

STATE

GROUP

INSURANCE

PROGRAM



State of Tennessee

Local Education and Local Government Employees

March 2008

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This handbook does not outline every limitation or exclusion of the state-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. Your department or facility (benefits section) has a copy or you obtain a copy from the Benefits Administrations web site.

The information contained in this handbook is accurate at the time of printing; however, the Insurance Committees or the Legislature may change the plans at their discretion, in which case you will be given written notice of the change. The benefits described in this handbook cannot be modified by any oral statements.

All health and dental coverages have their own member handbooks to explain benefits in detail. These handbooks are available from your agency benefits coordinator or you may obtain a copy from the Benefits Administrations web site.



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What Is This Information and Why Do I Need It?

PPO – A health insurance option where participants choose a network provider or a non-network provider. A network provider accepts a pre-negotiated fee. The participant is responsible for a percentage of the maximum allowable charge and an annual deductible. When a patient utilizes a non-network provider, care is paid at a percentage of the maximum allowable charge and charges above the maximum allowable are the patient's responsibility. Annual out-of-pocket maximums apply.

HMO – A health insurance option where care is coordinated through a primary care physician. No benefits, other than approved emergency or urgent care, are paid apart from the HMO's network. Copayments are paid each time services are received. There are no deductibles and preexisting conditions do not apply.

POS – A health insurance option where participants use in-network providers who have agreed to accept a fixed copayment. Use of out-of-network providers is covered at a percentage of the maximum allowable charge. Charges above the maximum allowable amount are the patient's responsibility. There are no deductibles or out-of-pocket maximums if you use in-network providers.

This *Insurance Handbook* has been provided to help you understand what insurance options are available to you. Health insurance is one of your most valuable employee benefits. Familiarize yourself with topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

If you meet the eligibility requirements listed on page 5, you will have the following options:

- Preferred Provider Organization (PPO) health option
- Preferred Provider Organization Limited health option (local government only)
- Point of Service (POS) health options *
- Health Maintenance Organizations (HMO) health options *
- Optional dental insurance, if offered by your employer

*Based on your county of residence or work, you may have the option of choosing coverage through a POS or HMO.

Regardless of which options you select, the eligibility section of this handbook applies to you. All health and dental coverages have their own member handbooks to explain their benefits. You may obtain a copy of these books from your agency benefits coordinator, the person in your department of facility designated to handle insurance matters, or from the Benefits Administration web site.

Every full-time employee and certain former employees, such as retirees, may be eligible for health insurance coverage through the state's group insurance program. Benefits Administration within the Department of Finance and Administration is responsible for administering and/or overseeing all components of the group insurance coverage. The healthcare options are self-insured which means claims are paid from funds controlled by the state, which consists of employee premiums and the employer's contributions, if applicable.

Another group is also eligible to provide health coverage for their employees and retirees through the state's group insurance program. State and higher education agencies that elect to participate also provide coverage through separate self-insured healthcare options.

Any changes in premiums or benefits will be communicated through a participant newsletter, *Your Health Network*, mailed to your home. It is important to maintain your correct address with your benefits coordinator at all times.

Words or phrases that may be unfamiliar to you, and are not explained in the text, are defined in the side margin. We hope you will find this information helpful, useful and easy to understand. Please contact the Benefits Administration communications office if you have comments or suggestions related to this publication or if you require this publication in an alternative format.

Who Governs the Group Insurance Program?

Local Education Plan

Benefits and premiums are set by the Local Education Insurance Committee. Members are:

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Education as designated by the Governor
- Three teachers elected by the representative assembly of the Tennessee Education Association
- One representative selected by the Tennessee School Board Association

Local Government Plan

Benefits and premiums are set by the Local Government Insurance Committee. Members are:

- 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

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

A Quick Reference

Your benefits coordinator is the person designated in your department or facility to handle insurance matters. He/she is available to answer your benefit questions and can provide you with any necessary forms or insurance booklets. Write his/her name in the space below so you can find it easily.

My benefits coordinator is: _____

Phone number: _____

Telephone Numbers You May Need

Benefits Administration

2600 William R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243-0295

615-741-3590
1-800-253-9981
(8:00–4:30 central time, M–F)

Tennessee Consolidated Retirement System (TCRS) Insurance Section

10th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

1-877-681-0155
(8:00–4:30 central time, M–F)

For member services telephone numbers, contact your agency benefits coordinator or refer to the back of your insurance identification card.

Web Site

Please visit the Benefits Administration web site at www.state.tn.us/finance/ins/ for the most up-to-date information regarding the insurance program. Most forms and publications mentioned in this handbook can be obtained from the site and links to the various health insurance vendor's web sites are also provided.

Is TennCare Related to My Benefits?

No. TennCare is the managed care program that replaced Medicaid in 1994. It is not the state's medical plan and is not funded with your premiums. For further information about TennCare, call 615-741-4800 or 1-800-669-1851, 8:00–4:30 central time, M–F. Should you be covered by TennCare and lose coverage, you may be eligible for state coverage if you apply within 60 days of the date coverage is lost.

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 web site or you may obtain a copy from your agency benefits coordinator.

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Who's Eligible?

Local Education Employees (K-12)

- A teacher as defined in Tennessee Code Annotated, Section 8-34-101-(46)
- An interim teacher whose salary is based on the local school system's schedule
- Employees not defined above who are regularly scheduled to work at least thirty hours per week in a non-seasonal, non-temporary position
- A non-certified employee that has completed 24 months of employment with a local education agency that participates in the plan and works a minimum of 25 hours per week — a resolution passed by the school system's governing body authorizing the expanded 25 hour rule for the local education agency must be submitted to Benefits Administration prior to enrollment
- School board members
- All other individuals cited in state statute or approved as an exception by the Local Education Insurance Committee

Employees NOT Eligible to Participate in the Plan

- Substitute teachers

Local Government Employees

- Any employee scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position
- Any member of the chief legislative body (defined as only those elected officials who have the authority to pass local legislation)
- Utility board members appointed or elected pursuant to TCA 7-82-307, but only during their term of service
- County officials as defined in TCA 8-34-101(9)(A), regardless of whether the agency participates in the plan, pursuant to TCA 8-27-207(i)
- All other individuals approved as an exception by the Local Government Insurance Committee

Employees NOT Eligible to Participate in the Plan

- Individuals performing services on a contractual basis

How Do I Pay for Coverage?

Insurance premiums are collected monthly. Agencies may pay all, a portion or none of an employee's insurance coverage(s). Your benefits coordinator will notify you of the deduction, if any, from your pay. If you experience a change in coverage, contact your benefits coordinator to determine what portion of the premium you are responsible for paying to your agency. Premiums for optional dental coverage are separate. Your benefits coordinator can provide the premiums for these coverages. Premiums are not prorated. The plan permits a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled retroactive to the date you last paid a premium with no provision for reinstatement of coverage. To obtain health coverage again, you would have to qualify through the late applicant process.

What Types of Health Coverage Are Available?

- Single: Covers employee only
- Family: Covers employee, spouse and all eligible dependent children

A participant cannot be covered under more than one contract in the same plan.

A husband and wife both employed by an agency that participates in the local education or local government plan and are both eligible for coverage under the plan will have two options:

- They may each elect individual coverage if they have no dependents
- One employee may elect family coverage and cover the spouse as a dependent under the family coverage — in no event may one spouse have family coverage and the other spouse have individual coverage in the local education plan

When Does Coverage Begin?

Local Education (K-12)

You have 31 days from the date of employment to submit an enrollment application. Coverage begins on the first day of the month, or subsequent month, after your enrollment application has been filed with your benefits coordinator, provided you are in a positive pay status on that day.

Local Government

You have from the first day of employment through the last day of the first full calendar month worked to submit an enrollment application. Coverage begins on the first day of the month, or subsequent month, after you have been employed one full month provided you are in a positive pay status on that day. Some local government agencies have a longer probationary period; however, the application must still be submitted during the time frame listed above.

Positive Pay Status –
Receiving monetary compensation even if the employee is not actually performing the normal duties of their job. This is related to annual leave, sick leave, compensatory leave and any other type of approved leave with pay.

If you fail to enroll in health coverage by the end of your eligibility period, you will only be eligible by satisfying one of the special enrollment provisions on page 12 or by qualifying through the late applicant medical underwriting process.

Dependent coverage is effective on the same date as yours unless newly acquired. Newly acquired dependents will become effective on the date they were acquired if you are in family coverage. You may also choose to have coverage effective the first day of the following month.

Coverage for an adopted child begins when appropriate documentation reflecting legal obligation of support of such child is submitted to your benefits coordinator. See complete definition of dependents on page 9.

Part-time employees will be effective the first day of the month after attaining full-time status if you have completed one full calendar month of employment. You may also choose the subsequent month for coverage to become effective.

Interim teachers who do not elect coverage when first eligible and who accept a permanent teaching position at the same school system without a break in employment will have 31 days from the hire date of the permanent teaching position to submit an enrollment application. The effective date of coverage will be the first day of the month after the employee completes the enrollment form.

You will receive an identification card at your home address within four weeks after the effective date of your coverage. You may call the health provider to request additional cards.

PPO and POS Preexisting Condition Clause

Preexisting condition shall mean a condition for which a covered person received treatment or advice during the six-month period immediately prior to coverage with a state-sponsored plan. The healthcare options that apply a preexisting condition clause are the PPO and the POS. The HMOs do not have preexisting condition requirements for their enrollees.

The preexisting condition clause does not apply to pregnancy, newborns or adopted children or children placed for adoption. Also, if you are enrolling (as a new hire) or transferring during the annual enrollment transfer period and have had health coverage without a 63-day lapse between prior health coverage, the six-month preexisting condition clause will be waived.

Employees and dependents who did not have previous health coverage, or if the prior coverage has been terminated for more than 63 days, will be required to satisfy the six-month preexisting condition requirement. Treatments for conditions determined to be preexisting shall not be considered eligible expenses until coverage has been in force for six months.

Newly hired eligible employees and their dependents will be required to furnish a Certificate of Coverage letter (letter on former employer or insurance carrier letterhead) stating they had prior coverage, the names of participants enrolled and the date the coverage terminated. This letter should be provided to your benefits coordinator and is required in order to be exempt from the preexisting requirements. There cannot be a lapse of coverage longer than 63 days. If a newly hired employee does not have the letter when first enrolled, they may provide the letter at a later date and the benefits coordinator can change their coverage to reflect that preexisting should not apply.

What Are the Distinguishing Features of Each Healthcare Option?

Preferred Provider Organization (PPO)

- Statewide network
- Annual deductible
- Prescription drug copays
- Separate out-of-pocket maximums
- Wider choice of doctors
- Preexisting conditions will apply if you had no prior coverage
- Benefits are paid whether in-network or out-of-network (percentages vary)

Point of Service (POS)

- Active employees must live or work in service areas
- Copayment are utilized for in-network benefits and out-of-network benefits are covered at a percentage of MAC
- Deductibles apply when using out-of-network physicians
- Preexisting conditions will apply if you had no prior coverage

Health Maintenance Organization (HMO)

- Active employees must live or work in service areas
- Must choose primary care physician (PCP) per covered family member
- Copayments for physician office visits, prescriptions and hospital admissions
- Preexisting conditions are covered
- No deductibles

Your benefits coordinator can provide you with a comparison of the state-sponsored insurance programs and a member handbook from each provider describing benefits.

What If I Need to Change My Coverage?

To make a change in your coverage (add or terminate a dependent, etc.), complete an enrollment/change application and return the completed form to your benefits coordinator. The eligibility requirements for dependents listed on page 9 apply.

What Dependents Are Eligible?

- Your spouse (legally married)
- Natural or adopted children (regardless of where they live)
- Stepchildren, if you or your spouse has legal custody, joint custody or shared parenting (must be permanent parenting, duly executed)
- Children living in the home for 12 months a year for whom you are the legal guardian
- Any dependent child living in your home for 12 months a year who is dependent upon you for support and maintenance as evidenced by being claimed as a dependent on your federal income taxes
- Adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption — the obligation may be determined by court records, federal income tax records or other appropriate documentation as determined by the Insurance Committee or its representative

Should a change in your dependent's eligibility status occur, notify your benefits coordinator promptly to terminate coverage.

All dependents must be listed by name on the appropriate enrollment/change application. Benefits are not provided for dependents not listed on this form. 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).

Full-time Student – One who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

Unmarried dependent children are eligible for coverage through the last day of the month of their 24th birthday. Dependent children between the ages of 19 and 24 must be claimed on your income tax or be a full-time student. Proof of a dependent's eligibility may be required.

Incapacitated children (mentally or physically disabled and incapable of earning a living) may continue health or dental, if applicable, coverage beyond age 24 as long as the incapacity existed before their 24th birthday and they were already insured under the state's group insurance program. The child must meet the requirements for dependent eligibility previously listed. ***A request for extended coverage must be provided to Benefits Administration within 90 days of the dependent's 24th birthday.*** Additional proof may be required periodically. Approval of the incapacitation request is determined by the claims administrator for your health insurance company. Coverage will not continue and will not be reinstated once the child is no longer incapacitated.

What Dependents Are Not Eligible?

- Ex-spouse (even if court ordered)
- Married children, regardless of age
- Parents of the employee or spouse
- Foster children
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Live-in companions who are not legally married to the employee

How Do I Add Dependents to My Coverage?

An enrollment/change application should be completed within 60 days of the date a dependent is acquired. The “acquire date” is the date of birth, marriage, change of student status, or, in case of adoption, the legal obligation and support of such child. Changes in type of coverage (single to family) are effective on the first day of the month in which the dependent was acquired or if requested, the first of the following month. If you maintained family coverage on the date the dependent was acquired, the effective date must be retroactive to the dependent’s acquire date if beyond the 60-day enrollment period.

An employee’s child named under a qualified medical support order may be added within 60 days of the court order, if a court so stipulates. If covering out-of-state dependents, you must be enrolled in the Preferred Provider Organization (PPO).

If you have single coverage and do not notify your benefits coordinator within 60 days of acquiring a dependent, the new dependent can only enroll if they meet one of the special enrollment provisions listed on page 12, or by qualifying through the late applicant medical underwriting process.

If dependents are added while you are on single coverage, you must request family coverage for the month the dependent was acquired in order for claims to be paid. This change in type of coverage is also retroactive and you must pay for family coverage for the entire month in which the dependent is insured.

How Do I Terminate a Dependent's Coverage?

To remove a dependent from your coverage, complete an enrollment/change application and return it to your benefits coordinator. (Check with your benefits coordinator to make sure your dependent is no longer eligible for coverage.) When you request cancellation, a dependent's coverage will terminate on the last day of the month in which the form is signed. In the case of ineligibility, the dependent is covered until midnight on the last day of the month that the ineligibility occurs. For adopted children, coverage terminates upon the termination of legal obligation. In the event of a divorce for any reason other than irreconcilable differences, your spouse cannot be removed from coverage until the divorce is final. ***All claims paid for ineligible dependents will be recovered. As the head of contract, you are responsible for reimbursing the plan for incorrect claims payments.***

Flexible Benefits – Please check with your human resource office before terminating your coverage to see if this has any impact on your flexible benefits program.

You can change your type of coverage by completing an enrollment/change application. Keep in mind that deleting a dependent may make you ineligible for family coverage. Refunds for premium overpayments will be issued for up to three months from the date of notification to Benefits Administration.

To verify claim payments are paid only for eligible dependents, aged 19–24, the health vendors are required by the state to request annually a verification form ***signed by the employee***. Claims cannot be paid until the form is returned to the vendor.

Benefits Administration reserves the right to request documented proof of eligibility of dependents. Failure to provide the requested proof will result in suspension of the dependent's coverage until such proof is provided.

If the dependent becomes ineligible, it is your responsibility to notify your benefits coordinator. Refunds for any premium overpayments will be limited to three months from the date of notification to Benefits Administration unless there are outstanding claims.

What If I Don't Enroll in Health Coverage When First Eligible?

If you do not elect coverage for yourself and/or your dependents when first eligible (see page 6) and you later decide to enroll, you and/or your dependents will be considered late applicants. ***You are encouraged to apply for health insurance when you are first employed rather than risk the possibility of being unable to obtain coverage as a late applicant.*** If approved through either of the following options, the enrollment will be for health coverage only. You may enroll in the optional dental coverage, if offered by your agency, during the annual enrollment transfer period.

Special Enrollment Provisions

The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll in health coverage under certain conditions. Exceptions will also be made for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse. The required documentation must be submitted to Benefits Administration and coverage applied for within 60 days of loss of health coverage.

Employee NOT currently enrolled acquires a new eligible dependent (spouse, newborn or adoptee)

- Copy of the birth certificate, marriage certificate or adoption documents

Death

- Copy of death certificate and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended

Divorce

- Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Legal separation

- Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing the names of covered participants, date coverage ended and the reason why coverage ended

Loss of eligibility (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause)

- Written documentation from the employer or insurance company on company letterhead providing names of covered participants, date coverage ended and the reason for the loss of eligibility

Loss of coverage due to exhausting lifetime benefit maximum

- Written documentation from the insurance company on company letterhead providing names of covered participants, date coverage ended and stating that lifetime maximum has been met

Loss of TennCare (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis)

- Certificate of coverage from TennCare stating that coverage has been or will be terminated

Termination of employment (voluntary and non-voluntary)

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

The reduction in the number of hours that caused loss of eligibility

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Employer's discontinuation of contributions to the spouse, ex-spouse or dependent insurance coverage (total contribution not partial)

- Written documentation from the employer on company letterhead providing names of covered participants and verifying the employer's discontinuation of total contribution toward health insurance coverage

The effective date of coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month or subsequent month following approval by Benefits Administration; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period. If you are currently enrolled in health coverage and have a dependent approved for coverage through a special enrollment qualifying event, you and your covered dependents may transfer to another healthcare option.

Medical Underwriting

If you or your dependents do not enroll during your eligibility period and do not qualify under a special enrollment provision of HIPAA, you may apply for health coverage at any time of the year by means of a health care evaluation application on yourself and every eligible dependent. The cost of the evaluation, along with the designated application fee is your responsibility. The application will be evaluated through the medical underwriting process for approval/disapproval and you will be notified by letter of the underwriter's decision. The employee (head of contract) must be approved or already participating in the plan before any dependents can be added for coverage. You may apply for coverage as many times as you wish should your medical condition change by submitting a new application and paying the required non-refundable application fee. Denied applications cannot be appealed through the plan's appeal process.

The effective date of coverage shall be the first of the month or subsequent month following the date of the approval letter, or the first of the month following the 60-day period after the approval letter.

Annual Enrollment Transfer Period

During the fall of each year you have the opportunity to transfer your existing state group health insurance coverage if you are currently enrolled. To transfer to the POS or HMO, you must live or work in the service area. Benefit information is mailed to your home address and you should review this information carefully to make the correct decision for you and your family. If you decide to transfer to another healthcare option, coverage will be effective on the following January 1, and you must remain enrolled in that healthcare option until the next year unless you move outside the HMO or POS service area. ***This is not an open enrollment period for health coverage.***

You may also enroll in optional dental coverage or change dental options during this period if this coverage is offered by your agency.

Transferring Between Plans Explained

Employees who are eligible for coverage under more than one state-sponsored plan will be allowed to transfer between the State, Local Education and Local Government Plans when it is to the advantage of the employee to do so. These employees will have the opportunity to apply for a transfer during the month of December with an effective date of January 1 of the following year. In no case may an employee transfer to another state-sponsored plan while remaining on the plan from which the transfer occurred *unless they are in a dependent status*.

How Do I Terminate Health Coverage?

If you wish to terminate insurance coverage, you must

- Complete an enrollment/change application
- Return the completed application to your benefits coordinator *before* the day the termination is to be effective

A dependent's insurance will be canceled on the last day of the month when he/she becomes ineligible for coverage. It is your responsibility to notify your benefits coordinator if your dependent no longer meets the dependent eligibility rules.

When canceled, either voluntarily or by work hours being reduced below the eligibility requirements (i.e., going full-time to part-time), insurance coverage ends at midnight on the last day of the month for which you paid your premium. All forms must be completed by the last day of the month to terminate coverage for the following month. For example, if you do not want coverage for the month of December, you must cancel the coverage in writing by the end of November. You cannot cancel coverage for the month of December once the month begins. ***Please check with your human resource office before terminating coverage to determine if this has any impact on your flexible benefits program.***

Any insurance continued for an *incapacitated dependent child* ends when he/she is no longer incapacitated, or at the end of the 31-day period after any requested proof is not furnished.

In the event of an employee's death, insured dependents may continue health coverage for six months at no cost, as long as they remain eligible. After this period, covered dependents may be eligible to continue coverage through COBRA (see page 15).

What If I Have Other Insurance?

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 an active employee, your health insurance coverage is generally considered primary for you. However, should you have other health coverage as the head of contract (not dependent coverage) for yourself, the oldest plan is considered your primary coverage. If covered under a retiree plan and an active plan, the active plan will always

be primary. If your spouse has coverage through his or her employer, that coverage would be primary for your spouse and secondary for you.

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

The health insurance providers have the right to subrogate claims. This means they can recover any payments made as a result of injury or illness caused by the action or fault of another person, or lawsuit settlement from payments made by a third party insurance company. ***This would include automobile or homeowners insurance, whether yours or someone else's.*** You are required to assist in this process.

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

On the Job Injuries

The plan will not be responsible for expenses for injuries or illnesses occurring in conjunction with employment.

How Do I Continue Coverage?

You may be able to continue medical (if eligible) and/or dental coverage under the Consolidated Omnibus Budget Reconciliation Act, a federal law referred to as COBRA. This law allows employees and eligible dependents whose medical or dental insurance would otherwise terminate, to continue the same medical or dental benefits for specific periods of time under certain conditions. Covered individuals may continue the medical or dental insurance if ***all*** of the following conditions are met:

1. Coverage is lost due to one of the "qualifying events" on page 16.
2. Covered individuals are not insured under another group medical plan as an employee or dependent. (This restriction is waived if you or your dependent enroll in another group medical plan that has a preexisting condition clause, and a condition exists that is not covered by the other plan.) In this situation, you must provide the following to Benefits Administration:
 - A letter from the new employer or claims administrator explaining that plan's preexisting condition clause and how long it applies
 - A letter from your physician stating your preexisting condition

Benefits Administration will send a COBRA notification packet to your home at the address on file within 7-10 days after your coverage has terminated because of one of the qualifying events described below. You or your eligible family member will then have 60 days from the date of the notification packet to return your application to Benefits Administration. Coverage will be reinstated immediately if premiums are returned with the application. Please make sure your correct home address is on file with your agency benefits coordinator. If you do not receive your notification letter within 30 days after your insurance terminates, you should contact Benefits Administration.

You or one of your family members must notify Benefits Administration if a dependent wants to continue coverage under COBRA because

- Of your divorce from that spouse
- The dependent child is no longer eligible for medical or dental coverage because of a loss of dependent status under the plan (your employer will notify Benefits Administration of other “qualifying events”)

When one of these two circumstances (divorce or loss of dependent status) occur, you or your dependent has 60 days from the date of the qualifying event or the date the insurance will terminate due to the qualifying event (whichever is later), to notify Benefits Administration. Benefits Administration will then send your dependent the COBRA enrollment packet to your address. Restrictions for returning the enrollment form (when premiums must be paid and other provisions) are outlined in the COBRA packet. Failure to report a dependent becoming ineligible to continue coverage within 60 days of the loss of eligibility will result in the dependent not being offered the opportunity to continue coverage under COBRA as their 60-day eligibility period will have lapsed.

There may also be a requirement for you to notify Benefits Administration in the event of a disability determination by the Social Security Administration. Additional information regarding disability extensions is provided further in this section.

Failure to notify Benefits Administration within the above prescribed time periods can result in a loss of certain COBRA rights.

How Long Does COBRA Last?

If you qualify for COBRA, the maximum length of time coverage may continue is based on which qualifying event causes your loss of medical coverage.

Qualifying Events for Employees

You may continue your single or family medical coverage for a **maximum of 18 months** if coverage is lost due to one of the qualifying events listed below.

- Employment is terminated for any reason other than gross misconduct
- Work hours are reduced below the eligibility criteria
- Changes in your job appointment make you ineligible for coverage (example: changing to a part-time position)

Qualifying Events for Dependents

Dependents may also continue their medical or dental coverage under COBRA for **18 months** based on the events listed for employees. Furthermore, dependents may continue medical or dental coverage for an **additional 18 months**—maximum of 36 months—if coverage is lost due to one of the qualifying events listed below.

- Your death
- Your divorce from your spouse
- You become entitled to Medicare prior to enrolling in COBRA (the 36-month period is retroactive to the date of Medicare entitlement)
- Your dependent child is no longer eligible as a dependent (married, in the armed forces on a full-time basis, over age 24 unless meeting qualifications for incapacitation, etc.)

Medicare – A program administrated by the federal government that provides health benefits for persons age 65 or older and some disabled persons.

A child born to, or placed for adoption with you during a period of COBRA continuation coverage is also eligible for continuation of coverage as long as coverage is requested within the 60-day time period.

How Much Are COBRA Premiums?

COBRA premiums are equal to 102 percent of the total monthly premium. (Total monthly premium includes employee and employer contributions.) Premiums are not prorated.

When your coverage through COBRA ends, you may be eligible to convert to a private, direct-pay plan with your health provider.

If you or your dependents are on an 18-month COBRA extension and were disabled when you originally lost coverage or within 60 days of when you or your dependent's coverage started, you and your dependents may continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payments after the 18th month. In order to qualify, an award letter from the Social Security Administration (SSA) must be sent by the COBRA participant to Benefits Administration within 60 days of your receiving SSA's disability letter. You will be notified if the additional 11 months are approved.

When Does COBRA Coverage End?

Any COBRA coverage ends on the earliest of the following:

- The required premium is not paid by the due date
- You or your dependents become insured under another group health plan after the date you elect COBRA coverage under this plan. (However, your COBRA coverage will not be terminated if, on the date you obtained the other coverage, the other group health plan contained a preexisting condition clause that applies to, or is not otherwise satisfied by, you or your dependent by reason of the provisions of HIPAA. Please contact Benefits Administration if you believe this applies or you have questions.)
- You or your dependent becomes entitled to Medicare after the date you elect COBRA coverage under this plan
- Coverage has been extended for up to 29 months due to a disability and there has been a final determination during the 11-month extension period that the individual is no longer disabled
- On the last day of the appropriate 18-, 29- or 36-month period

Note: It is your responsibility to share this explanation of COBRA benefits with your covered dependents.

What If I Go on Leave?

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees to take up to 12 weeks of leave during a 12-month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to receive the portion of your health insurance premium that your employer would pay if you were in a positive pay status. Initial approval for family and medical

leave is at the discretion of each agency head. Employees must have completed a minimum of 12 months of employment immediately preceding the onset of leave.

Leave Without Pay – Insurance Continued

If you choose to continue coverage while on an approved leave of absence, once you have been without pay for one full calendar month you will be responsible for the total monthly premium—*employee and employer share*—and will be billed at home each month. The maximum period for a leave of absence is two continuous years. At the conclusion of the two continuous years of leave, you must immediately report back to work for a period of no less than one full calendar month to be eligible for an additional two continuous years of insurance continuation under the leave without pay category. If you do not immediately return to work upon the expiration of the two continuous years of leave, coverage is terminated and COBRA eligibility will not apply.

Leave Without Pay – Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. You may reinstate coverage when you return to work. ***If your coverage is canceled for nonpayment, it cannot be reinstated unless you qualify for one of the special enrollment provisions or if you qualify through late applicant medical underwriting.***

To Reinstate Coverage After Your Return

Within 31 days of your return to work, you must submit a completed enrollment/change application to your benefits coordinator, enrolling in the same healthcare option you had previously. If you do not enroll within 31 days of your return to work, you can only re-enroll by meeting one of the special enrollment provisions or by qualifying through the late applicant medical underwriting process. The following guidelines apply:

If returning within six months

- No waiting period, coverage is effective the first of the following month after returning to work
- Preexisting condition does not apply (PPO and POS)

If returning after six months

- Must wait one full calendar month before coverage is effective
- Must satisfy the six-month pre-existing condition clause (see page 7) unless employee provides a certificate of coverage letter reflecting other coverage while on leave and there has not been a 63-day lapse (PPO and POS)

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

Reinstatement for Military Personnel Returning From Active Service

An employee who returns to the employer's active payroll following active military duty may reinstate insurance coverage on the earliest of the following:

- The first day of the month which includes the date on which the military person was discharged from active duty
- The first of the month following the date of discharge from active duty
- The date on which the military person returns to the employers active payroll
- The first of the month following the military persons return to the employer's active payroll

If coverage is reinstated before the employee returns to the employer's active payroll, the employee must pay 100 percent of the total premium. In all instances, employees must pay whole month premiums.

Reinstatement of coverage is not automatic. Returning military personnel must re-apply within 90 days from the end of their leave before coverage can be reinstated. No preexisting condition provision or waiting period requirements will apply.

What Can I Expect If I Terminate Employment?

Your insurance coverages will cancel automatically when your agency terminates your employment and this information is provided to Benefits Administration. You will receive a COBRA notification, if eligible, at your home address.

What If I Retire?

All covered employees who meet the qualifications may continue medical insurance at retirement for themselves and covered eligible dependents. If you are enrolled in either the HMO or POS by virtue of working in the service area, but not living in the service area, you will be allowed to continue in that option even though you no longer meet the live or work requirement. However, other than emergency care, HMO participants are required to see a participating network provider for benefits to be paid. While POS participants may seek care out-of-network, out-of-pocket costs will be significantly higher. A detailed brochure, *Continuing Insurance At Retirement*, is available from your benefits coordinator or by calling the Tennessee Consolidated Retirement System (TCRS) Insurance Section. If your retirement is under a separate retirement system, call Benefits Administration.

To continue coverage as a retiree, you must submit an application to continue coverage within one full calendar month from the effective date of your retirement. An individual cannot be classified as a retiree and maintain active coverage as an employee in the same plan. If an agency withdraws from the state's group insurance program, any retirees previously covered by that agency will lose coverage. Years of service applies to eligibility to retire, not necessarily toward premium support. State premium support is provided to certified teachers only.

Retirees or covered dependents who are eligible for Medicare may be eligible for the State's Medicare Supplemental Plan. The supplemental policy becomes effective

State Service – Employment with the State of Tennessee, a higher education institution or a local education agency participating in the plan. Unused sick leave can be counted for TCRS participants only. Military service that did not interrupt employment or leave of absence cannot be counted toward employment for the purpose of continuing insurance at retirement.

Local Education Employment with the Employer – Employment with a participating local education agency in Tennessee or any agency of state government participating in the state plan. For purposes of this plan, accumulated unused sick leave is defined as Employment with the Employer. Military service that did not interrupt employment, educational leave, leave of absence, or service with a local government agency are not defined as Employment with the Employer.

Local Government Employment with the Employer – Employment with the participating local government agency from which the employee is retiring. For purposes of this plan, accumulated unused sick leave is defined as Employment with the Employer. Military service that did not interrupt employment, educational leave, leave of absence, employment with an agency participating in the state or local education plans, or service with another local government agency are not defined as Employment with the Employer.

Local Education Qualifications

TCRS

- Minimum of 10 years of state service and covered through the state’s group insurance program for three years immediately prior to retirement
- Twenty years of state service and covered through the state’s group insurance program for one year immediately prior to retirement

Non-TCRS

- Age 55 at final termination and at least 10, but less than 20, total years of employment with a participating local education agency or the state, with three continuous years of insurance coverage in the plan immediately prior to final termination
- Age 55 and 20 or more total years of employment with a participating local education agency or the state, with one year of insurance coverage in the plan immediately prior to final termination
- Twenty-five years of service with a participating local education agency or the state, with one year of insurance coverage in the plan immediately prior to final termination

Retirees and dependents may retain coverage until they are eligible for Medicare due to age. If a retiree becomes eligible for Medicare Part A prior to age 65, Medicare Part B must be retained to continue coverage.

TCRS and Non-TCRS

- School board members must have at least 20 years of service as a member of the same school board from which they retire, must be age 55 and be enrolled in the plan for one full year immediately prior to retirement or 30 years of service from the same school board and enrolled at least one year in the plan immediately prior to retirement

Local Government Qualifications

TCRS and Non-TCRS

- Age 55 with at least 10 years of service with the agency from which they are retiring and covered under the state’s group insurance program for at least three full calendar years immediately before retirement
- Age 55 with at least 20 years of service with the agency from which they are retiring and be covered under the state’s group insurance program for at least one full year immediately prior to retirement
- Thirty years of service with the agency from which they are retiring and covered under the state’s group insurance program for at least one full calendar year immediately before retirement, provided they aren’t Medicare eligible

Non-TCRS Only

- Public safety employees age 50 with at least 25 years of creditable service within the same agency, must be covered under the state’s group insurance program for at least one full year immediately prior to retirement and must qualify for an unreduced benefit

Retiree coverage ends on the last day of the month prior to becoming eligible for Medicare Part A, regardless of age, unless the individual has end-stage renal disease.

the first of the month following termination of your group insurance. There is no preexisting condition requirement, waiting period or lapse in coverage. Enrollment material is automatically sent to your home address approximately 90 days prior to your 65th birthday, or you may request it by calling TCRS.

What If I Don't Qualify?

Retired employees who cannot continue health insurance coverage because of the service requirements may convert to a private direct payment plan or may be eligible to continue coverage through COBRA. Eligibility requirements for COBRA can be found on pages 15–17. Dental insurance may also be continued through COBRA.

What Happens to My Medical Insurance If I Become Disabled?

If you become totally and permanently disabled while covered under the PPO medical option, you (as a former employee) may continue health coverage, for that condition only, for one year. Coverage is not provided for any other injury or illness and is in lieu of any other option offered by the state group insurance program. You must request this continuation option in writing within 30 days of the date your active insurance coverage is terminated. No premium contribution is required, but you will be responsible for your deductible and coinsurance amounts. Pharmacy charges must be paid at the time of service and reimbursement is subject to the terms and conditions of the plan.

If you completed at least five years of service, you may be able to continue health coverage beyond one year if you are determined to be totally and permanently disabled in accordance with the TCRS medical review panel or submission of an award letter from Social Security Administration and are covered under the state group insurance program at the time the disabling injury or illness occurred.

If you remain disabled for a period of two years and become eligible for Medicare Part A and B, you are required to purchase Part B. Medicare will become primary at this time. Your coverage through the state will become secondary. The state coverage will remain primary for a period of 30 months if diagnosed with end-stage renal disease. You will remain eligible for the state coverage until you become eligible for Medicare due to age.

What Happens to My Covered Dependents If I Die?

If You Are an Active Employee

Your covered dependents may continue health coverage with the state's group insurance program for six months at no cost. After that, they may continue health coverage under COBRA guidelines for a maximum of 36 months as long as they remain eligible. Dental coverage, if applicable, will terminate at the end of the month of the death of the employee; however, continuation of coverage through COBRA will be available.

If You Are a Covered Retiree

Your covered dependents will receive six months of health coverage at no cost. Dependents may be eligible to continue to be covered as long as they continue to meet eligibility guidelines and receive a monthly benefit check through TCRS.

If You Are Covered Under COBRA

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

How Is Incorrect Information Handled?

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

If your covered dependent(s) becomes ineligible, it is your responsibility to inform your benefits coordinator and complete an enrollment/change application within one full calendar month of that dependent losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, 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, it is your responsibility to notify your benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from the employee.

Fraud, Waste and Abuse

Financial losses as a result of fraud, waste or abuse have a direct effect on you as a plan member. When fraudulent claims are paid or benefits provided to an individual that is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your healthcare. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or participant fraud. You can help prevent fraud and abuse of the plan by working with us 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 toll-free number on the reverse side of your identification card to question any charge that you do not understand — this will prevent providers from billing for services not provided to you or your dependents or misrepresenting the date of service, the amount charged or the type of service provided
- Report anyone who permits a relative or friend to “borrow” his or her insurance identification card
- Report anyone who makes false statements on their enrollment applications
- Report anyone who fabricates 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.

Is There an Appeal Process?

Claims Appeal

Before initiating a health claims-related appeal, you should first contact the insurance company to get an explanation of the claims payment. If you are unable to resolve your issue, you may then request an appeal.

Appealing to the Insurance Company

Some insurance companies have their own internal appeals process (also known as grievance/complaint procedures) that must be followed prior to appealing to the state. You should refer to your member handbook to determine if this step applies to you. If you are still unsure, you should contact the toll-free customer service number given for your insurance company.

Mental Health and Substance Abuse Appeals

Mental health claims and medical claims are handled by different companies. To expedite your appeal for mental health and/or substance abuse services, make sure that you appeal directly to the company handling your mental health claims by calling their customer service number. You should complete all levels of appeal through your mental health carrier's appeal process. If your appeal is denied at the final level, you may then appeal to Benefits Administration.

Administrative Review

You may also request a review of administrative issues, including certain decisions made on behalf of the plans. To request this type of review, provide your agency benefits coordinator with a letter detailing the circumstances of your situation. The benefits coordinator will forward your letter to Benefits Administration. Your correspondence will be reviewed and you will receive a written response to your request.

Appealing to the Plan Administrator

This level of appeal is available to you if you have already been through the internal appeals process offered by your insurance company without a satisfactory resolution or if your insurance company does not have an internal appeals process and you have been unable to resolve your issue through their customer service department. If either one of the above is true, you can file an appeal by writing to Benefits Administration.

The appeal should be in the form of a letter (from the employee) detailing the events leading to the denial of the insurance claim. Copies of all correspondence and explanation of benefits relating to the claim should accompany the letter. Also include any other documented information, such as names of personnel you have talked with, dates of the communications, physicians' statements, etc. It is very important that you provide a phone number or email address where you can be reached during business hours so that you can be contacted with questions or information about your appeal. The deadline for filing an appeal is two years after claim rejection.

Appeal Review

When the appeals coordinator in Benefits Administration receives your information, it will be thoroughly reviewed to determine the exact nature of your appeal. The majority of requests for appeals require additional review by the insurance company. The appeals coordinator will request that the insurance company provide (in writing) the criteria used in making its determination of benefits. The average review takes approximately 60 days to complete. Some cases take longer depending on whether additional information is needed, the response time for the requested information and the complexity of the medical condition. Some cases may also require review by the state's independent medical consultant. The determination to request such a review will be made by the appeals coordinator.

Many appeals are resolved during this review phase of the process. If, however, your appeal is not resolved, it may be scheduled for presentation to the Staff Review Appeals Committee.

Staff Review Committee

The Staff Review Committee is composed of employees within state government selected by the Insurance Committees. The Staff Review Committee meets once a month to review appeals that have not been resolved. Prior to the Staff Review Committee meeting, you will be furnished with a copy of your case file and will have the opportunity to notify Benefits Administration if you feel that any information in the file is incorrect or incomplete. You may make a personal presentation to the Staff Review Committee, or your appeal can be reviewed based on the written record. After the Staff Review Committee has heard your appeal, their votes are tallied and the results are forwarded to the Insurance Appeals Subcommittee.

Insurance Appeals Subcommittee

The Subcommittee consists of selected State Insurance Committee members. This Committee receives a written report of each appeal and is advised of the recommendation from the Staff Review Committee's meeting. After reviewing the written appeals, each Subcommittee member votes individually by written ballot and returns the ballot to the appeals coordinator in Benefits Administration. If the majority of the Subcommittee votes that they agree with the decision of the Staff Review Committee, the decision will stand. If, however, the majority of the Subcommittee votes for an additional review of the case, it will be scheduled for presentation at a second meeting.

If your appeal is scheduled for a second meeting, you will again be given the opportunity to make a personal presentation. You may make a personal presentation at this level even if you did not appear at the first meeting, or your case can be reviewed on the written record.

You will receive written notification of the outcome of your appeal after all the Subcommittee votes have been returned. It normally takes about two weeks (from the date of the first appeals meeting). The decision of the Subcommittee is final and is the last step in the administrative appeals process.

Pursuing Further Action

If an appeal is denied by both the Staff Review Committee and the Insurance Appeals Subcommittee, state and local education employees may take further action. Along with the notification of the decision on your appeal, you will receive information about contacting the Tennessee Division of Claims in the Department of Treasury. Local government employees may take further action through independent legal counsel.

Once you have filed a claim with the Department of Treasury, the State Attorney General's Office will be notified of your claim for damages. The following is an outline of guidelines followed by the Attorney General's Office once your claim for money damages is received in their office. Regardless of whether you choose to present your claim at a hearing or by affidavit, you must produce competent evidence in support of your claim. You have the burden of proof.

Hearing

You may request a hearing from the claims commissioner. At the hearing, you will be given the opportunity to present evidence to support your claim for money damages against the state. An assistant attorney general will present evidence to the contrary. The hearing will be conducted like cases in General Sessions Court. Based upon the evidence presented at this hearing, the claims commissioner will rule on your claim.

Affidavit

This is a sworn statement by you and/or any witness in support of your claim. An affidavit must be sworn to before a notary public. If you want to have your claim decided by affidavit without a hearing, you must sign an Agreed Order of Waiver of Hearing. A claims commissioner will sign the order and copies will be sent to you and the undersigned assistant attorney general. When you receive a copy of the order, you should file any affidavits in support of your claim in accordance with the schedule set forth in the order. Once all the affidavits are filed, the claims commissioner will decide the claim based only upon those affidavits.

OTHER PROGRAMS

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Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential counseling and referral service for all employees covered under a state-sponsored plan. As long as you are enrolled in health coverage, your eligible dependents are also eligible for services, regardless of whether they are enrolled in health coverage. The EAP can handle problems related to

- emotional
- family
- workplace
- grief
- financial
- mental health
- substance abuse
- legal
- stress
- family/marital
- chronic illness
- elder care

Personal growth workshops and seminars are offered to employees on a quarterly basis at nine locations across the state. Others are available upon request.

How Do I Access Services?

All services are strictly confidential and can be accessed by calling the contracted vendor who is available 24 hours a day, 365 days a year. The counselor who takes your call will ask you some questions and refer you to a provider based on the information you provide.

How Much Does It Cost?

You and your eligible dependents may receive up to six counseling sessions per problem episode at no cost to you. If it is determined that you need greater assistance than through EAP, you will be referred to your insurance provider's mental health and substance abuse benefits. For further questions and information, you may call 615-741-1925.

Dental Insurance

The State of Tennessee offers dental insurance to all eligible employees and their dependents. Participation and your premium payment are determined by your agency. Contact your benefits coordinator to determine participation and premium rates. Two options are available—a Prepaid plan and a PPO plan.

In the Prepaid plan, you must select from a specific group of dentists. Under the PPO plan, you may visit the dentist of your choice; however, members receive maximum savings when visiting a PPO network provider. Both dental options have specific guidelines for benefits such as exams and major procedures, and have a three-tier premium structure—single, employee plus one dependent and multi-dependent coverage.

You can enroll in dental coverage as a new employee or during the annual enrollment transfer period, provided this coverage is offered by your agency. You do not have to be enrolled in health coverage to be eligible for dental insurance. Please call your benefits coordinator for a brochure which includes a full schedule of benefits and premiums.

What's the Difference Between the Dental Options?

Prepaid Plan

- Must select a participating network provider for each covered family member
- Major services at predetermined copayments
- No claim forms
- Preexisting conditions are covered
- No maximum benefit levels
- No deductibles
- No charge for oral exams, routine semiannual cleanings, most x-rays and fluoride treatments; however, an office visit copay will apply

PPO Plan

- Select any dentist
- \$1,000 calendar year benefit maximum per person
- \$0 calendar year deductible per individual in-network, \$100 per individual out-of-network
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of \$1,250 for orthodontia

State of Tennessee
Department of Finance and Administration
Benefits Administration

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