you can contribute up to \$2,500 for the year. If you are married and file jointly or you file as head of household, the maximum is \$5,000. You can use your pre-tax contributions to pay for eligible dependent day care expenses.

Parking Reimbursement Account

With a parking reimbursement account, you can set aside up to \$215 per month to pay for qualified parking expenses with your pre-tax contributions. You may enroll in a parking reimbursement account at any time.

Transportation Reimbursement Account

With a transportation reimbursement account, you can set aside up to \$110 per month to pay for qualified transportation expenses with your pre-tax contributions. You may enroll in a transportation reimbursement account at any time.

Long-Term Care

Qualified state and higher education employees, their eligible dependents, retirees, parents and parents-in-law are eligible to enroll in long-term care coverage. This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging or a serious illness often brings on this need.

Services covered include nursing home care, assisted living, home health care, home care and adult day care. Benefits are available through different options based on a daily benefit amount (\$100, \$150 or \$200) for either a three-year or five-year coverage period. The benefits are also available with or without inflation protection.

In addition to these choices, there are a number of fixed features. There is a 90-day period that must be met—much like a deductible—by having a person qualify for services before the insurance coverage begins to pay for those services. The plan covers respite care, providing care for up to 21 days per calendar year at home or in a facility to give the primary caregiver a rest. Bed reservation is also covered for up to 21 days per calendar year to hold your bed in an assisted living facility, nursing home or hospice facility if you have to go to the hospital. The plan even covers home health agency services for household tasks that do not require a trained home health aide.

The plan is guaranteed renewable, which means it can never be canceled as long as you pay your premium. The coverage is portable, so you may continue to pay premium directly to the insurance company under the same terms and conditions as active employees if you leave employment. The plan includes a waiver of premium so that if you qualify for benefits and satisfy the 90-day period, you can stop payment of premium and the coverage will remain in effect.

As a new employee, you have 90 days to enroll and have guaranteed issue of coverage. You may sign-up for coverage by completing the enrollment form enclosed in the enrollment kit, over the phone by speaking with customer service or on-line via the insurance carrier's website. Your spouse, eligible dependent children, parents

and parents-in-law may also apply for coverage; however, they must provide information about their health status and will be subject to medical underwriting review for approval to enroll. After the initial guaranteed issue period, you may still apply for coverage, but will also be subject to the same medical underwriting review for approval to enroll.

You must pay 100 percent of the premium if you choose this coverage. Premiums are based on age at the time of enrollment. So the younger you are when you apply, the lower your monthly premium will be. You may choose to have the premium taken from your payroll check, or may opt for a direct bill arrangement with the provider. Direct billing, or payment by bank draft or credit card, can be set up on a quarterly, semi-annual or annual basis.

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together and pay up to 100 percent of the eligible charges. At no time should payments exceed 100 percent of the eligible charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, if you have other health coverage as the head of contract, the oldest plan is your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his or her employer, that coverage would be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage.

From time to time, carriers will send letters to members asking for other coverage information. This is necessary because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. In addition to sending a letter, the carriers may also attempt to gather this information when members call in. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

If you do not respond to requests for other coverage information, your claims may be pended or held for payment. When claims are pended, it does not mean that coverage has been terminated or that the claims have been denied. However, claims will be denied if the requested information is not received by the deadline. Once the carrier gets the requested information, they will update the information regarding other coverage, and claims that were pended or denied will be released or adjusted for payment.

Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover the following:

- Any payments made as a result of injury or illness caused by the action or fault of another person
- A lawsuit settlement that results in payments from a third party or insurer of a third-party
- Any payments made due to a workplace injury or illness

These payments would include payments made by worker's compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation department. Failure to respond to the plan's requests for information, and to pay the plan back for any money received for medical expenses, will result in disenrollment from the plan for you and your dependents.. If disenrolled from the plan due to failure to cooperate and pay outstanding medical expenses you and your dependents cannot rejoin the plan for three years and are not eligible for COBRA.

On the Job Illness or Injury

Work-related illnesses or injuries are not covered under the plan. The plan will not cover claims related to a work-related accident or illness regardless of the status of a worker's compensation claim or other circumstances.

Fraud, Waste and Abuse

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. Eligibility requirements for employees and dependents are covered in detail in this guide.

If your covered dependent becomes ineligible, you must inform your benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he or she cannot be covered even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, you must notify your benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your healthcare. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or member fraud. You can help prevent fraud and abuse by working with your employer and plan administrator to fight those individuals who engage in fraudulent activities.

How You Can Help

- Pay close attention to the explanation of benefits (EOB) forms sent to you when a claim is filed under your contract and always call the carrier to question any charge that you do not understand.
- Report anyone who permits a relative or friend to “borrow” his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who makes false claims or alters amounts charged on claim forms

Please contact Benefits Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

To File an Appeal

If you experience a problem relating to the plan policies or the services provided, there are established internal and external procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

You should direct any specific questions regarding initial levels of appeal (the internal appeal process) to the insurance carrier. Other appeal questions may be directed to the Benefits Administration appeals coordinator at 615-741-4517 or 1-866-576-0029.

Administrative Appeals

To file an appeal about an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues, or timely filing issues) contact your agency benefits coordinator and explain your request. The benefits coordinator will forward your request to Benefits Administration for review and response.

Benefit Appeals

Before starting an appeal related to benefits (e.g., a prior-authorization denial or an unpaid claim), you should first contact the insurance company to discuss the issue. You may ask for an appeal if the issue is not resolved as you would like.

Different insurance companies manage approvals and payments related to your medical, mental health, substance abuse and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you direct your request to the correct company. You have insurance cards for medical and pharmacy. You can find member service numbers for medical and mental health and substance abuse on your medical card. Your pharmacy card will have the member service number for pharmacy.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), call the toll-free member service number on your insurance card. You may file a formal request for an appeal or member grievance by completing a form or as otherwise instructed.

The insurance company will process internal levels of appeal – Level I and Level II appeals. Decision letters will be mailed to you at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

Pursuing Further Action

In cases where internal and external appeal procedures have been completed, decision letters will notify you of the option to pursue further action through litigation.

LEGAL NOTICES

Information in this Guide

This guide does not give every detail of the state-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. If information in this guide conflicts with the Plan Document, the Plan Document will control. Your department or facility (benefits section) has a copy or you can obtain a copy from the Benefits Administration website.

The information contained in this guide is accurate at the time of printing. The Insurance Committees may change the plans at their discretion. Changes to federal and/or state laws may also impact the plans. You will be given written notice of changes. The benefits described in this guide cannot be changed by any oral statements.

All health, dental and life coverages have member handbooks to explain benefits in detail. Those are available from your agency benefits coordinator or you may obtain a copy from the Benefits Administration website.

Member Privacy

The state group insurance program considers your protected health information (PHI) private and confidential. In accordance with the federal Health Insurance Portability and Accountability Act (HIPAA), policies and procedures are in place to protect such information against unlawful use and disclosure. PHI is individually identifiable health information. This includes demographics such as age, address, e-mail address and relates to your past, present or future physical or mental health condition. We are required by law to make sure your PHI is kept private.

When necessary, your PHI may be used and disclosed for treatment, payment and healthcare operations. For example, your PHI may be used or disclosed, including, but not limited to:

- In order to provide, coordinate or manage your healthcare
- To pay claims for services which are covered under your health insurance
- In the course of the operation of the state group insurance program to determine eligibility, establish enrollment, collect or refund premiums, and conduct quality assessments and improvement activities
- To coordinate and manage your care, contact healthcare providers with information about your treatment alternatives
- Conduct or arrange for medical review, auditing functions, fraud and abuse detection, program compliance, appeals, right of recovery and reimbursement/subrogation efforts, review of health plan costs, business management and administrative activities
- To contact you with information about your treatment or to provide information on health-related benefits and services that may be of interest to you

To obtain a copy of the privacy notice describing, in greater detail, the practices concerning use and disclosure of your health information, visit our website or you may obtain a copy from your agency benefits coordinator.

Medicare Part D

Medicare eligible retirees have access to a Medicare supplement plan. The supplemental plan does not include pharmacy benefits and retirees should enroll in a Medicare Part D plan for prescription drug benefits.

TERMS AND DEFINITIONS

Acquire Date

The acquire date is the date that establishes a relationship between you and your dependents, such as date of marriage for a spouse, date of birth for a natural child, or date of legal obligation if you are appointed as a guardian.

Claims

Claims are the bills received by the plan after a member obtains medical services.

Coinsurance

Coinsurance is the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service. The amount you pay in coinsurance (for eligible services) will count towards your out-of-pocket maximum.

Copay

A copay is a flat dollar amount that you pay for certain services like office visits and prescriptions.

Deductible

A fixed dollar amount you must pay each year in coinsurance before the plan pays certain benefits. See the benefit grid in your member handbook for details.

Drug List

The drug list is a list of covered drugs. The listing includes generic and preferred brand drugs covered by the plan. This list is often called a formulary.

Drug Tiers

The drugs covered by the state's pharmacy benefit are grouped into three tiers — generic, preferred brand and non-preferred brand. Each tier has a different copay amount.

Fully-Insured Plan

Under a fully insured plan, an insurance company, rather than a group sponsor (like the state) pays all claims. The sponsor pays a premium to the insurance company. Only the state's dental plans are fully insured.

Generic Drug (Tier One)

A generic drug (also called Tier One) is a Food and Drug Administration (FDA) approved copy of a brand name drug. A generic medicine is equal to the brand name product in safety, effectiveness, quality and performance. You pay the least when you fill a prescription with a generic drug.

Guarantee Issue

Guarantee issue means that you cannot be denied coverage and do not have to answer questions about your health history and long as you enroll within a certain amount of time.

Head of Contract

The head of contract is an employee who works for a participating employer group and enrolls in coverage during the initial eligibility timeframe. Two married employees who both work for participating employer groups could each be the head of their own contract or one could be the head of contract and the other a covered dependent spouse.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is legislation that protects health insurance coverage for persons who lose or change jobs and establishes a privacy rule and national standards for protecting personal health information. HIPAA means your personal health information can't be shared without your consent and protects your privacy.

In-Network Care

In-network care is provided by a network provider. Costs for in-network care are usually less expensive than out-of-network care as a result of special agreements between insurance carriers and providers.

Maximum Allowable Charge (MAC)

The maximum allowable charge (MAC) is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay the difference between the MAC and the actual charge.

Meeting Your Medical Deductible

Meeting your medical deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays benefits. It applies to hospital charges and other services that require coinsurance. It does not apply to services with a copay such as a visit to your primary care doctor or to prescription drugs. Note: The Limited PPO option has a separate deductible for pharmacy.

Network

A network is a group of doctors, hospitals and other health care providers contracted with a health insurance plan to provide services to plan members for set fees.

Non-Preferred Brand Drug (Tier Three)

A non-preferred brand drug (also called tier three) belongs to the most expensive group of drugs. You will pay the most if your prescription is filled with a non-preferred brand.

Out-of-Network Care

Out-of-network care refers to health care services from a provider who is not contracted with your insurance carrier. Costs for out-of-network care are usually more than for in-network care. The benefits paid are usually based on the maximum allowed by the plan. When out-of-network charges are higher than the maximum allowed, the member pays the difference.

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you will pay for your deductible and coinsurance each year. The out-of-pocket maximum does not include premiums or copays. Once you reach your out-of-pocket maximum, the plan pays 100 percent of covered medical expenses for the rest of the year.

Preferred Brand Drug (Tier Two)

A preferred brand drug (also called Tier Two) belongs to a group of drugs that cost more than generics but less than non-preferred brands.

Preferred Provider Organization (PPO)

A PPO gives plan participants direct access to a network of doctors and facilities that charge pre-negotiated (and typically discounted) fees for the services they provide to members. Plan participants may self-refer to any doctor or specialist in the network. The benefit level covered through the plan typically depends on whether the member visits an in-network or out-of-network provider when seeking care.

Premium

The amount you pay each month for your coverage, regardless of whether or not you receive health services. What you pay depends on where you work (state, higher education, local education or local government) and the PPO you select.

Prescription Drug Copay

Typically, members must pay a prescription drug copay when filling a prescription. This is the fixed dollar amount you pay, such as \$25 per prescription. The copay is lowest for a generic, higher for a preferred brand and highest for a non-preferred brand.

Preventive Care

Preventive care refers to services or tests that help identify health risks. For example, preventive care includes mammograms and colonoscopies as well as regular blood pressure checks. In many cases, preventive care helps a patient avoid a serious or even life-threatening disease.

Primary Care Physician

Primary care physician (also known as PCP) refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, an OB/GYN or a pediatrician, a nurse practitioner, physician's assistant, or nurse midwife (licensed healthcare facility only) working under the supervision of a primary care provider.

Self-Insured Plan

Under a self-insured plan, a group sponsor (like the State) or employer, rather than an insurance company, is financially responsible for paying the plan's expenses, including claims and plan administration costs. The state's health insurance plans are self-insured.

Special Enrollment Provision

A rule that allows persons to request enrollment beyond the initial eligibility period due to certain life events.

Special Qualifying Event

A personal change in status, such as divorce or termination of spouse or ex-spouse's employment, which may allow persons to change benefit elections.

The Plan

In the broadest sense of the word, Plan is the applicable State of Tennessee Preferred Provider Organization (PPO) Comprehensive Medical and Hospitalization Program. Plan may also refer to specific group plans within the larger comprehensive plan, such as the State Plan, the Local Education Plan, or the Local Government Plan.