

PARTNERS
FOR HEALTH

State Group
Insurance Program

**Continuing
Insurance at
Retirement**

Local Education

If you need help...

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

	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981	www.tn.gov/finance/ins www.partnersforhealthtn.gov Email: benefits.administration@tn.gov
Health Insurance	BlueCross BlueShield of Tennessee Cigna	800.558.6213 800.997.1617	www.bcbst.com/members/tn_state www.cigna.com/stateoftn
Pharmacy Benefits	CVS Caremark	877.522.TNRX (877.522.8679)	www.caremark.com
Mental Health, Substance Abuse and Employee Assistance Program	Magellan	855.HERE.4.TN (855.437.3486)	www.Here4TN.com
Wellness and Nurse Advice Line	Healthways	888.741.3390	www.partnersforhealthtn.gov
Dental Insurance	Assurant Employee Benefits Delta Dental	800.443.2995 800.223.3104	www.assurantemployeebenefits.com/stoftn www.deltadentaltn.com/statetn
Vision Insurance	EyeMed Vision Care	855.779.5046	www.eyemedvisioncare.com/stoftn
Long-Term Care Insurance	MedAmerica	866.615.5824	www.ltc-tn.com

Forms and handbooks...

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

Online resources...

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

INTRODUCTION

Overview

This guide is provided to help you understand the insurance options that are available to you at retirement. It is important that you familiarize yourself with the topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

This guide begins by explaining eligibility and enrollment requirements. **Please note that the Eligibility and Enrollment section contains separate subsections based on your participation in the Tennessee Consolidated Retirement System (TCRS). The first subsection is for TCRS participants and the second subsection is for non-TCRS participants.** It is very important that you refer to the section that applies to you regarding eligibility. If your agency does NOT participate in the Tennessee Consolidated Retirement System, you should review the non-TCRS section.

For Additional Information

Your agency benefits coordinator (ABC) is the person designated in your department or facility to handle insurance matters and is your primary contact as you prepare for retirement. Your ABC is typically located in your human resource office, and he or she is available to provide you with any necessary forms and insurance booklets.

For questions about eligibility regarding insurance as a retiree, contact Benefits Administration. The Benefits Administration service center will be your main point of contact regarding insurance eligibility and enrollment once you leave employment for retirement. You can contact our service center by calling 800.253.9981.

In addition to being available from your ABC, all enrollment forms and handbooks referenced in this guide are located on the Benefits Administration website (www.tn.gov/finance/ins — just click on Publications and Forms), or you can get a copy from Benefits Administration by emailing retirement.insurance@tn.gov or by calling our office. Please be sure to include your Edison ID (found on your Caremark card) when emailing our office.

Our ParTNers for Health website also has information about all of 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.

Authority

Benefits and premiums for local education members are set by the Local Education Insurance Committee. The Insurance Committee is authorized to (1) add, change or end any coverage offered through the state group insurance program, (2) change or discontinue benefits, (3) establish premiums and (4) change the rules for eligibility at any time, for any reason.

Local Education Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Education as designated by the Governor
- Two teachers serving from the east and west grand divisions appointed by the speaker of the senate and one teacher serving from the middle grand division appointed by the speaker of the house
- One representative selected by the Tennessee School Board Association

ELIGIBILITY AND ENROLLMENT

TCRS PARTICIPANTS

Continuing Coverage at Retirement

All covered local education employees who meet the qualifications may continue medical insurance at retirement for themselves and covered eligible dependents (spouse and/or children). Retired employees may continue coverage under the local education plan until they become eligible for Medicare by virtue of age. Covered dependents will also be allowed to continue coverage until they become eligible for Medicare by virtue of age or no longer qualify as eligible dependents. Retirees or their dependents who become entitled to Medicare prior to age 65 must enroll in Medicare parts A and B to continue group health coverage in the plan until they become entitled to Medicare by virtue of age. Participants who are eligible for Medicare may be eligible to enroll in Medicare supplement coverage. More information about the Medicare supplement plan offered by the state is included at the end of this section of the guide.

To continue insurance benefits, the agency from which you retire must continue to participate in the Local Education Plan. If your former agency leaves the state group insurance program, you and/or your covered dependent's coverage will also be terminated.

If your spouse is also an eligible covered employee participating in one of the state-sponsored plans, you may continue coverage as a dependent on the active spouse's contract instead of electing retiree coverage. When your spouse terminates employment, you may resume coverage under your own eligibility if not yet eligible for Medicare due to age. Retirees who are no longer eligible for the group health plan are not eligible to apply to cover their dependents via the special enrollment provision.

If you meet the eligibility guidelines, you will have the opportunity to continue enrollment in comprehensive group health coverage or enroll in optional dental coverage, Medicare supplement coverage and other optional products. This section of the guide explains your options and the requirements for each type of coverage.

All health, vision, dental and Medicare supplement coverages have their own member handbooks to explain their benefits. You may obtain a copy of these books from your agency benefits coordinator or from the Benefits Administration website.

Service Requirements to Continue Group Health Coverage

Eligible members must have at least ten years of creditable service to continue insurance coverage. Accumulated 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 a local government agency cannot be counted.**

You may include employment with the state of Tennessee or a state higher education institution to calculate total employment (only creditable service with the state or a higher education institution or a local education agency that participates in the state group health plan will count). Years of service with local education, state or higher education employers participating in the plan applies to the length of service requirement for continuing coverage at retirement, not necessarily toward premium reduction. Premiums may be calculated to include service with state and local education employers participating in TCRS. On local education service, state premium support is provided on teaching service only.

If you are eligible to combine creditable state service with creditable local education service, you will be classified as a retiree under the plan from which you terminated employment immediately preceding your retirement. For example, if you worked for a state agency for 10 years, then worked for a participating local education agency for 10 years and retire, you will be considered a local education retiree with 20 years of service for insurance purposes.

The eligibility guidelines are:

- Ten years of creditable service with the state or a participating local education agency **and** at least three continuous years of insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits commence (effective date of retirement with TCRS) must be on or before the date on which your active state coverage ceased. Note: the requirement for immediate commencement of retirement benefits will be waived for employees leaving the plan and becoming insured by the state or a local government agency that participates in the state group insurance program.
- At least 20 or more years of creditable service with the state or a participating local education agency **and** at least one continuous year of insurance coverage in the plan immediately prior to final termination of employment. The period of time between your final employment termination date and the date retirement pension benefits commence (effective date of retirement with TCRS) may be up to five years. Note: the five-year requirement for commencement of retirement benefits will be waived for employees leaving the local education plan and becoming insured by a state or local government agency that participates in the state group insurance program.
- School board members are eligible to continue their coverage at the time of retirement as long as they meet the eligibility guidelines. To be eligible to continue insurance at retirement, the school board member 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 of coverage immediately prior to retirement or 30 years of service as a member of the same school board from which they retire and at least one full year of coverage on the plan immediately prior to retirement. Coverage must begin immediately upon termination of active group health insurance, unless the retiree goes to work for another agency participating in a state-sponsored plan. Should the school system from which the school board member retired cancel participation in the state-sponsored plan, individual retirees may no longer participate. School board members are required to pay the entire monthly premium.

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

If you are retiring through TCRS, you must be receiving a monthly retirement benefit to continue coverage as a retiree. TCRS participants who choose a lump-sum retirement benefit are not eligible to continue insurance at retirement.

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

Application to Continue Group Health Coverage

Eligible employees who wish to continue group health insurance coverage at retirement should submit the application to continue insurance at retirement to their agency benefits coordinator to begin the certification of eligibility process. The application must be submitted within one full calendar month of the expiration of active insurance. You must continue in the same health insurance PPO you were enrolled in immediately prior to retirement. However, you can change carriers if you move outside the service area. You will also have a chance to make changes to your insurance during the annual enrollment transfer period each fall.

If you have 20 or more years of service and there is an allowed gap between your date of termination and date of retirement (the effective date of your TCRS pension benefit), the application must be submitted within one full calendar month of the date of retirement.

Effective Date of Retiree Group Health Coverage

For eligible retirees, continuation of group health coverage will be effective on the first day of the month following the expiration of active insurance coverage. If you have an allowed gap between your termination date of employment and your date of retirement (the effective date of your TCRS pension benefit), group health coverage will be effective on the first of the month following the date of retirement.

Individuals Eligible for Medicare: Medicare Supplement Coverage

Retirees and their dependents who are eligible for Medicare part A by virtue of age cannot continue in standard health coverage, unless grandfathered by the Local Education Insurance Committee. You may apply for the state's Medicare supplemental coverage called the Tennessee Plan if you are enrolled in Medicare part A and receive a monthly TCRS pension benefit. Your dependents who are eligible for Medicare Part A may also apply for the Tennessee Plan. This coverage is a standard Medicare supplemental policy that helps fill most of the coverage gaps that Medicare creates. Individuals who qualify and enroll within 60 days of initial eligibility 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 terminates or date of Medicare eligibility, whichever is later.

The Tennessee Plan is a supplement for Medicare part A and B; 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 Medicare supplement will not coordinate benefits if you are currently enrolled in or join a Medicare Advantage Plan. This means the plan will not pay any deductibles, copayments or other cost sharing. If you have a Medicare Advantage Plan, the Tennessee Plan will not pay out any benefits.

Application for Medicare Supplement Coverage

Employees who are eligible for Medicare at retirement (or who have Medicare eligible dependents) can select Medicare supplement coverage on their application to continue insurance at retirement. You have 60 days from the initial eligibility date to enroll in the Tennessee Plan Medicare supplement. Coverage will be effective the first of the month following your termination of active state group health coverage or the first of the month following date of retirement, whichever is later.

Retirees and their dependents who become eligible for Medicare by virtue of age after retirement will be sent an application approximately three months before the date of their 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 enrollment is not selected within 60 days of initial eligibility, you and/or your eligible dependent may apply through medical underwriting, which means enrollment is subject to approval and may be denied. If you or your eligible dependent is applying outside of your initial 60-day eligibility period you must contact Benefits Administration to request an application. Benefits Administration will submit the application for review to the Tennessee Plan Medicare supplement vendor.

Once approved for the Tennessee Plan, you will receive a card from the Tennessee Plan Medicare supplement vendor with 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 any premiums paid in advance. Any claims paid during this period will be recovered.

End-Stage Renal Disease

Retirees eligible for Medicare as a result of end-stage renal disease may be eligible for extended group health coverage benefits and should contact Benefits Administration immediately for additional information on the eligibility criteria.

Vision Coverage

Continuation of vision insurance is **NOT** automatic at retirement.

COBRA Vision

If you do not qualify to enroll in group health on the retiree plan, but you were covered under a state-sponsored vision plan when your employment terminated, you will be given the opportunity to continue your vision coverage for 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). A COBRA notification will be mailed to your home upon termination of active coverage. Please note the COBRA enrollment form is a separate enrollment form and is not the same as the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must complete and return the COBRA enrollment form to Benefits Administration within 60 days of termination of your active coverage and will be billed directly for the premiums due. COBRA vision premiums cannot be deducted from your TCRS pension check.

These vision plan options are discussed in more detail in the All Plan Members section of this guide. You can also find more information, including current vision premiums, on the ParTNeers for Health website.

Retiree Vision

Members must be enrolled in the retiree group health plan and be receiving a monthly pension from TCRS to be eligible to enroll in coverage in the retiree vision plan. If the retiree or dependent is not enrolled in the retiree group health plan they are not eligible to enroll in the retiree vision plan. If you do not select vision coverage for eligible members upon your retirement, members who are enrolled in the retiree group health plan will have the option of joining during the annual enrollment transfer period each fall.

Vision coverage will terminate when the member's enrollment in the retiree group health plan terminates. If the retiree comes off the plan but was covering dependents that are still eligible, the coverage will change to the corresponding dependent only level.

Dental Coverage

Continuation of dental insurance is **NOT** automatic at retirement. If you want to continue coverage under one of the state dental plans, you may enroll in COBRA or retiree dental coverage.

COBRA Dental

If you were enrolled in dental coverage as an active employee under a state-sponsored plan when your employment terminated, you will be given the opportunity to continue your dental coverage for 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). A COBRA notification will be mailed to your home upon termination of active coverage. Please note the COBRA enrollment form is a separate enrollment form and is not the same as the Application to Continue Insurance at Retirement. If you choose to continue dental through COBRA, you must complete and return the COBRA enrollment form to Benefits Administration within 60 days of termination of your active coverage. Please indicate on the signature page of the COBRA enrollment form that you are a TCRS retiree.

Retiree Dental

If you do not qualify to continue dental insurance through COBRA or simply wish to enroll in the retiree dental plan upon termination of active insurance coverage, you may select retiree dental on your application to continue insurance at retirement. Please note, to enroll in retiree dental you must be receiving a monthly TCRS pension benefit. Retiree dental enrollments are not retroactive; your enrollment will be effective on the first of the month following receipt of your enrollment form. If you do not select dental coverage upon your retirement, you will have the option of joining during the annual enrollment transfer period each fall.

These dental plan options are discussed in more detail in the All Plan Members section of this guide. You can also find more information, including current dental premiums, on the ParTners for Health website.

Long-Term Care Coverage

This coverage is portable, meaning that you can continue under the same terms and conditions as active employees. Coverage is guaranteed renewable, so it can never be cancelled as long as you continue to pay the premium. TCRS participants can choose to have the premium deducted from the monthly pension benefit. You may also choose to have the premium deducted from your bank account or credit card either monthly, quarterly, semi-annually or annually. You may also pay premiums by direct billing with the insurance carrier either quarterly, semi-annually or annually. **All questions should be directed to MedAmerica at 866.615.5824.**

Disability Participants

Disability retirees insured through a participating local education agency at the time of the injury or illness which resulted in their disability may continue coverage provided that no lapse in medical coverage has occurred by meeting either the requirements of Section 4.06(B) for TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability. Employees who qualify for disability retirement may continue coverage if they participated in the plan at the time the injury or illness occurred and, for such retirees, the date retirement benefits commence (retirement date) must be on or before the date on which their active state coverage ceased. Employees who are granted a service retirement, but are also disabled, must prove that total disability exists 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 physician review of medical records documenting the disability. The required proof must show total disability existed on or before the date on which their active coverage ended.

Upon eligibility for part A of Medicare, you and your eligible dependents may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred, provided you remain eligible for the disability allowance and part B of Medicare is retained.

If you continue participation in the local education plan and subsequently qualify for Medicare due to a disabling condition, you must enroll in Medicare parts A and B to continue to be eligible for coverage until such time as you would have been eligible for Medicare by virtue of age. If you do not enroll in part B at the first opportunity, coverage will be terminated as of July 1 following refusal to take part B.

Medicare will be the primary coverage and the local education plan will be secondary. Coverage will terminate once you or your dependents reach the normal age for Medicare part A.

Disabled retirees whose coverage has lapsed from their last period of employment and whose effective date of disability retirement has been determined by the employer-sponsored retirement plan to be after the date on which their coverage as a full-time employee ceased are not eligible for reinstatement of medical coverage.

NON-TCRS PARTICIPANTS

Continuing Coverage at Retirement

All covered local education employees who meet the qualifications may continue medical insurance at retirement for themselves and covered eligible dependents (spouse and/or children). Retired employees may continue coverage under the local education plan until they become eligible for Medicare by virtue of age. Covered dependents will also be allowed to continue coverage until they become eligible for Medicare by virtue of age or no longer qualify as eligible dependents. Retirees or their dependents who become entitled to Medicare prior to age 65 must enroll in Medicare parts A and B to continue group health coverage in the plan until they become entitled to Medicare by virtue of age. If you do not enroll in part B at the first opportunity, coverage will be terminated as of July 1 following refusal to take part B. Participants who are eligible for Medicare are not eligible to enroll in the state's Medicare supplement coverage.

To continue insurance benefits, the agency from which you retire must continue to participate in the local education plan. If your former agency leaves the state group insurance program, you and/or your covered dependents coverage will also be terminated.

If your spouse is also an eligible covered employee participating in one of the state-sponsored plans, you may continue coverage as a dependent on the active spouse's contract instead of selecting retiree coverage. When your spouse terminates employment, you may resume coverage under your own eligibility if not yet eligible for Medicare due to age. Retirees who are no longer eligible for the group health plan are not eligible to apply to cover their dependents via the special enrollment provision.

If you meet the eligibility guidelines, you will have the opportunity to continue enrollment in group health coverage and optional dental coverage. This section of the guide explains your options and the requirements for each type of coverage.

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 or from the Benefits Administration website.

Service Requirements to Continue Group Health Coverage

Eligible members must have at least ten years of creditable service to continue insurance coverage. Accumulated unused sick leave may be counted. **Military service that did not interrupt employment, educational leave, leave of absence, or service with a local government agency cannot be counted.**

You may include employment with the state of Tennessee or a state higher education institution to calculate total employment (only creditable service with a local education agency that participates in the state group health plan will count). If you are eligible to combine creditable state service with creditable local education service, you will be classified as a retiree under the plan you terminated employment from immediately preceding your retirement. For example, if you worked for a state agency for 10 years, then worked for a participating local education agency for 10 years and retire, you will be considered a local education retiree with 20 years of service for insurance purposes. Years of service with the state, higher education or local education employers participating in the plan applies to the length of service requirement for continuing coverage at retirement, not necessarily toward premium reduction. On local education service, state premium support is provided on teaching service only.

The eligibility guidelines are:

- Ten years of creditable service with the state or a participating local education agency, must be age 55 at the time active employment terminates with the participating agency **and** at least three years of continuous insurance coverage in the plan immediately prior to final termination for retirement. The date retirement insurance benefits

commence must **immediately** follow active group health coverage ending due to final termination from employment. (The requirement for immediate commencement of retirement insurance benefits will be waived for employees leaving the local education plan and becoming insured by the state or a local government agency that participates in the state group insurance program.)

- At least 20 or more years of creditable service with the state or a participating local education agency, attainment of age 55 **and** at least one continuous year of insurance coverage in the plan immediately prior to final termination for retirement. The period of time between your final termination date from the participating agency and attainment of age 55 may be up to five years. (The five year requirement for commencement of retirement group health insurance benefits will be waived for employees leaving the local education plan and becoming insured by the state or a local government agency that participates in the state group insurance program.)
- Twenty-five years of creditable service with the state or a participating local education agency **and** one continuous year of insurance coverage immediately prior to final termination for retirement. The period of time between the employee's final termination date from the participating agency and the commencement of retirement group health insurance may be up to five years. (The five year requirement for commencement of retirement insurance benefits will be waived for employees leaving the local education plan and becoming insured by the state or a local government agency that participates in the state group insurance program.)

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

Application to Continue Group Health Coverage

Eligible employees who wish to continue group health insurance coverage at retirement should submit an application to continue insurance at retirement to their agency benefits coordinator for certification of eligibility. Your ABC will complete the employer certification section and submit the form to Benefits Administration. The application must be submitted within one full calendar month from the expiration of active insurance. You must continue in the same health insurance PPO you were enrolled in immediately prior to retirement. However, you can change carriers if you move outside the service area. You will also have a chance to make changes to your insurance during the Annual Enrollment Transfer Period each fall.

If you have 20 or more years of service and there is an allowed gap between your date of termination and the date insurance benefits commence, the application must be submitted within one full calendar month of the date of meeting conditions for continuing coverage.

Effective Date of Retiree Group Health Coverage

For eligible retirees, continuation of group health coverage will be effective on the first day of the month following the expiration of active insurance coverage. If you have an allowed gap between your termination date of employment and your date of retirement, group health coverage will be effective on the first of the month following the date of eligibility due to meeting conditions for continuing coverage.

Individuals Eligible for Medicare

Retirees and their dependents who are eligible for Medicare part A by virtue of age cannot continue in standard health coverage, unless grandfathered by the Local Education Insurance Committee. The state group insurance program's Medicare supplement coverage is not an available option to non-TCRS local education participants. If you are interested in obtaining a Medicare supplement policy, you should obtain coverage through a private carrier.

If a retiree or covered dependent becomes entitled to Medicare due to disability prior to the age of 65, Medicare parts A and B must be retained in order to maintain coverage under the state group health plan until Medicare entitlement is reached by virtue of age. If you do not enroll in part B at the first opportunity, coverage will be terminated as of July 1 following refusal to take part B. Medicare becomes primary and the state group health plan would pay secondary.

End-Stage Renal Disease

Retirees eligible for Medicare as a result of end-stage renal disease may be eligible for extended group health coverage benefits and should contact Benefits Administration immediately for additional information on the eligibility criteria.

Vision Coverage

If you were covered under a state-sponsored vision plan when your employment terminated, you will be given the opportunity to continue your vision coverage for 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). A COBRA notification will be mailed to your home upon termination of active coverage. Please note the COBRA enrollment form is a separate enrollment form and is not the same as the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must complete and return the COBRA enrollment form to Benefits Administration within 60 days of termination of your active coverage and will be billed directly for the premiums due.

Retirees who do not receive a monthly TCRS pension are not eligible to apply for the retiree vision option.

These vision plan options are discussed in more detail in the All Plan Members section of this guide. You can also find more information, including current vision premiums, on the ParTNers for Health website.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement. If you were enrolled in dental coverage as an active employee under a state-sponsored plan when your employment terminated, you will be given the opportunity to continue your dental coverage for 18 months under COBRA. A COBRA notification will be mailed to your home upon the termination of your active coverage. To continue dental through COBRA, you must complete and return the COBRA enrollment form to Benefits Administration within 60 days of your active coverage terminating.

Long-Term Care Coverage

This coverage is portable, meaning that you can continue under the same terms and conditions as active employees. Coverage is guaranteed renewable, so it can never be cancelled as long as you continue to pay the premium. You may choose to have the premium deducted from your bank account or credit card either monthly, quarterly, semi-annually or annually. You may also pay premiums by direct billing with the insurance carrier either quarterly, semi-annually or annually. **All questions should be directed to MedAmerica at 866.615.5824.**

Disability Participants

Disability retirees insured through a participating local education agency at the time of the injury or illness which resulted in their disability may continue coverage provided that no lapse in medical coverage has occurred by meeting either the requirements of Section 4.06(D) for non-TCRS participants or by having at least five years of employment with the employer immediately prior to final termination due to disability. Employees who qualify for disability retirement may continue coverage if they participated in the plan at the time the injury or illness occurred and, for such retirees, the date retirement benefits commence (retirement date) must be on or before the date on which their active state coverage ceased. Employees who are granted a service retirement, but are also disabled, must prove that total disability exists 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 physician review of medical records documenting the disability. The required proof must show total disability existed on or before the date on which active coverage ended.

Upon eligibility for part A of Medicare, you and your eligible dependents may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred, provided Part B of Medicare is retained.

If you continue participation in the local education plan and subsequently qualify for Medicare due to a disabling condition continue, you must enroll in Medicare parts A and B to continue to be eligible for coverage until such time as you would have been eligible for Medicare by virtue of age. If you do not enroll in part B at the first opportunity, coverage will be terminated as of July 1 following refusal to take part B.

Medicare will be the primary coverage and the local education plan will be secondary. Coverage will terminate once you or your dependents reach the normal age for Medicare part A.

Disabled retirees whose coverage has lapsed from their last period of employment and whose effective date of disability retirement has been determined by the employer-sponsored retirement plan to be after the date on which their coverage as a full-time employee ceased are not eligible for reinstatement of medical coverage.

GENERAL INFORMATION FOR ALL PLAN MEMBERS

This section explains policies and procedures for all retirees, both TCRS and non-TCRS participants.

Dependent Coverage

Retirees may continue insurance coverage for eligible dependents if the individuals were covered at retirement.

Dependents may continue coverage as long as they meet plan eligibility requirements. Newly acquired dependents must be added within 60 days.

Dependent Eligibility

The following dependents are eligible for coverage:

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

All dependents must be listed by name on the 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 or (if applicable) dental coverage beyond age 26 if they were disabled before their 26th birthday and they were already insured under the state group insurance program. The child must meet the requirements for dependent eligibility listed above. A request for extended coverage must be provided to Benefits Administration within 90 days before the dependent’s 26th birthday.

The insurance carrier will decide if a dependent is eligible based on disability. Coverage will end and will not be restored once the child is no longer disabled.

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

A retiree insurance change application must be completed within 60 days of the date a dependent is acquired. The “acquire date” is the date of birth, marriage, or, in case of adoption, when a child is adopted or placed for adoption. Proof of the dependent’s eligibility is also required to add dependents not previously covered. Refer to the dependent definitions and required documents chart included on the enrollment application for the types of proof you must provide. Premium changes start on the first day of the month in which the dependent was acquired or the first of the next month depending on the coverage start date.

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

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

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

If you have single coverage

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

If you have family coverage

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

More information about qualifying events is provided under the special enrollment provisions topic in this section of this guide.

Updating Personal Information

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

Annual Enrollment Transfer Period

During the fall of each year, you have the opportunity to transfer or cancel your existing state group health insurance, vision or dental coverage if you are currently enrolled. Benefit information is mailed to your home address prior to the transfer period. Reviewing it carefully will help you make informed decisions for you and your family. The options you choose during the enrollment period will take effect on the following January 1 and remain in effect through December 31, unless you lose eligibility or have a qualifying event or family status change during the year.

Canceling Health, Vision and Dental Coverage

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

- You lose eligibility for the state group insurance program, or
- You experience a special qualifying event, family status change or other qualifying event as approved by Benefits Administration, or
- You are enrolled in the Assurant 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 group health, vision and/or retiree dental coverage for yourself and/or your dependents outside of the annual enrollment transfer 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.)
- From part time to full time employment (self or dependent)

To cancel health, vision or retiree dental coverage for yourself or your dependent(s), due to becoming newly eligible for coverage under another plan or (for Assurant members) no participating general dentist within a 40-mile radius of your home, please fill out the insurance cancel request application.

This form is available in the "forms" section of the Benefits Administration website listed on the inside cover of this guide. If you do not have internet access, please call our office at 800.253.9981 and select the retirement option to request the form. You may also send an email to retirement.insurance@tn.gov to request a form be mailed to you. Please include the ID number on your Caremark card and your current mailing address.

If You Do Not Apply When First Eligible

If you are eligible and do not apply to continue group 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 at a later date through a special enrollment provision, you must still be eligible for the retiree group health coverage and have also met the eligibility criteria to continue group health coverage at the time active employment terminated. Retirees who are no longer eligible for the group health plan are not eligible to apply to cover their dependents via the special enrollment provision.

Special Enrollment Provisions

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

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

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

Important Reminders

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

Coverage Reinstatement Following Voluntary Cancellation

In the event that a policyholder has voluntarily canceled medical insurance coverage for themselves and/or their eligible dependents and wants the coverage reinstated, the policyholder may do so by meeting all of the following conditions:

- Premiums were paid current on the coverage termination date;
- The policyholder and/or their dependents continue to meet the eligibility requirements of the plan;
- The policyholder submits a written request for reinstatement within one full calendar month of the coverage termination date.

Coverage for Dependents in the Event of Your Death

Group Health

Upon the death of a retiree, a covered spouse or dependent will receive six months of free insurance coverage. Dependents of a deceased retiree may continue coverage only if they were covered by the plan at the time of the retiree's death **and** continue to meet dependent eligibility requirements.

Medicare Supplement

Upon the death of a retiree, coverage will terminate as of the first of the month following the retiree's death. The surviving spouse or dependents may continue Medicare supplement coverage if they were covered under the Medicare supplement plan at the time of the retiree's death. The surviving spouse or dependent must apply to continue coverage within 60 days of the termination of coverage under the retiree.

Optional Dental and/or Vision

Coverage under optional products will terminate the first of the month following the retiree's death. The surviving spouse or dependents may continue coverage on optional dental or vision if they were covered on the plan at the time of the retiree's death. The surviving spouse or dependents must apply to continue optional dental or vision coverage within 60 days of the termination of coverage under the retiree as long as they continue to meet the eligibility criteria.

Premiums for Surviving Dependents

Premiums will be deducted from any continuing monthly TCRS retirement benefits; otherwise, individuals will be billed directly. Dependents acquired by the survivor(s) after the death of the retired employee will not be eligible for coverage under the state-sponsored plans.

Premium Payment

Premiums for health, dental, vision and Medicare supplement are deducted from the monthly retirement benefit of retirees who receive a TCRS pension benefit. If the premium is greater than the retirement benefit or the retiree is a non-TCRS participant, the retiree will be billed directly by Benefits Administration each month or they can elect to pay by bank draft.

If you are billed directly and pay your monthly premium by sending a check, it must be received in Benefits Administration by the last day of the month for the following month's coverage. For example, your January 2012 premium check is due no later than December 31, 2011.

If you are billed directly and pay your premiums by automatic deduction (ACH) from your bank account, your monthly premium is withdrawn for the current month on or after the 15th of the month. For example, your January 2012 premium will be withdrawn from your bank account on or after January 15, 2012.

Coverage will be cancelled retroactively to the last month paid if premiums are not paid in full within 30-days of the due date. As a result of this policy, members whose group health insurance is canceled because they did not get their premium payments in on time can apply **ONE TIME ONLY** to get their coverage back. A request must be submitted within 30 days of the cancelation 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

Claims

Retirees who continue group health coverage will use the same insurance identification cards that were used while they were actively employed. Please note that you may receive a new card if changes are made to the plan. Any 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 when you continue insurance at retirement. For more detailed information, visit the ParTNers for Health website or consult your member handbook.

Health Insurance

You have a choice of two health insurance options:

- Partnership PPO
- Standard PPO

PPO stands for preferred provider organization. With a PPO, you can see any doctor you want. However, the PPO has a list of doctors, hospitals and other health care providers that you are encouraged to use. These providers make up what insurance carriers call a network. You can visit any physician or facility in the network. These providers have agreed to take lower fees for their services. The cost for members is higher when using out-of-network providers. The PPOs cover the same services, treatments and products.

Partnership Promise

There is one important difference between the partnership PPO and the standard PPO. If you choose the partnership PPO, you will be required to sign a partnership promise. The partnership promise requires you to take certain steps to get or stay as healthy as you can. In return, you will pay less than you would with the standard PPO.

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

Pre-existing Conditions

Pre-existing condition shall mean a condition for which a covered person received treatment or advice during the six-month period immediately prior to coverage with the state group insurance program.

The pre-existing condition clause does not apply to pregnancy, newborns or dependent children up to age 26. If you add a dependent spouse to your coverage who did not have previous health coverage, or if the prior coverage has been terminated for more than 63 days, he or she will be required to satisfy the pre-existing condition requirement. Treatments for conditions determined to be pre-existing shall not be considered eligible expenses until coverage has been in force for 12 months.

Dental Insurance

If you are eligible to continue dental benefits at retirement, you will have access to the same dental benefits as active employees which include a prepaid plan and a preferred dental organization (PDO) plan.

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

Prepaid Plan

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

PDO Plan

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

Vision Insurance

If you are eligible to continue vision benefits at retirement, you will have access to the same vision benefits as active employees. You can choose from two plans: a basic plan and an expanded plan. Both plans offer the same services, including:

- Annual routine eye exam
- Frames
- Eyeglass lenses
- Contact lenses
- 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.

As with other optional products, the state's vision insurance is an employee pay-all option. This means the state does not pay any part of the premium. Members are responsible for the full premium.

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 also available.

Employee Assistance Program

If you are enrolled in group health coverage, 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 is your place to turn for those times when you need some direction or clarity with a variety of issues including everything from balancing your checkbook to learning how to rebalance your life. Just a few of the issues that your EAP can help you with include:

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

You and your eligible dependents may receive up to five 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.

Services can be easily accessed by calling Magellan at 855.437.3486, 24 hours a day, 365 days a year. The program is available to all retirees covered under a state-sponsored group health plan.

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. Health coaches can help you reach your personal health goals, and will schedule calls when it's convenient for you. All calls are confidential.
- ParTNers for Health Website. This website links you to powerful online tools and health information at your fingertips. Choose from a variety of online health improvement programs and keep track of your progress to reach your personal goals.
- 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. Available to all group health plan members, discount agreements have been secured 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 and click on the Wellness tab under Other Benefits.

Long-Term Care Insurance

Long-term care insurance is available to local education retirees who receive a TCRS benefit or a non-TCRS optional retirement benefit. This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness, or an accident may bring on this need. Enrollment is subject to medical underwriting review for approval. Call MedAmerica at 866.615.5824 or refer to their website (www.ltc-tn.com) for more information about this coverage and to obtain enrollment information.

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 worker's compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

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

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

Appealing to the Insurance Company

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

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

Pursuing Further Action

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

LEGAL NOTICES

Information in this Guide

This guide does not give every detail of the state-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. If information in this guide conflicts with the Plan Document, the Plan Document will control. 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.

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, such as date of marriage for a spouse, date of birth for a natural child or date of legal obligation if you are appointed as a guardian.

Balance Billing

When obtaining services out-of-network, members 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 medical service provider's actual charges and the amount that the provider will be reimbursed from the patient's insurance benefits 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 they write off the rest of the charge. An out-of-network provider has not agreed to any reduced rates as they do 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 will owe the out-of-network provider the additional \$25.

By Virtue of Age

By virtue of 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 by virtue of age on the first of the prior month.

Claims

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

Coinsurance

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

Copay

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

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 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 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.

Non-TCRS participants earn creditable service for insurance based on the years of service with the employer that participates in the 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 in coinsurance before the plan pays certain benefits. See the benefit grid in your member handbook for details.

Drug List

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

Drug Tiers

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

Fully Insured Plan

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

Generic Drug (Tier One)

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

Group Health Plan

Group health plan refers to the partnership and standard PPOs 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 enrolls in coverage during the initial eligibility timeframe. 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 can't be shared without your consent and protects your privacy.

In-Network Care

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

Maximum Allowable Charge (MAC)

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

Meeting Your Medical Deductible

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

Network

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

Out-of-Pocket Maximum

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

Preferred Brand Drug (Tier Two)

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

Preferred Provider Organization (PPO)

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

Premium

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

Prescription Drug Copay

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

Preventive Care

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

Primary Care Physician

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

Self-Insured Plan

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

Special Enrollment Provision

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

Special Qualifying Event

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

The Plan

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

FREQUENTLY ASKED QUESTIONS

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

If you meet the minimum criteria to continue group health coverage by virtue of years of service, length of participation in the plan and are in paying status (if you are a TCRS participant), you may continue spouse-only group health coverage if your spouse was covered on your plan when you retired. There cannot be a lapse in coverage. If you do not continue spouse only immediately upon retirement you will not be eligible to add them to coverage at a later date due to a special qualifying event.

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?

If you or your covered dependent becomes entitled to Medicare prior to the age of 65, Medicare parts A and B must be obtained to keep group health coverage until you or your affected dependent would have become Medicare eligible by virtue of age. Medicare will become primary and the state group health plan will pay secondary. If parts A and B are not taken when first eligible as a retiree, coverage will be terminated.

Is my spouse eligible for the Medicare supplement plan?

If you are receiving a monthly TCRS benefit and your spouse is enrolled in at least Medicare part A, you may apply to cover your spouse on the Medicare supplement plan. If you do not apply within 60 days of initial eligibility, your spouse must apply as a Medicare supplement 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 are not receiving 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 your employment terminated and you retired, you may apply for the state's group health plan through a special enrollment provision if you lose other creditable health coverage and still meet the plan eligibility rules.

Can I change my health insurance and/or dental carrier when I continue coverage at retirement?

You must continue with the same health insurance PPO and dental carrier you were enrolled with immediately prior to retirement. You will be able to switch carriers if you move outside of the service area. You will also have a chance to make changes to your insurance during the annual enrollment transfer period in the fall.

If you have a special qualifying event, you may choose to change to another health and/or dental plan if eligible.

VISION COVERAGE

I am over 65 and enrolled on the Tennessee Plan Medicare supplement. Am I eligible to enroll in coverage on the retiree vision plan?

No. You must be covered on the retiree group health plan to enroll on the retiree vision plan. If you were covered on 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.

I am continuing spouse only coverage on the retiree group health plan. Can I enroll my spouse on the retiree vision plan?

Yes, if you are receiving a monthly TCRS pension and your spouse is covered as your dependent under the retiree group health plan and you apply timely, you may apply for spouse only coverage on the retiree vision plan.

I am receiving a monthly TCRS pension and I am continuing single coverage on the retiree group health plan. Can I enroll in retiree plus spouse coverage on the vision plan?

No, if your spouse is not covered as your dependent on the retiree group health plan you may not enroll them on the retiree vision plan.

DENTAL COVERAGE

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

To qualify for dental coverage, retirees 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 the optional retiree dental coverage, your eligible dependents are also eligible for dental coverage. You must provide documentation to verify your dependents' eligibility before they can be enrolled in dental coverage. Required dependent verification documents are listed on the back of the retiree enrollment form.

Incapacitated dependents enrolled in a state-sponsored plan prior to their 26th birthday may be eligible to enroll in the retiree dental benefit.

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

The best way to receive up-to-date network information is to call directly or through the online dentist search on the carriers' websites. You can also request printed copies of the provider directories by contacting the carriers directly using the contact information in the front of this guide.

My old school system provides other dental coverage. Can I still apply for state-sponsored dental coverage?

If your school system provides dental coverage to retirees, you have the choice to enroll in the school system's dental plan, one of the state's dental plans or a combination of the two. If you wish to enroll in both the school system and state's plans, you will need to contact the dental carriers to see if coordination of benefits is possible.

Please Note: Benefits Administration can only assist you with questions about dental coverage under the state-sponsored plans. For questions about other coverage, you will need to contact those plans or ask your former school system for assistance.

How will the state deduct my dental premiums?

The state will deduct the dental premium from your TCRS check each month. If there is not enough money in your TCRS check to pay the dental premium the state will send a bill to your home.

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

Out-of-state retirees who are receiving a monthly TCRS pension benefit are eligible to enroll in the retiree dental plan. If you select Assurant's prepaid plan you must still select and use a participating Tennessee dentist in the Assurant network.

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 to enroll in the retiree dental plan. You must indicate the requested future effective date when you submit your application.

Will I have the option to change dental plans later?

You will be given the opportunity to change dental plans each fall during the annual enrollment transfer period. Any changes you make during the transfer period will take effect January 1 of the following year.

Because out-of-state retirees must still use a participating Tennessee dentist for the Assurant plan, retirees enrolled in the Assurant plan will be allowed to switch to the Delta Dental plan if they move out of state. They may request to change to the Delta Dental PDO within 30 days of their move.

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

You may only cancel your enrollment during AETP in the fall (with a January 1 effective date) unless you have a qualifying event. Requests to terminate coverage due to a family status change must be submitted within 60 days of the qualifying event and include supporting documentation. The Insurance Cancel Request Application provides detailed information about qualifying events and is available on the forms section of the Benefits Administration website.

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

A comparison of the two dental options is available in the dental section of the ParTNers for Health website. If you would like more detailed information on covered services, please contact the carriers (Assurant and Delta Dental) directly using the contact information in this guide.