

**PARTNERS
FOR HEALTH**

**State Group
Insurance Program**

Continuing Insurance at Retirement

Local Government
January 2017

If you need help...

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

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 — M-F, 8-4:30	tn.gov/finance partnersforhealthtn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness and Nurse Advice Line	Healthways	888.741.3390 — M-F, 8-8	partnersforhealthtn.gov (wellness tab)
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	mybenefits.metlife.com/ StateOfTennessee
Vision Insurance	EyeMed Vision Care	855.779.5046 — M-Sat, 7:30-10 Sun, 10-7	eyemedvisioncare.com/stoftn
Long-term Care Insurance	MedAmerica	866.615.5824 — M-F, 8:30-6	ltc-tn.com
Medicare Supplement	POMCO	888-477-9307	TheTennesseePlan.com

Forms and handbooks...

All enrollment forms and handbooks referenced in this guide are located on our website at tn.gov/finance.

Online resources...

Visit the **ParTNers for Health website at 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.

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INTRODUCTION

Overview

The insurance options available to you at retirement are outlined in this guide. The first section explains eligibility and enrollment requirements and includes two subsections. The first is for Tennessee Consolidated Retirement System (TCRS) participants. The second is for non-TCRS participants. It is important that you refer to the subsection that applies to you. If your agency does not participate in the Tennessee Consolidated Retirement System, you should review the non-TCRS section.

If your first employment with the participating agency commenced on or after July 1, 2015, you are not eligible to continue insurance at retirement.

For Additional Information

Your agency benefits coordinator (ABC) is your primary contact. He or she can provide you with forms and handbooks you need. For questions about eligibility, contact Benefits Administration. Our service center is your main point of contact regarding insurance once you retire.

All forms and handbooks referenced in this guide are on the Benefits Administration website. You can also get copies by calling our office or emailing retirement.insurance@tn.gov. You must include your Edison ID (found on your Caremark card) and your address in your email.

Our Partners for Health website also has information about your benefits, definitions and answers to common questions.

Authority

Benefits and premiums for local government members are set by the Local Government Insurance Committee. The committee is authorized to:

- add, change or end any coverage offered through the state group insurance program
- change or discontinue benefits
- set premiums
- change the rules for eligibility at any time, for any reason

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

TCRS PARTICIPANTS

Continuing Coverage at Retirement

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement until you become eligible for Medicare. Covered dependents can also continue coverage until they become eligible for Medicare or no longer qualify as eligible dependents.

If you are eligible for Medicare, you may be eligible for Medicare supplement coverage. More information about the state's Medicare supplement plan is included in this guide.

To continue insurance benefits, the agency from which you retire must continue to participate in the local government plan. If your former agency leaves the state group insurance program, you and your dependent's coverage will be canceled.

If your spouse is an employee enrolled in state group health insurance, you may continue coverage as a dependent on his or her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retirees who are Medicare eligible are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the state group health plan via the special enrollment provision.

You may also be eligible to enroll in dental and vision coverage. This guide explains your options and the rules for each type of coverage.

Service Requirements

You must have at least ten years of creditable service with the agency you are retiring from to continue insurance coverage. Unused sick leave may be counted. Military service that did not interrupt employment, service that was previously cashed out and not paid back to TCRS, educational leave, leave of absence or service with another local government agency cannot be counted.

The eligibility guidelines are:

- Ten years of creditable service, must be age 55 or older and at least three years of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.
- Twenty years of creditable service, must be age 55 or older and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.
- Thirty years of creditable service and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active coverage ends.

The requirement for immediate commencement of retirement benefits will be waived if you become insured by the state, a participating local education agency or another participating local government agency.

The one-year and three-year participation requirements will be waived if the local government agency has joined the state plan for the first time and has not participated in the plan for that length of time.

You must receive a monthly TCRS retirement benefit to continue coverage. If you choose a lump-sum retirement benefit you are not eligible to continue insurance at retirement.

Detailed information on the rules to continue insurance as a retiree can be found in the Local Government Plan Document. This document is available in the publications section of the Benefits Administration website.

Application to Continue Group Health Coverage

You must submit an application to continue coverage at retirement to your ABC within one full calendar month of the end of active insurance. You must continue in the same health insurance option in which you are currently enrolled. You can change carriers if you move outside the service area. You will also be able to make changes to your insurance during the annual enrollment period each fall.

Effective Date of Retiree Group Health Coverage

Retiree coverage is effective on the first day of the month following the end of active insurance coverage.

Individuals Eligible for Medicare

If you are eligible for Medicare Part A, you cannot continue in group health coverage, unless grandfathered by the Local Government Insurance Committee. You may apply for the state's Medicare supplemental coverage called The Tennessee Plan. You must be enrolled in at least Medicare Part A and receive a monthly TCRS pension benefit. You may also apply to cover your dependents who are eligible for Medicare when you enroll in The Tennessee Plan. If you qualify and enroll within 60 days of initial eligibility, you cannot be turned down for coverage due to age or health. The initial eligibility date is the date of TCRS retirement, the date active state group health coverage ends or the date of Medicare eligibility, whichever is later.

The Tennessee Plan is a supplement for Medicare parts A and B that helps fill most of the coverage gaps that Medicare creates. It does not cover prescription drugs. If you participate in The Tennessee Plan, you will need a separate Part D plan for your prescription drug needs. The Tennessee Plan will not coordinate benefits if you are currently enrolled in or join a Medicare advantage plan. This means if you have a Medicare advantage plan, The Tennessee Plan will not pay out any benefits.

Application for Medicare Supplement Coverage

If you are eligible for Medicare at retirement you can select Medicare supplement coverage on the application to continue insurance at retirement. You have 60 days from the initial eligibility date to enroll. Coverage is effective the first of the month following the end of your active insurance coverage or the first of the month following your date of retirement, whichever is later.

If you become eligible for Medicare due to age after retirement you will be sent an application approximately three months before your 65th birthday. The application must be submitted within 60 days of Medicare eligibility. Coverage will become effective on your date of Medicare entitlement provided the application is received timely. If you enroll in The Tennessee Plan and your spouse becomes entitled to Medicare at a later date, you have 60 days from the date of your spouse's eligibility to apply to add him or her to coverage.

If enrollment is not selected within 60 days of initial eligibility, you and your eligible dependent may apply through medical underwriting. Enrollment is subject to approval and may be denied. Benefits Administration will submit the application for review to the vendor. You must be enrolled in The Tennessee Plan to cover a dependent.

Once approved, you will receive an ID card from the vendor. It will show your name, identification number and effective date. If you are not satisfied with The Tennessee Plan, you can cancel it within 30 days after receipt. You will receive a refund of premiums paid in advance. Any claims paid during this period will be recovered.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement.

COBRA Dental

If you are enrolled in the state-sponsored dental plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. Please note on the COBRA enrollment form that you are a TCRS retiree.

Retiree Dental

You may also choose to enroll in retiree dental coverage. Just select dental on your application to continue insurance at retirement. To enroll you must receive a monthly TCRS pension benefit. Dependent-only coverage is not available.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement.

COBRA Vision

If you are enrolled in the state-sponsored vision plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. COBRA vision premiums cannot be deducted from your TCRS pension check.

Retiree Vision

If you continue health insurance at retirement, you are eligible for retiree vision coverage. If you do not select vision coverage at retirement, you can enroll during the annual enrollment period. Coverage will end when your group health enrollment ends. Dependents enrolled in group health coverage are eligible for coverage even if you are not enrolled in group health coverage.

Long-term Care Coverage

You can continue this coverage under the same terms and conditions as active employees. Coverage is guaranteed renewable, so it can never be canceled as long as you continue to pay the premium. Premiums can be deducted from your monthly TCRS pension benefit. You may also choose to have the premium deducted from your bank account or set up direct billing with the insurance carrier. All questions should be directed to the carrier.

ELIGIBILITY AND ENROLLMENT

NON-TCRS PARTICIPANTS

Continuing Coverage at Retirement

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement for yourself until you become eligible for Medicare. Covered dependents can also continue coverage until they become eligible for Medicare or no longer qualify as eligible dependents.

To continue insurance benefits, the agency from which you retire must continue to participate in the local government plan. If your former agency leaves the state group insurance program, your and your dependent's coverage will be canceled.

If your spouse is an employee enrolled in state group health insurance, you may continue coverage as a dependent on his or her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retirees who are Medicare eligible are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the state group health plan via the special enrollment provision.

You may also be eligible to continue dental and vision coverage. This guide explains your options and the rules for each type of coverage.

Service Requirements

You must have at least ten years of creditable service with the agency you are retiring from to continue insurance coverage. Unused sick leave may be counted. Military service that did not interrupt employment, educational leave, leave of absence or service with another local government agency cannot be counted.

The eligibility guidelines are:

- Ten years of creditable service, must be age 55 or older and at least three years of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.
- Twenty years of creditable service, must be age 55 or older and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.
- Thirty years of creditable service and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement insurance starts must immediately follow the date your active coverage ends.

Public safety employees (police and firemen)

To be eligible to continue insurance at retirement, you must:

- Have 25 years of creditable service, be age 50, be enrolled in the plan for one full year of coverage immediately prior to retirement and be qualified for an unreduced benefit.

Utility board members

To be eligible to continue insurance at retirement, you must:

- Have 20 years of creditable service, be age 55 and be enrolled in the plan for one full year of coverage immediately prior to retirement.
- Have 30 years of creditable service and be enrolled in the plan for one full year of coverage immediately prior to retirement.

The date retirement benefits start must immediately follow active coverage ending.

The requirement for immediate commencement of retirement benefits will be waived if you become insured by the state, a participating local education agency or another participating local government agency.

The one-year and three-year participation requirements will be waived if the local government agency has joined the state plan for the first time and has not participated in the plan for that length of time.

Application to Continue Group Health Coverage

You must submit an application to continue coverage at retirement to your ABC within one full calendar month of the end of active insurance. You must continue in the same health insurance option in which you are currently enrolled. You can change carriers if you move outside the service area. You will also be able to make changes to your insurance during the annual enrollment period each fall.

Effective Date of Retiree Group Health Coverage

Retiree coverage is effective on the first day of the month following the end of active insurance coverage.

Individuals Eligible for Medicare

If you are eligible for Medicare Part A, you cannot continue in group health coverage, unless grandfathered by the Local Government Insurance Committee. The state's Medicare supplement coverage is not available to non-TCRS local government members.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement. If you are enrolled in the state-sponsored dental plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. Retiree dental coverage is not available to non-TCRS participants.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement. If you are enrolled in the state-sponsored vision plan, you can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. Retiree vision coverage is not available to non-TCRS participants.

Long-term Care Coverage

You can continue this coverage under the same terms and conditions as active employees. Coverage is guaranteed renewable, so it can never be canceled as long as you continue to pay the premium. You may choose to have the premium deducted from your bank account or set up direct billing with the insurance carrier. All questions should be directed to the carrier.

GENERAL INFORMATION FOR ALL MEMBERS

Dependent Coverage

You may continue coverage for eligible dependents if they are covered at your retirement. Newly acquired dependents must be added within 60 days. If you are no longer eligible for the group health plan you cannot add dependents to your coverage.

Dependent Eligibility

The following dependents are eligible for coverage:

- Your spouse (legally married)
- 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 application to continue insurance at retirement. 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.

Children who are mentally or physically disabled and not able to earn a living may continue health, dental and vision 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 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.

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

Adding New Dependents

To add new dependents to your coverage, submit a retiree insurance change application within 60 days of the date the 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. Proof of the dependent's eligibility is required. Refer to the dependent definitions and required documents chart for the types of proof you must provide. Premium changes start on the first day of the month in which the dependent is acquired or the first of the next month depending on the coverage start date. A 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 enroll if he or she has a qualifying event under the special enrollment provisions or during the annual enrollment period.

If you have family coverage

- The new dependent can enroll if he or she has a qualifying event under the special enrollment provisions or during the annual enrollment period.
- The new dependent can also enroll if the level of family coverage you had on the date the dependent was acquired is sufficient to include the 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 about qualifying events is provided under the special enrollment provisions topic in this section of this guide.

Updating Personal Information

You must update personal information, such as home address, by calling the Benefits Administration service center. You will be required to provide the last four digits of your social security number, Edison ID, date of birth and previous address. You must also confirm authorization of the change before our office can update your information. It is your responsibility to keep your address and phone number current with Benefits Administration. TCRS retirees must submit a separate request directly to TCRS.

Annual Enrollment Period

During the fall of each year, you can make changes in your health, vision or dental coverage. Information is mailed to your home address prior to the enrollment period. The options you choose during the enrollment period will take effect on the following January 1. Coverage will remain in effect through December 31.

Canceling Health, Vision and Dental Coverage

Outside of the annual enrollment period, you can only cancel coverage for yourself and your dependents, if:

- You lose eligibility for the state group insurance program, or
- You experience a special qualifying event, family status change or other approved qualifying event, or
- You are enrolled in the prepaid dental option and there is not a participating general dentist within a 40-mile radius of your home

You must notify Benefits Administration within one full calendar month 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. In the case of 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 only cancel coverage outside of the annual enrollment period if you become newly eligible for another plan. You have 60 days from the date of the event to turn in an application and proof to Benefits Administration. The required proof is shown on the application. Approved reasons to cancel are:

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

To cancel coverage, you must submit an insurance cancel request application. This form is available in the forms section of the Benefits Administration website in the retirement section.

If You Do Not Apply When First Eligible

If you do not apply to continue health coverage within a full calendar month of your initial eligibility, you may only apply later if you experience a special qualifying event. To apply you must still be eligible for retiree health coverage and meet the criteria to continue coverage at the time your employment ended. If you are no longer eligible for health coverage, you may not enroll your dependents through a special enrollment event.

Special Enrollment Provisions

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that 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, dental and vision coverage.

The following are considered special qualifying events if they result in a loss of coverage:

- Death of a spouse or ex-spouse
- Divorce
- Legal separation
- Loss of eligibility (does not include 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)

If you experience one of these events, contact Benefits Administration or complete the retiree insurance change application. Application must be made within 60 days of the loss of coverage.

Important Reminders

- If enrolling dependents who qualify, you may change to another health option, if eligible
- Premiums for coverage type selected must be paid before the coverage can start

- Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause

Reinstatement Following Voluntary Cancellation

If you cancel coverage and change your mind, coverage can be reinstated if you meet all of the following conditions:

- Premiums are paid current on the coverage termination date;
- You and your dependents continue to meet the eligibility requirements; and
- You submit a written request for reinstatement within one full calendar month of the coverage termination date.

Disability Participants

If you experience an injury or illness which results in disability and have at least five years of creditable service, you may be able to continue health coverage as a disability retiree. There can be no lapse in coverage. The date retirement benefits start (retirement date) must be on or before the date your active coverage ceased. If you are eligible for a service retirement, you must prove that total disability existed at the time of retirement. Proof of total disability must be shown by submitting an award letter from the Social Security Administration or approval by TCRS based on review of medical records. The required proof must show total disability existed on or before the date your active coverage ended.

If the effective date of your disability retirement is determined to be after the date that your active coverage ended, you are not eligible for reinstatement of health coverage.

If eligible for Medicare, you cannot continue coverage under the local group health government plan.

Coverage for Dependents in the Event of Your Death

Survivor insurance is a continuation of insurance that allows covered dependents to apply to continue enrollment in the event of your death. There is no provision to allow enrollment of your non-covered dependents after your death.

Group Health

Your surviving dependents will receive six months of free health insurance coverage. Dependents must be covered at the time of your death and continue to meet eligibility rules. The surviving dependent must apply to continue coverage within 60 days of the expiration of the six months of free coverage.

Medicare Supplement

Your surviving dependents may continue coverage if they were enrolled in the Medicare supplement plan at the time of your death. Surviving dependents must apply to continue coverage within 60 days of the end of coverage under your enrollment.

Dental and Vision Coverage

Your surviving dependents may apply to continue coverage after your death as long as they still meet the eligibility rules. Application must be made within 60 days.

Premiums for Surviving Dependents

Premiums will be deducted from any continuing TCRS retirement benefits. Otherwise, individuals will be billed directly. Dependents acquired by the survivor(s) after your death are not eligible for coverage.

Premium Payment

TCRS Retiree

Premiums are deducted from your monthly TCRS pension benefit. If the premium is greater than your retirement benefit, you will be billed directly by Benefits Administration each month. If the premium is greater than your retirement benefit, you can also choose to pay by bank draft.

Non-TCRS Retiree

You will be billed directly by Benefits Administration each month or you can choose to pay by bank draft.

Direct Billing

If you send a check for your premium, it must be received by the last day of the month for the next month's coverage. For example, your January premium is due no later than December 31.

If you pay your premiums by automatic deduction (ACH) from your bank account, the premium is withdrawn for the current month on or after the 15th of the month. For example, your January premium will be withdrawn from your bank account on or after January 15.

Non-payment of Premiums

Coverage will be canceled retroactively to the last month paid if premiums are not paid in full within 30 days of the due date. If your coverage is canceled due to failure to pay premiums on time, you can apply ONE TIME ONLY to get your coverage back. A request must be submitted within 30 days of the cancellation of coverage. Requests for reinstatement must be submitted in writing, and must fully explain why premiums were not paid on time. The letter should be sent to: Benefits Administration, Attn: Retirement, 312 Rosa L. Parks Ave., Suite 1900, Nashville, TN 37243. Coverage will not be reinstated until all past-due and current premiums are paid in full.

Claims

If continuing group health coverage, you will continue to use your current ID cards after you retire. You may receive a new card if changes are made. Questions regarding payment of claims should be directed to the insurance company. Questions about Medicare claims processing should be directed to Medicare.

AVAILABLE BENEFITS

This section provides a brief overview of the benefits available to you. For more detailed information, visit the Benefits Administration website or consult your member handbook.

Health Insurance

You have a choice of four health insurance options:

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

You also have a choice of three insurance carrier networks:

- BlueCross BlueShield Network S
- Cigna LocalPlus
- Cigna Open Access Plus (monthly surcharge applies)

With each healthcare option, you can see any doctor you want. However, each carrier has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. These providers make up a network, and they have agreed to take lower fees for their services. Your cost is higher when if you use out-of-network providers.

Partnership Promise

If you choose the Partnership PPO, you must agree to a Partnership Promise. The promise requires you to take certain steps to get or stay as healthy as you can. In return, you will pay lower health insurance rates and have lower costs for services. If only the spouse is enrolled in retiree group health insurance, only the spouse is required to fulfill the Partnership Promise.

The promise is an annual commitment. The requirements will change slightly from year to year. You can read more about the current Partnership Promise on the ParTners for Health website.

Dental Insurance

The state offers two dental options.

- Prepaid Dental Plan provides services at fixed copay amounts. A limited network of dentists and specialists must be used to receive benefits.
- Dental Preferred Provider Organization (DPPO) provides services with coinsurance. Any dentist may be used to receive benefits, but you will pay less if an in-network provider is used.

Prepaid Plan

- Must select and use a network provider for each covered family member
- 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

DPP0 Plan

- Use any dentist
- \$1,500 calendar year benefit maximum per person
- Deductible applies for basic, major and out-of-network dental care
- You or your dentist will file claims for covered services
- 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

Vision Insurance

The state offers two vision options.

- Basic Plan offers discounted rates and allowances for services.
- Expanded Plan provides services with a combination of copays, greater allowances than the Basic Plan and discounted rates.

Both offer the same services, including:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglass lenses or contact lenses once every calendar year
- Discount on LASIK/refractive surgery

What you pay for services depends on the plan you choose. With the basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials. The expanded plan provides services with a combination of copays, allowances and discounted rates.

The basic and expanded plans are both administered by EyeMed Vision Care. You will receive the maximum benefit when visiting a provider in their Select network. However, out-of-network benefits are available.

Employee Assistance Program

The Employee Assistance Program (EAP) is a no-cost, comprehensive and confidential support tool that helps you, and those around you, deal with personal issues and situations. The EAP can provide support and resources for:

- Family and relationships
- Anxiety and depressed
- Dealing with addiction
- Legal and financial
- Child and elder care
- Difficulties and conflicts
- Grief and loss
- Work/life balance

You and your covered dependents may receive up to five counseling sessions per episode at no cost to you. If you need greater assistance than through EAP, you will be referred to your insurance provider's behavioral health and substance abuse benefits.

Services can be easily accessed by calling 855.437.3486, 24 hours a day, 365 days a year. The program is available to all retirees enrolled in health coverage.

ParTNers for Health Wellness Program

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

Services available through the wellness program include:

- 24/7 Nurse Advice Line. Get information and support from a nurse, 24 hours a day, 7 days a week, at no cost to you.
- Health Coaching. Coaching can help you reach your personal health goals. Calls are private and scheduled when it's convenient for you.
- ParTNers for Health Website. This website links you to online tools and information at your fingertips. Choose from a variety of online health improvement programs and keep track of your progress to reach your personal goals.
- Weekly Health Tips by E-mail. Sign up on the ParTNers for Health website to receive free weekly health tips by e-mail.
- Fitness Center Discounts. Discounts are available from fitness centers throughout the state. Refer to our website to view a list of participating fitness centers.

To access these services, call the ParTNers for Health Wellness Program at 888.741.3390 or visit the ParTNers for Health website.

Long-term Care Insurance

You are eligible to apply for long-term care coverage at any time. Long-term care is the assistance you need if you are unable to carry out the basic activities of everyday living — bathing, continence, dressing, toileting, eating, or transferring, such as from a chair or bed. The need could arise from an accident, injury, debilitating illness or could be simply the natural result of aging. This type of care is different from skilled, short-term care you would receive in a hospital. It is extended care you would receive in your home, in an assisted living facility or nursing home, adult day care center or hospice program. Coverage acceptance is subject to medical underwriting review. Call the carrier for more information and to learn how to apply for coverage.

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, benefits will be coordinated for reimbursement if you follow the guidelines for your medical plan. At no time should reimbursement exceed 100 percent of charges.

As a retiree, your health insurance coverage through your former employer is generally considered primary for you unless you have Medicare. Even then, your health plan may be primary for a period of time if you have Medicare due to end-stage renal disease. Should you have other coverage, the consideration of primary and secondary benefits can depend on factors such as whether you are the head of contract or a dependent in those plans and whether the plan is an employee or retiree plan. If you are the head of contract in more than one retiree plan, the oldest plan is considered your primary coverage. If your spouse has coverage through his or her employer, that coverage will generally 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.

The plans require an annual verification of other coverage. This information must be returned to your health insurance carrier in order to process claims. Claims will not be processed until this information is received.

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 workers' 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 section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses the plan has already paid for, you may be subject to collections activity.

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 retirees and dependents are covered in detail in this guide.

If your covered dependent becomes ineligible, you must inform Benefits Administration 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 Benefits Administration. 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 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 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 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) you may submit your request for review in writing to Benefits Administration.

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 to your satisfaction.

Different insurance companies manage approvals and payments related to your medical, behavioral 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 behavioral 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. A copy of the Plan Document is available on the Benefits Administration website or by calling Benefits Administration.

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 and dental coverages have member handbooks to explain benefits in detail. These are available from the Benefits Administration website or by calling Benefits Administration.

Discrimination

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, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.

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 call Benefits Administration to request a copy.

TERMS AND DEFINITIONS

Acquire Date

The acquire date is the date that establishes a relationship between you and your dependents. Some examples are 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.

Balance Billing

If you get treated by out-of-network providers, you can be subject to balance billing by the out-of-network provider. This is the process of billing a patient for the difference between the provider's charges and the amount that the provider will be reimbursed from the patient's insurance plan. For example, let's say that a doctor typically charges \$100 for a certain service. An in-network doctor has agreed to provide the same service for a reduced rate of \$75 and he or she writes off the rest of the charge. An out-of-network provider has not agreed to any reduced rates as he or she does not have a contract with the carrier and will bill the entire charge of \$100. However, the insurance carrier will not reimburse more than \$75 for the service which means that you may owe the out-of-network provider the additional \$25.

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.

Copay

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

Creditable Service

You earn creditable service when an agency that participates in the state group health plan contributes to your pension with TCRS for your service with the state of Tennessee or a participating local education or local government agency. Local government service cannot be combined with any other local government, local education or state service. Vested members may also establish credit in TCRS for up to four years of eligible military service. If this service did not interrupt your state employment, it cannot be counted for insurance eligibility purposes. At retirement, unused sick leave may be converted to retirement service credit. If you cashed out TCRS service and did not buy it back, you will not be able to count those years as creditable service for insurance purposes or as your first date of hire with the state or participating local education agency. Non-TCRS participants earn creditable service for insurance based on the years of service with the employer that participates in the state plan in which the employee qualified for insurance coverage.

Date of Retirement

For TCRS participants, your date of retirement is the effective date of your retirement pension.

Deductible

A fixed dollar amount you must pay each year before the plan pays for services that require coinsurance.

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 payment amount.

Due to Age (Medicare Eligibility)

Due to age refers to the first of the month that a member turns age 65. If your birthday falls on the first day of the month, then you will be considered eligible due to age on the first of the prior month. You may also become Medicare eligible prior to age 65 due to disability.

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. The state's dental, long-term care and vision 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.

Group Health Plan

Group health plan refers to the healthcare options offered by the state group insurance program. It does not include the Medicare supplement plan.

Guarantee Issue

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

Head of Contract

The head of contract is the retiree who worked for a participating employer group and enrolled in coverage. Two married retirees who both worked 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. A surviving spouse who continues coverage based on the eligibility through a deceased retiree also becomes a head of contract on the new enrollment.

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 cannot 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 Deductible

Meeting your deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays for services that require coinsurance.

Network

A network is a group of doctors, hospitals and other healthcare providers contracted with a health insurance carrier 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 healthcare 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 services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services. A separate out-of-pocket maximum applies to in-network pharmacy in the standard and partnership options.

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 benefit option you select.

Preventive Care

Preventive care refers to services or tests that help identify health risks. For example, preventive care includes screening 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, pediatrics or an OB/GYN. Nurse practitioners, physician's assistants and nurse midwives (licensed healthcare facility only) may also be considered primary type providers when 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 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.

Q&A

If I am Medicare eligible when I retire, can I continue to cover my spouse who is not yet Medicare eligible?

If you meet the criteria to continue group health coverage and are in paying status (if you are a TCRS participant), you may continue your spouse's group health coverage. If you do not continue spouse coverage immediately upon retirement, you cannot add them to coverage at a later date.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If I become eligible for Medicare prior to the age of 65, will my insurance be terminated? What about my dependents?

If you or your covered dependent becomes entitled to Medicare prior to the age of 65, coverage will be terminated.

Is my spouse eligible for the Medicare supplement plan?

If you are enrolled in the Tennessee Plan Medicare supplement, you may apply to cover your Medicare-enrolled spouse. If you do not apply within 60 days of initial eligibility, your spouse must apply as a late applicant and will be subject to approval.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If you do not receive a monthly TCRS benefit, you and your spouse are not eligible to apply for the Tennessee Plan Medicare supplement.

If I do not continue group health coverage when I retire because I will have coverage through my spouse, can I apply for coverage later?

If you met the minimum criteria to continue group health coverage when you retired, you may apply for the state's group health plan through a special enrollment provision if you lose other creditable health coverage. You must still meet the plan eligibility rules.

Can I change my health insurance option or carrier when I continue coverage at retirement?

You must continue with the same health insurance option you were enrolled in immediately prior to retirement. You will be able to switch carriers if you move outside of the service area.

VISION COVERAGE

If I am over age 65 and enrolled in the state's Medicare supplement plan, am I eligible to enroll in the retiree vision plan?

No. You must be covered by the retiree group health plan to enroll in the retiree vision plan. If you were covered by the vision plan as an active employee, you should receive a COBRA notification and may apply to continue the vision coverage through COBRA. Premiums for COBRA vision will be billed directly to you.

If I continue coverage in the retiree group health plan for my spouse only, can my spouse enroll in the retiree vision plan?

If you receive a monthly TCRS pension and your spouse is covered under the retiree group health plan, you may apply for spouse-only coverage in the retiree vision plan.

If I continue coverage in the retiree group health plan for myself only, can my spouse and I both enroll in the retiree vision plan?

No. If your spouse is not enrolled in the health plan, you cannot enroll him or her in vision.

DENTAL COVERAGE

How do I know if I am eligible for retiree dental benefits?

To qualify for retiree dental coverage, you must receive a monthly retirement check from TCRS.

How do I know if my dependents are eligible for dental benefits?

If you are eligible for retiree dental coverage, your dependents are also eligible. You must provide documentation to verify your dependents' eligibility before they can be enrolled in coverage.

How do I find out which dentists are considered in network?

To find up-to-date network information, call the dental carrier directly or do an online search on the carriers' website. You can also request a printed provider directory by calling the carrier.

How will the state deduct my dental premiums?

Premiums will be deducted from your TCRS check each month. If there is not enough money in your TCRS check, the state will send a bill to your home.

If I live out of state, can I still enroll in dental coverage?

As long as you receive a monthly TCRS pension benefit you can enroll in coverage. If you select the prepaid plan you must still select and use a network dentist.

What if I recently retired and now have COBRA dental coverage?

If you had dental coverage when you stopped working, then you can often keep this coverage at the COBRA premium. This coverage lasts for 18 months. If you meet the eligibility criteria, you can enroll in retiree dental coverage when your COBRA coverage expires. You will need to contact Benefits Administration 60 days prior to the expiration of your COBRA coverage to request an application. You must indicate the requested future effective date when you submit your application.

Can I cancel retiree dental coverage if I change my mind?

You may only cancel coverage during the fall enrollment period unless you have a qualifying event. Requests to cancel coverage due to a family status change must be submitted within 60 days of the qualifying event. Supporting documents must be provided. The insurance cancel request application provides information about qualifying events. It is available on the forms section of the Benefits Administration website.

Who do I call if I have questions about my dental benefit?

For information on covered services, please contact the dental carriers directly.