2012 DECISION GUIDE

Annual Enrollment Transfer Period
October 1 – November 1, 2011

State and Higher Education

Active Employees and COBRA Participants

PARTNERS FOR HEALTH

If you need help…

Contact your agency benefits coordinator. Besides being a local benefits contact, your agency benefits coordinator has received special training in our insurance programs. If he or she cannot answer your question, you'll be directed to someone who can. If you are planning to retire in 2012, see your agency benefits coordinator for information on eligibility and enrollment. You may also review the "Continuation of Coverage for Retirees" section in the Plan Document, which is available on the publications page of the Benefits Administration website.

For additional information about a specific benefit or program, refer to the chart below.

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	1.800.253.9981	www.tn.gov/finance/ins/ www.partnersforhealthtn.gov Email: benefits.administration@tn.gov
Health Insurance	BlueCross BlueShield of Tennessee CIGNA	1.800.558.6213 1.800.997.1617	www.bcbst.com/members/tn_state/ www.cigna.com/stateoftn
Pharmacy Benefits	CVS Caremark	1.877.522.8679	www.caremark.com
Mental Health, Substance Abuse and Employee Assistance Program	Magellan	1.800.308.4934	www.magellanassist.com
Wellness and Nurse Advice Line	APS Healthcare	1.888.741.3390	www.partnersforhealthtn.gov
Dental Insurance	Assurant Employee Benefits Delta Dental	1.800.443.2995 1.800.223.3104	www.assurantemployeebenefits.com/stoftn www.deltadentaltn.com/statetn/
Basic Term Life and Accidental Death **Optional Accidental Death**	Dearborn National	1.800.348.4512	n/a
Optional Term and Universal Life	Unum Group	1.866.310.6784	w3.unum.com/enroll/StateofTennessee/index.aspx
Long-Term Care	MedAmerica	1.866.615.5824	www.ltc-tn.com
OTHER PROGRAMS			
Edison	TN Department of Finance & Administration		https://www.edison.tennessee.gov
Flexible Benefits (state employees only)	TN Department of Treasury	1.615.741.3131	www.treasury.tn.gov/flex
Employee Sick Leave Bank (state employees only)	TN Department of Human Resources	1.615.741.5431	www.tn.gov/dohr/

Enrollment forms and handbooks…

All enrollment forms and handbooks referenced in this Guide are located on our website **(www.tn.gov/finance/ins)** or you can get a copy from your agency benefits coordinator.

Online resources…

Visit the ParTNers for Health website (www.partnersforhealthtn.gov). Our ParTNers for Health website has information about all the benefits described in this Guide—plus definitions of insurance terms that may be unfamiliar and answers to common questions from members. The website is updated often with new information and frequently asked questions.

ENROLLMENT TRANSFER PERIOD

The annual enrollment transfer period (AETP) for 2012 benefits will be held from October 1 through November 1, 2011. The enrollment period allows members the opportunity to make the following insurance changes:

- Change health options — switch between the Partnership and Standard PPOs, **subject to eligibility***
- Change health insurance carriers — select either BlueCross BlueShield of Tennessee or CIGNA
- Enroll in health insurance for yourself or your eligible dependents (please note, a monthly late applicant fee will apply — see page 2)
- Cancel health coverage
- Enroll in, cancel or transfer between dental options
- Apply for optional life coverage, or to increase or decrease optional life coverage amounts, if eligible

*** Members enrolled in the Standard PPO may switch to the Partnership PPO for 2012. If you enrolled in the Partnership PPO for 2011 and you or your spouse did not meet the requirements of the Partnership Promise, you are not eligible to continue in this option during 2012. You will still have coverage; however, you will be automatically switched to the Standard PPO.**

If you DO NOT want to make changes

If you are happy with your current benefit selections, **no action** is required to remain enrolled in coverage. If you are currently enrolled and choose to stay in the Partnership PPO, you (and your covered spouse) are automatically agreeing to fulfill the 2012 Partnership Promise.

If you DO want to make changes

Members have two options when making health and dental benefit selections for 2012:

- Make your changes online, using Employee Self Service in Edison
- Complete an enrollment application and submit it to your agency benefits coordinator

Using Employee Self Service

Rather than completing a paper form and sending it to your agency benefits coordinator, you can make your changes online using the Edison system. You can access Edison from your computer at work or home. Edison is available to all state employees. Higher education employees should check with your agency benefits coordinator to find out if this option is available. Detailed information on how to make changes is available on our website.

The options you choose during the enrollment period will take effect on January 1, 2012, and remain in effect through December 31, 2012, unless you lose eligibility or have a qualifying event or family status change during the year. A qualifying event or family status change is something that results in a covered person becoming newly eligible for other coverage. Examples include birth, a change in marital status and new employment. If you or your covered dependent(s) experience one of these events and need to make changes to your coverage, or you need more information about reasons to cancel coverage and who qualifies, contact your agency benefits coordinator.

What's Changing for 2012

Not much is changing for 2012, but there are a few new and enhanced benefits. These include:

- Reduced copay for convenience care or urgent care facility visits
- New, separate out-of-pocket copay maximum for primary and specialist office visits
- Decrease in health insurance deductible and out-of-pocket maximums for those enrolled in the Employee + Child(ren) premium tier in both health options
- Reduced late applicant fee
- New low-cost copays for certain drugs when obtaining a 90-day supply — including diabetic medications and supplies

Urgent Care Copays

The copay to receive services at a convenience clinic or urgent care facility, such as a MinuteClinic® or Take Care Clinic℠, will decrease by $20 in each PPO option in 2012. The copay is the same for in- and out-of-network facilities.

Physician Office Visit Out-of-Pocket Copay Maximum

To reduce expenses for members who require frequent doctor visits, there will be a limit on the amount of money you pay in copays for in-network primary and speciality care. This benefit excludes the following:

- Visits subject to deductible and coinsurance, such as physical, occupational or speech therapy
- Chiropractic office visits

This out-of-pocket maximum is separate from your out-of-pocket maximum for services that require coinsurance.

Deductible and Out-of-Pocket Maximum Decrease

To correct a cost difference for two married employees who both work for an agency that participates in our plans, the deductible and out-of-pocket coinsurance maximum will decrease in 2012 for the "Employee + Child(ren)" premium category. This applies to both in- and out-of-network costs in both PPOs.

EMPLOYEE + CHILD(REN) DEDUCTIBLE			
PARTNERSHIP		STANDARD	
In-Network	Out-of-Network	In-Network	Out-of-Network
$550	$1,100	$1,100	$2,200

EMPLOYEE + CHILD(REN) OUT-OF-POCKET MAXIMUM			
PARTNERSHIP		STANDARD	
In-Network	Out-of-Network	In-Network	Out-of-Network
$2,150	$4,300	$2,800	$5,600

Late Applicant Fee

In 2012, the monthly late applicant fee for members who joined the plan during the 2011 AETP will be less. **In addition, employees or their eligible dependents who did not join the health plan when they were initially eligible will be allowed to enroll in benefits during AETP if they agree to pay the monthly late applicant fee while they are enrolled through December 31, 2013.**

	STATE/HIGHER EDUCATION
Employee Only	$65
Spouse Only	$72
Employee and Spouse	$137

Pharmacy

In 2012, copays will be lower for certain medications from the special, less costly 90-day network. **Diabetic medications and supplies will no longer be provided free of cost in 2012.** However, the plans are making changes to the pharmacy benefit on certain drug classes for members who choose to use the mail order benefit or a 90-day network retail pharmacy. As an incentive to use pharmacies that cost the plan less, there will be lower copays on a large group of maintenance drugs. For diabetics, the cost of some medications may go up compared to what you were paying previously. However, the cost of other drugs you are taking will probably go down depending on your particular situation. Below is a list of the drug groups that will cost less for members obtaining a 90-day supply:

- Statins (cholesterol lowering drugs)
- Oral diabetic medications, insulins and supplies
- Anti-hypertensives, including beta blockers, calcium channel blockers, diuretics and ACE/ARBs (angiotensin-converting enzyme inhibitors and angiotensin receptor blockers)

Some of the more common drugs used by our plan members which will be eligible for the reduced copays are: Metformin, Glimepiride, Actos, Januvia, Novolog, Simvastatin, Crestor, Lipitor, Pravastatin, Lovastatin, Lisinopril, Hydrochlorothiazide, Amlodipine and Atenolol. Please call CVS Caremark to determine if your particular medication may qualify.

If you choose to receive a 90-day supply of a medication listed in the above classes via mail order or from a 90-day mail-at-retail network pharmacy, you will pay the copay listed below.

For members who choose to receive a 30-day supply of their medication, the normal 30-day copay applies. See the benefit grid on page 4 for these copay amounts.

90-DAY MAINTENANCE COPAYS		
BRANDS	PARTNERSHIP	STANDARD
Generic	$5	$10
Preferred	$30	$40
Non-Preferred	$160	$180

HEALTH BENEFITS

Your Health Insurance Options

For 2012, subject to eligibility, you will continue to have the choice of two insurance options:

- Partnership PPO
- Standard PPO

And two insurance carriers:

- BlueCross BlueShield of Tennessee
- CIGNA Healthcare

Both PPOs cover services, treatments and products, such as:

- 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
- 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 and physician visit copay costs

Free preventive health services include, but are not limited to, flu vaccination, pneumococcal vaccination, annual preventive visit (i.e., physical exam), annual well woman visit, cholesterol test, osteoporosis screening for women and screenings for colon, breast or cervical cancer (women only) or prostate cancer (men only). **If other services or related treatment are received during the same visit, an office visit copay may apply**.

The Partnership PPO and Standard PPO cover the same services, treatments and products. However, for some procedures, different medical criteria may apply based on the carrier you select.

Each carrier has its own network of preferred doctors, hospitals and other health care providers. Many doctors and hospitals are in more than one network. So, you may find yours listed under both of the insurance carrier options. On the other hand, some doctors and hospitals may be in one network but not the other. **Check the networks carefully when making your selection.**

Although BlueCross BlueShield of Tennessee and CIGNA have PPO networks available throughout Tennessee, you will probably want to choose your insurance carrier based on whether or not your doctor, hospital or lab/facility participates in their network. Doctors and facilities move in and out of networks from time to time, so be sure to double check that you are comfortable with the provider options offered by the PPO network you select.

Depending on where you live, BlueCross BlueShield of Tennessee and CIGNA have slight variations in premiums because the networks have different costs in each region. If you're in East or Middle Tennessee, the CIGNA plan costs $10 more per month for employee only coverage and $20 more per month for all other premium levels. If you're in West Tennessee, the BlueCross BlueShield of Tennessee plan costs $10 more per month for employee only coverage and $20 more per month for all other premium levels.

Both carriers also offer discounts for certain value-added benefits not covered by traditional insurance. This could include programs for weight loss, tobacco cessation, fitness club membership or laser vision care. Refer to the carrier's member handbooks or websites for more information.

Individuals who select BlueCross BlueShield as their insurance carrier have access to providers in Network S. Individuals who select CIGNA have access to providers in the Open Access Plus, OA Plus, Choice Fund OA Plus.

Services that Require Copays

Services in this table ARE NOT subject to a deductible and costs DO NOT APPLY to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Preventive Care				
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, prostate, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No charge	$45 copay	No charge	$50 copay
Outpatient Services				
Primary Care Office Visit * • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25 copay	$45 copay	$30 copay	$50 copay
Specialist Office Visit * • Including surgery in office setting	$40 copay	$65 copay	$45 copay	$70 copay
Mental Health and Substance Abuse * [2] [3]	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation and results (not including advanced x-rays, scans and imaging)	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable	100% covered after office copay, if applicable	100% covered up to MAC after office copay, if applicable
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% up to MAC
Allergy Injection with Office Visit *	$25 copay primary; $40 copay specialist	$45 copay primary; $65 copay specialist	$30 copay primary; $45 copay specialist	$50 copay primary; $70 copay specialist
Chiropractors	Visits 1-20: $25 copay Visits 21 and up: $40 copay	Visits 1-20: $45 copay Visits 21 and up: $65 copay	Visits 1-20: $30 copay Visits 21 and up: $45 copay	Visits 1-20: $50 copay Visits 21 and up: $70 copay
Pharmacy				
30-Day Supply	$5 copay generic; $30 copay preferred brand; $80 copay non-preferred brand	Copay plus amount exceeding MAC	$10 copay generic; $40 copay preferred brand; $90 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$10 copay generic; $60 copay preferred brand; $160 copay non-preferred brand	Copay plus amount exceeding MAC	$20 copay generic; $80 copay preferred brand; $180 copay non-preferred brand	Copay plus amount exceeding MAC
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [4]	$5 copay generic; $30 copay preferred brand; $160 copay non-preferred	Copay plus amount exceeding MAC	$10 copay generic; $40 copay preferred brand; $180 copay non-preferred	Copay plus amount exceeding MAC
Urgent Care				
Convenience Clinic or Urgent Care Facility	$30 copay		$35 copay	
Emergency Room				
Emergency Room Visit (waived if admitted)	$80 copay		$100 copay	

*** Out-of-Pocket Maximum — per individual** (applies to **in-network** office visits for primary care, specialist care and mental health and substance abuse treatment); **$900 Partnership PPO; $1,100 Standard PPO**

Services that Require Coinsurance — Deductibles and Out-of-Pocket Coinsurance Maximums

Services in this table ARE subject to a deductible and eligible expenses CAN BE APPLIED to the annual out-of-pocket coinsurance maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK [1]	IN-NETWORK	OUT-OF-NETWORK [1]
Hospital/Facility Services • Inpatient care [3] • Outpatient surgery [3] • Inpatient mental health and substance abuse [2] [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care [3] • Home health • Home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [3]; outpatient • Skilled nursing facility [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [3] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies [3] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance	40% coinsurance
	10% coinsurance non-contracted providers (i.e. dentists, orthodontists)		20% coinsurance non-contracted providers (i.e. dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [3]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
Deductible				
Employee Only	$350	$700	$700	$1,400
Employee + Child(ren)	$550	$1,100	$1,100	$2,200
Employee + Spouse	$700	$1,400	$1,400	$2,800
Employee + Spouse + Child(ren)	$900	$1,800	$1,800	$3,600
Out-of-Pocket Coinsurance Maximum				
Employee Only	$1,350	$2,700	$1,700	$3,400
Employee + Child(ren)	$2,150	$4,300	$2,800	$5,600
Employee + Spouse	$2,700	$5,400	$3,400	$6,800
Employee + Spouse + Child(ren)	$3,500	$7,000	$4,500	$9,000

No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. 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.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS difference between MAC and actual charge.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization, and intensive outpatient therapy.

[3] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

[4] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies; statins.

Monthly Premiums for State Plan Active Employees

	EAST AND MIDDLE TENNESSEE				WEST TENNESSEE			
	BCBST		CIGNA		BCBST		CIGNA	
	EMPLOYEE SHARE	EMPLOYER SHARE	EMPLOYEE SHARE	EMPLOYER SHARE	EMPLOYEE SHARE	EMPLOYER SHARE	EMPLOYEE SHARE	EMPLOYER SHARE
PARTNERSHIP PPO								
Employee Only	$106.39	$484.67	$116.39	$484.67	$116.39	$484.67	$106.39	$484.67
Employee + Child(ren)	$159.59	$727.01	$179.59	$727.01	$179.59	$727.01	$159.59	$727.01
Employee + Spouse	$223.42	$1,017.81	$243.42	$1,017.81	$243.42	$1,017.81	$223.42	$1,017.81
Employee + Spouse + Child(ren)	$276.62	$1,260.15	$296.62	$1,260.15	$296.62	$1,260.15	$276.62	$1,260.15
STANDARD PPO								
Employee Only	$131.39	$484.67	$141.39	$484.67	$141.39	$484.67	$131.39	$484.67
Employee + Child(ren)	$184.59	$727.01	$204.59	$727.01	$204.59	$727.01	$184.59	$727.01
Employee + Spouse	$273.42	$1,017.81	$293.42	$1,017.81	$293.42	$1,017.81	$273.42	$1,017.81
Employee + Spouse + Child(ren)	$326.62	$1,260.15	$346.62	$1,260.15	$346.62	$1,260.15	$326.62	$1,260.15

Monthly Premiums for State Plan COBRA Participants

	EAST AND MIDDLE TENNESSEE		WEST TENNESSEE	
	BCBST	CIGNA	BCBST	CIGNA
PARTNERSHIP PPO				
Employee Only	$602.88	$612.88	$612.88	$602.88
Employee + Child(ren)	$904.33	$924.33	$924.33	$904.33
Employee + Spouse	$1,266.05	$1,286.05	$1,286.05	$1,266.05
Employee + Spouse + Child(ren)	$1,567.50	$1,587.50	$1,587.50	$1,567.50
STANDARD PPO				
Employee Only	$628.38	$638.38	$638.38	$628.38
Employee + Child(ren)	$929.83	$949.83	$949.83	$929.83
Employee + Spouse	$1,317.05	$1,337.05	$1,337.05	$1,317.05
Employee + Spouse + Child(ren)	$1,618.50	$1,638.50	$1,638.50	$1,618.50

Partnership Promise

Members who enroll in the Partnership PPO must agree to the terms of the Partnership Promise each year. The 2011 Partnership Promise encouraged members to become more aware of their health by completing an online questionnaire to assess potential risk factors for disease and by having a biometric screening to learn important health "numbers" (e.g., body mass index, blood pressure, cholesterol and blood glucose levels).

The requirements of the Partnership Promise in 2012 are still simple. Members and covered spouses must:

- Participate in health coaching if an opportunity to improve your health is identified by the Partners for Health wellness staff during 2012 *
- Keep address, phone number and email, if you have one, current with your employer

Members will not have to attend a screening or complete a health questionnaire in 2012. **However, we are asking members to take a more active role in managing their health and wellness.** For members with certain health conditions or risk behaviors, this will involve working with a health coach to establish goals to improve their health and reduce identified health risk behaviors. Members will also be required to keep their contact information up to date with their employers. If a member's information changes during the year, it is the member's responsibility to make sure the employer has the correct information on record.

Both you and your covered spouse must meet the 2012 Partnership Promise requirements to remain eligible for the Partnership PPO in 2013. All members enrolled in the Partnership PPO must fulfill the Partnership Promise even if the Partnership PPO is not the primary insurance plan. Children do not have to meet the requirements of the Partnership Promise.

Working with a Health Coach

If you enroll in the Partnership PPO and you are asked to participate in health coaching, a health coach will work with you to set goals, provide tools to track your progress and offer educational resources to help you make better choices and manage your health. A health coach is a trained health care professional who can help you achieve your personal health goals. All conversations with your health coach are confidential and cannot be shared with your employer, your insurance carrier (BlueCross or CIGNA) or the State. Information will only be shared with your health care provider with your permission.

Your coach can help you:

- Understand your medications
- Understand any lab test results or doctor's directions
- Set goals for healthier living
- Plan healthy meals and exercise habits
- Find a doctor, if you need one

There are two types of health coaching programs:

- **Lifestyle Management** programs can help you improve your health by changing habits. They can help with high blood pressure, high cholesterol, tobacco cessation and weight management.
- **Disease Management** programs, for those with chronic health conditions, work with you and your doctor to help you with self-management skills to make sure that you are taking prescribed medicines and are getting the correct preventive care. Disease management programs include asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), diabetes, depression, obesity and musculoskeletal conditions such as low back pain and arthritis.

When you participate in health coaching, a ParTNers for Health wellness coach may contact you at any time during the plan year (January 1 – December 31, 2012). You may communicate via phone or email. There is no set number of emails or phone calls required. You and your coach will talk as needed, based on your health issues, and will develop a schedule that works best for you. Coaches are available Monday – Friday from 8:00 a.m. until 8:00 p.m. CST.

The ParTNers for Health wellness staff will determine who should participate in health coaching based on medical conditions and behaviors that may negatively affect your health and/or cause long-term health issues. Health conditions and behaviors are determined using information from health insurance claims, your health questionnaire responses and health screening results,

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

including cholesterol levels, blood pressure, glucose levels and body mass index (BMI).

Opportunities to improve health and behaviors are based on national standards and guidelines scientifically proven to benefit health and wellness or prevent the development of chronic health conditions. Examples of opportunities to improve someone's health and wellness include:

> A member with diabetes and high blood sugar may benefit from assistance with nutrition, blood sugar monitoring, weight loss, education or other needs.

> A member who has been hospitalized for heart disease, heart failure or other conditions may need assistance understanding discharge instructions, managing medications and following his or her recommended plan of care once he or she is released.

> A member with asthma or chronic obstructive pulmonary disease (COPD) who has frequent shortness of breath or infections requiring emergency room visits may benefit from coaching on the appropriate use of inhaler medications, self-monitoring of symptoms or peak flow measurements at home or getting vaccinated for the flu or pneumonia.

> A member who has health risk behaviors such as tobacco use or unhealthy eating habits resulting in weight gain may benefit from coaching to make lifestyle improvements.

> A member with depression, arthritis or low back pain may benefit from coaching to provide encouragement and guidance for coping with symptoms and maintaining the ability to perform normal activities.

All health coaches are employees of the company the state has contracted with to manage the wellness program. Health coaches have expertise in a variety of areas. They include registered nurses and dieticians, clinical social workers, certified health educators and those with degrees in exercise physiology, exercise science and health promotion. This vast experience allows you access to speak with different coaches based on your needs and personal health goals.

Members can work with both their health coach and primary care provider to develop a plan that is clinically appropriate. **Your physician's recommendations will always take priority over any recommendation made through the ParTNers for Health Wellness Program.**

You should share your physician's plan of care or health recommendations with your coach so that he/she can be aware and work as part of your health care team. With your permission, your coach can communicate with your health care provider's office to share your health goals and plan of care.

To be considered an active participant, you must work with your health coach to:

> Identify challenges to achieving or maintaining good health and set long- and short-term goals.

> Develop an individualized plan of care specific to your needs. Your plan of care could include discussing with your provider nationally recommended disease-specific measures or receiving appropriate preventive care services for your age and gender. With guidance from your coach, you will be able to choose the disease-specific or preventive care services that are most important to achieving your own health goals.

> Communicate (via phone or email) as needed.

> Engage in other health and wellness activities such as webinars, community events, or on-line health modules provided by the Wellness Program.

> Work to make continued positive improvement toward meeting the goals in your plan of care.

Failure to follow your individualized plan of care can make you ineligible for the Partnership PPO and transfer you to the Standard PPO in 2013 with a higher premium, deductible and out-of-pocket costs.

As long as you make an effort to work towards your goals and communicate with the health coach, you can remain in the Partnership PPO. Your health coach will work with you to establish reasonable and achievable goals, which can be adjusted at any time when appropriate.

If you are found to be eligible for a disease or lifestyle management program, you will be expected to participate in the program until your goals are met. If you are able to adequately improve your health and reduce your health risk behaviors, you will graduate from coaching. However, a future change in your health status might prompt your coach to follow up with you to enroll in a disease or lifestyle management program again and to establish new goals and plans to improve your health and wellness. You may choose to opt-out of a program but it will impact your eligibility for the Partnership PPO in 2013.

DENTAL BENEFITS

Your Dental Insurance Options

Eligible employees can choose between two dental options—the Prepaid Plan and the Preferred Dental Organization (PDO).

- The Prepaid Plan provides dental services at predetermined copay amounts from a limited network of participating dentists and specialists
- Under the PDO, you can choose any dentist; however, you receive maximum benefits when you use a network provider

During the enrollment period, eligible employees can enroll in or transfer between the two options.

As with health insurance, you pay premiums up front for dental coverage regardless of whether or not you use any services. **If you don't ask to change your current dental carrier or cancel coverage, you will keep your current coverage.**

Prepaid Plan — Assurant Employee Benefits

The Prepaid Plan is administered by Assurant Employee Benefits. It provides dental services at predetermined copay amounts. These copays are reduced fees for dental treatments from your selected participating general dentist or from any participating specialist. There are no deductibles to meet, no claims to file, no waiting periods for covered members, no annual dollar maximum and pre-existing conditions are covered. Referrals are not required. To receive benefits, you must select a dentist from the Prepaid Plan list, complete a dentist selection form and return it to Assurant. The form is located on the back of the prepaid dental handbook which is available on our website or you can get a copy from your agency benefits coordinator.

Premiums **will not** increase in 2012 in the prepaid plan.

PDO — Delta Dental

The PDO is administered by Delta Dental. With the PDO, you can choose any dentist; however, you receive maximum benefits when visiting an in-network provider. You pay coinsurance for covered services, which is a percentage of the maximum allowable charge, or MAC. In addition, a deductible applies for out-of-network dental care, but not for in-network services.

No referrals are required with the PDO, and you or your dentist will file claims for covered services. Some services require waiting periods and limitations and exclusions apply.

Premiums **will** increase slightly in 2012 for the PDO.

Monthly Premiums for Active Members

	PREPAID PLAN	PDO PLAN
Employee Only	$9.35	$19.86
Employee + Child(ren)	$19.42	$45.66
Employee + Spouse	$16.57	$37.56
Employee + Spouse + Child(ren)	$22.79	$73.50

Monthly Premiums for COBRA Participants

	PREPAID PLAN	PDO PLAN
Employee Only	$9.54	$20.26
Employee + Child(ren)	$19.81	$46.57
Employee + Spouse	$16.90	$38.31
Employee + Spouse + Child(ren)	$23.25	$74.97

Covered Dental Services

Here is a comparison of deductibles, copays and your share of coinsurance for 2012 under the dental options. Costs represent what the member pays.

	PREPAID OPTION		PDO OPTION	
COVERED SERVICES	GENERAL DENTIST	SPECIALIST DENTIST	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None		None	$100 single; $300 family, per policy year [5]
Annual Maximum Benefit	None		$1,500 per person, per policy year	
Pre-existing Conditions	Covered		Some exclusions	
Office Visit	$10 copay [3]		No charge	20% of MAC
Periodic Oral Evaluation	No charge		No charge	20% of MAC
Routine Cleaning Adult	No charge		No charge	20% of MAC
X-ray — Intraoral, Complete Series	No charge	$5 copay	20% of MAC	40% of MAC
Amalgam (silver) Filling — 2 Surfaces Permanent	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$250 copay	$600 copay	50% of MAC	
Major Restorations — Crowns (porcelain fused to high noble metal)	$275 copay, plus lab fees [1]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	$100 copay	$120 copay	50% of MAC	
Dentures — Complete Upper	$310 copay, plus lab fees [1]		50% of MAC	
Orthodontics	25% off participating orthodontist's usual fees		50% of MAC	
• Annual Deductible	None		None	
• Lifetime Maximum	None		$1,250 (including any benefits received under a prior dental plan) [2]	
• Waiting Period	None		12 months	
• Age Limit	None		Up to age 19	

MAC—Maximum Allowable Charge

The benefits listed are a sample of the most frequently utilized dental treatments. Refer to vendor materials for complete information on coverage, limitations and exclusions.

[1] Members are responsible for additional lab fees for these services.

[2] If an individual had coverage through another dental plan, they may also have had a lifetime maximum for orthodontia. The orthodontia maximum is a lifetime benefit, which means, if an individual enrolls under the PDO, the benefit amount will not start over again. The benefits for orthodontia under the PDO would be adjusted based on the benefits a member may have received previously through another dental plan.

[3] A charge of $20 may apply for a missed appointment when the member does not cancel at least 24 hours prior to the scheduled appointment.

[4] A 12-month waiting period applies.

[5] Does not apply to diagnostic and preventive benefits such as periodic oral evaluation, cleaning and x-ray.

ADDITIONAL BENEFITS

Basic Term Life and Accidental Death Insurance

The State provides a basic level of term life insurance ($20,000) and accidental death and dismemberment insurance ($40,000) to all employees. If you are enrolled in health insurance as the head of contract, your coverage increases with your salary — to a maximum of $50,000 for basic term life insurance and $100,000 for accidental death insurance.

Optional Universal Life and Term Life Insurance

If you qualify, you may be able to purchase optional coverage for yourself and coverage for your dependent spouse and children. You can apply for up to five times your annual base salary (to a maximum of $300,000) for yourself and the equivalent of your annual base salary (to a maximum of $30,000) for your spouse. You can also apply for coverage for your children equal to $2,500 or $5,000.

If you are currently enrolled and are eligible for an increase, information will be mailed to you.

If you and/or your dependents are not presently enrolled, you will be required to present evidence of insurability through a health questionnaire. For enrollment forms and additional information, call Unum Group or visit their website.

Premiums for optional term life will decrease by three percent effective January 1, 2012.

Optional Accidental Death Insurance

If you would like additional accident protection, you may enroll in Optional Accidental Death and Dismemberment insurance for yourself and your dependents. Coverage is available at low group rates—no questions asked. Premiums vary by age and salary. The maximum benefit available is $60,000. The enrollment form is available on our website.

Employee Assistance Program (EAP)

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. All services are confidential, and available at no cost to members. Services can be easily accessed by calling Magellan — available 24 hours a day, 365 days a year. You and your eligible dependents may get up to five counseling sessions (effective 2012) per problem episode at no cost to you.

Long Term Care

Qualified employees, their eligible dependents (spouse and children ages 18 through 25), 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, a serious illness or an accident may bring 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.

You and your eligible family members may apply for long-term care coverage at any time, but will be subject to medical underwriting review for approval to enroll. Call MedAmerica or refer to their website to obtain enrollment information.

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 MedAmerica. Direct billing or payment by bank draft or credit card can be set up on a quarterly, semi-annual or annual basis.

Flexible Benefits

State employees (excludes higher education and off-line agencies) have access to a flexible benefits plan. This program is administered by the Department of Treasury and is designed to help employees reduce taxes. It allows you to be reimbursed for certain expenses from your pre-tax rather than your after-tax income.

All state employees enrolled in insurance benefits are automatically enrolled in the program. This means that the premiums you pay for health or dental insurance are automatically paid with tax-free earnings.

The program also offers you the opportunity to pay medical expenses, dependent care expenses and parking and transportation expenses. Enrollment in these additional options is not automatic and you must apply to participate.

Higher Education employees have access to their own flexible spending accounts. Please contact your agency benefits coordinator for additional information.

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.

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.

If you are interested in participating in either a medical or dependent day care account, you must sign up each year during the enrollment period. Selections made for medical and dependent day care in previous years do not continue automatically.

If you want a medical and/or dependent day care reimbursement account in 2012, you must sign up between October 1 through November 1, 2011 — even if you are already participating. You can complete an enrollment form or enroll online using Edison ESS.

With a **parking reimbursement account,** you can set aside up to $230 per month to pay for qualified parking expenses with your pre-tax contributions. An employee may enroll in a parking reimbursement account at any time. You are not required to re-enroll annually.

With a **transportation reimbursement account,** you can set aside up to $120 per month to pay for qualified transportation expenses with your pre-tax contributions. An employee may enroll in a transportation reimbursement account at any time. You are not required to re-enroll annually.

Employee Sick Leave Bank

The Tennessee Department of Human Resources administers the Employee Sick Leave Bank (SLB). The SLB provides sick leave to qualifying members who are medically 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.

Open enrollment is August 1 through October 31 each year. You must be a full-time state employee for 12 consecutive months and have at least six days of sick leave by November 1 of your enrollment year. New members must contribute four sick leave days to enroll. This information is a summary only. See the SLB Guidelines, eligibility requirements, FAQs and enroll on-line on the SLB website (www.tn.gov/dohr/) — click on the "For Employees" link.

Glossary of Terms

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 for services that require coinsurance before the plan pays certain benefits. See the benefit grid in your member handbook for details.

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.

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.

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 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.

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

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.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, or national origin. If you have a complaint regarding discrimination, please call 1.866.576.0029 or 615.741.4517.

The information contained in this Decision Guide is a brief, general overview of some of the benefits available to you through the State of Tennessee. More complete and specific information is contained within the formal plan documents. If there is any discrepancy between the information in this Guide and the formal plan documents, the plan documents will govern in all cases.

Tennessee Department of Finance and Administration. Authorization Number 317379, 68,000 copies, August 2011.
This public document was promulgated at a cost of $0.32 per copy.

STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
26TH FLOOR, 312 ROSA L. PARKS AVENUE
WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102

PRESORTED STANDARD
U.S. POSTAGE
PAID
NASHVILLE, TN
PERMIT NO. 936

PARTNERS FOR HEALTH

OPEN IMMEDIATELY

IMPORTANT BENEFITS INFORMATION ENCLOSED