

District Attorneys General Conference Office: New Employee Information Pack and Directions

Employee Appointment Form

Complete form. It does require the General's signature

Payroll Request (FA-0722)

Employee completes and signs form and attach a voided check at the bottom left

Direct Deposit of Paycheck Statement (FA0955)

Employee completes and signs and Administrator or AA signs

W4 (MUST USE CURRENT YEAR FORM, old forms will not be accepted)

Fill out completely 1-5 and 7 if applicable, Sign and date at the bottom

Employee Record Form (DA0007)

Employee completes entire form

I-9 Form

Fill out page 4 completely and send in all appropriate paperwork

Payroll Deduction Authorization for Property (FA-0973)

Have employee sign and date, Administrator or AA signs and dates

Revenue Funded Position Acknowledgement

Employee signs, General signs and dates, Bottom of form will be completed by Conference

*Southeast Financial Credit Union (FA-0722)

Employee sets up account with Credit Union to complete this form

*Higher Education Fee Discount or Fee Waiver (optional forms)

Follow instructions on form

Drug Free Workplace Policy

Employee signs and dates, fills out their social security number

Leave Beneficiary Form

Employee needs to fill out and have notarized. If any employee passes away while still employed and has an annual/sick leave balance and this form is not on file the leave will be paid out to the TCRS beneficiary that is on file.

TennCare Notice

If your employee is on TennCare, they need to contact the TennCare office to inform them of employer having insurance available.

Enrollment Form (FA-1043)

Fill out Parts 1-4 and Part 6 completely. If Part 5 applies, fill out completely and attach all eligible dependent proof at time of completing paperwork.

Basic Life Insurance Beneficiary Form (FA-1005)

Fill out completely and send in whether you are taking out health insurance or not, if this form is not submitted to the Conference at the time of the employee passing, no one will receive the benefit.

*Optional Special Accident (FA-0831)

Fill out form completely. Effective date is the same date as insurance effective date.

*Flexible Benefits Plan

Medical or Daycare Expense- fill out FA-1009 completely

Transportation and Parking- fill out FA-1020 completely

*Long Term Care Insurance

Contact MedAmerica for enrollment and information

Additional Forms:

Assistant District Attorney/Criminal Investigators:

Completely fill out and send in Notarized any of the following that are applicable:

Oat of Office

Affidavit of Intent

Prior Service Request

Affidavit of Prior Service

Enclose: Certification from former employer if requesting prior prosecutorial credit; Copy of Law License; DD-214 if requesting Military credit

Affidavit of Prior Service- Criminal Investigator

All forms with an "" beside it are optional forms and the employee can opt out of it by not sending the paperwork in. All other forms must be turned back in to the Conference office.*

Also, please make sure that all new employees complete the Title VI Training and questionnaire that is located on the internet/intranet.

TENNESSEE DISTRICT ATTORNEY GENERAL CONFERENCE

EMPLOYEE PERSONNEL FORMS AND REFERENCE AUDIT

Name _____ SSN: _____

- _____ Appointment Letter
 - _____ Employee Record Form
 - _____ W-4
 - _____ Direct Deposit
 - _____ Copy of Resume
 - _____ Copy of Degree or Transcript
 - _____ Copy of Law License
 - _____ Prior Service Credit Request
 - _____ Affidavit of Prior Service
 - _____ Oath of Office
 - ===== Affidavit of Intent
- _____ Insurance Form (See Insurance File)
 - _____ Insurance Checklist
 - _____ Drug Free Workplace Policy
 - _____ Leave Beneficiary Designation
 - _____ Grant Position Funding
 - _____ I9 Form and Documentation
 - _____ Title VI Training Questionnaire

OPTIONAL FORMS

- _____ Credit Union
- _____ Deferred Comp (for employees that were employed prior to July 1, 2014)
- _____ Life Insurance Forms (See Insurance File)
- _____ Other _____

ALL NEW EMPLOYEES WILL BE SENT A PACKAGE IN THE MAIL FROM THE TENNESSE CONSOLIDATED RETIREMENT SYTEM.

Comments: _____

EMPLOYEE APPOINTMENT

_____ HAS BEEN
(NAME) (SOCIAL SECURITY NO.)

APPOINTED TO THE POSITION OF _____

EFFECTIVE _____ AT A SALARY OF _____

THIS POSITION WAS FORMERLY HELD BY _____

BUDGET CODE: _____

DISTRICT ATTORNEY GENERAL

DISTRICT

DATE

THE EMPLOYEE IS _____, IS NOT _____ TRANSFERRING
FROM ANOTHER STATE AGENCY. STATE AGENCY _____

THE EMPLOYEE IS _____, IS NOT A FORMER STATE EMPLOYEE

TENNESSEE DISTRICT ATTORNEYS GENERAL CONFERENCE

EMPLOYEE RECORD FORM

_____ JUDICIAL DISTRICT

Employee Name _____
(Last) (First) (Middle)

Home Address _____ County _____
(Street & Number)

City _____ State _____ County No. _____ Zip Code _____

ADDRESS TO WHICH MAIL SHOULD BE SENT IF NOT SAME AS ABOVE

Street Address _____

City _____ Zip Code _____

WORK ADDRESS

Street _____ City _____ Zip Code _____

PERSONAL INFORMATION

Social Security Number _____ Date Employed _____

Veteran _____ Sex _____ Race _____ Handicapped _____ Date of Birth _____ U.S. Citizen _____

Marital Status _____ Home Phone _____ Office Phone _____

Title of Position _____ Signature _____

EDUCATIONAL BACKGROUND

Are you a high school graduate? Yes _____ No _____ Date _____ if no, do you have a GED certificate? Yes _____ No _____ Date _____

Schools Attended After High School-- College, Business, Trade or Technical Training

Schools Attended	Dates Attended	Did you Graduate	Type of Degree	Major
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

A COPY OF DEGREE MUST BE SUBMITTED

THE FOLLOWING MUST BE COMPLETED FOR THE PURPOSE OF COMPUTING LONGEVITY:

I have _____ have not _____ previously been employed by the State of Tennessee or a District Attorney General



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (*Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.*)

Last Name (<i>Family Name</i>)		First Name (<i>Given Name</i>)		Middle Initial	Other Names Used (<i>if any</i>)	
Address (<i>Street Number and Name</i>)			Apt. Number	City or Town		State Zip Code
Date of Birth (<i>mm/dd/yyyy</i>)	U.S. Social Security Number [][]-[][]-[][][][]	E-mail Address			Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

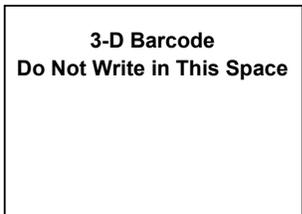
- A citizen of the United States
- A noncitizen national of the United States (*See instructions*)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (*See instructions*)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date (<i>mm/dd/yyyy</i>):
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Preparer and/or Translator Certification (*To be completed and signed if Section 1 is prepared by a person other than the employee.*)

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (<i>mm/dd/yyyy</i>):	
Last Name (<i>Family Name</i>)		First Name (<i>Given Name</i>)	
Address (<i>Street Number and Name</i>)		City or Town	State Zip Code



Employer Completes Next Page



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name)		Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
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C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 5. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Payroll Deduction Authorization

Employee Name:

Social Security Number: - -

Position Number:

I hereby acknowledge that I have received state funds and/or property and I am obligated to return the funds and/or property upon my termination from state government. I understand that the state funds and/or property are provided for use during my employment and are not my personal funds or property. I agree that upon termination of my employment, I will return any property in good condition, with the exception of normal wear, to my immediate supervisor within **one business day** of my last day worked.

In the event that the state funds and/or property are stolen or damaged while in my custody, I understand that I should notify my supervisor immediately.

If at such time of my termination of employment, I do not return the state funds or property listed below within **one business day** of my last day worked, in good condition, I understand that I have incurred a debt to the State. I agree that upon termination of my employment, I will reimburse the State for any amount outstanding. I hereby authorize the State to deduct the appropriate amount as indicated below from my last payroll check.

I understand that at the time of my termination if I disagree with the amount of funds being deducted from my last paycheck, I have the right to an immediate Pre-decision Meeting with a person who has direct access to the appointing authority for this purpose.

I have read and understand this agreement and by signing, I indicate that the terms of this agreement are satisfactory to me.

Employee Signature

Date

Witness Signature

Date

Description and Dollar Amount of State Funds / Cost of Property at Time of Issuance:

Qty	State Tag No.	Item Description	Unit Cost	Total Cost	Date Issued	Date Returned
			.	.		
			.	.		
			.	.		

Employee Signature

Fiscal Officer

REVENUE-FUNDED POSITION ACKNOWLEDGEMENT

I, _____, do understand that I am employed in a revenue-funded position. Further, I understand that at any such time as the revenues supporting this position cease to exist the State is under no obligation to continue my employment.

Signed this day by:

Employee

District Attorney General

Date

District: _____

Fiscal Year: _____

Cost Center: _____

Position Number: _____ Title: _____

Funding Source:

- Grant
- Economic Crime, Fines & Forfeitures, etc.
- Drug Task Force
- County/City
- Other

RETIREMENT CHANGES EFFECTIVE FOR EMPLOYEES HIRED ON OR AFTER JULY 1, 2014

There are no changes to current state employees.

New Hybrid Pension Plan (for all employees, except the DA). This plan consists of a Defined Benefit Portion (TCRS) and a Defined Contribution Portion (401K) that are not optional to the employee.

Effective July 1, 2014 all new employees will be entered into the new Hybrid Pension Plan instead of the Old Legacy System, unless the following apply to the newly hired employee.

Has prior state service and was vested (5 years of creditable service) and wasn't refunded their account balance when employment terminated.

Has prior state service and wasn't vested but has been gone from state employment less than 7 years.

Contribution and Benefit Changes

Employee pays 5% of salary into their retirement and the state will pay 3.87%. (Old Legacy System for current employees, the employee pays nothing. All contributions are paid by the state.)

Employee pays 2% of salary into a 401K plan and the state will pay 5%. New employees have the option to opt out of the 2% contribution within the first 30 days of employment but the state will still pay 5% into the 401K Plan. New employees can also contribute more than the 2%. If the employee contributes \$50 or more into the 401K they get the 5% state contribution plus the \$50 match. (401K is optional for current employees with a \$50 match for employees contributing at least \$50 monthly.)

Vesting is the same for both plans. Employees must have 5 years of state service before vesting.

Employees will receive a package at home from both the TCRS and the 401K Vender explaining their benefits. It also includes instructions on selecting beneficiaries.

Eligibility to retire: Full Service Retirement – Rule of 90 (example: 55 years old with 35 years of service) or age 65 with 5 years of service.

Early Retirement – Rule of 80 (example: 57 years old with 23 years of service) or age 60 with 5 years of service.

Current employees in the Legacy System are eligible for full retirement at age 60 and vested or 30 years of service. Early retirement is age 55 with 10 years of service.

Service Retirement Formula:

The annual base benefit on the Defined Benefit Portion (TCRS portion) will be calculated at 1.0% instead of the current Legacy System amount of 1.57%. The Defined Contribution Portion will be handled by the 401K Provider.

Service Retirement Formula - The annual service retirement allowance (or annual base benefit) payable to a member is equal to 1.0% of the member's AFC (average final compensation), multiplied by the number of years of creditable service. The annual service accrual (1.0% formula) may be decreased as part of the cost controls for the Plan.

The following example shows the formula used for computing the TCRS retirement allowance for a member with 10 or more years of service. The example uses a 60-year-old member retiring under the maximum plan with an AFC of \$50,000 and 30 years of service. In this example, TCRS service retirement benefits replace 30% of the member's AFC after 30 years of service.

Accrual Factor		Years of AFC		Creditable Service		
.01	x	\$50,000	x	30		= \$15,000
						÷ 12
					Monthly Benefit \$	1,250

- The 1.0% annual service accrual formula and the employer/employee contributions may be decreased/increased in the future as part of the cost controls for the plan.

Terminations:

If employee leaves employment they can apply for a refund of their accumulated contributions plus interest but the employer contributions to the Defined Benefit Portion are not refundable. If employee obtains a refund they give up their TCRS membership and all rights and benefits in the retirement system.

With the Defined Contribution Benefit Portion (401K), the employee upon termination or retirement may leave his/her account in the plan to withdraw in the future or withdraw

immediately or rollover their benefits to another qualified investment program. There are penalties for early withdrawals for the 401K Portion just as there is now.

TENNESSEE DISTRICT ATTORNEYS GENERAL CONFERENCE
DRUG-FREE WORKPLACE POLICY

Illegal and excessive use of drugs has become an epidemic in our state. Any abuse and use at the workplace are subjects of immediate concern in our society. From a safety perspective, the users of drugs may impair the well-being of all employees, the public at large, and result in damage to state property. Drug use may also seriously impair an employee's ability to perform his or her job; therefore, it is the policy of the State of Tennessee that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in the state's workplace is prohibited. Any employees violating this policy will be subject to discipline up to and including termination. The specifics of this policy are as follows:

1. The unlawful manufacture, distribution, possession or use of a controlled substance is prohibited in or on the workplace. Such manufacture, distribution, possession or use while on the job or state property will subject the violator to discipline up to and including termination.
2. The term "controlled substance" means any drug listed in 21 U.S.C. 812 and other federal regulations. Generally, these are drugs which have a high potential for abuse. Such drugs include, but are not limited to, Heroin, Marijuana, Cocaine, PCP, and "Crack." They also include "legal drugs" which are not prescribed by a licensed physician to an alleged violator.
3. Each employee is required by law to inform this agency within five (5) days after he or she is convicted for violation of any federal or state criminal drug statute where such violation occurred on state property. A conviction means a finding of guilt (including a plea of nolo contendere) or the imposition of a sentence by a judge or jury in any federal or state court.
4. The Personnel Director must then notify the U.S. Government agency with which the grant was made within ten (10) days after receiving the notice from the employee or otherwise receiving actual notice of such a conviction.
5. If an employee is convicted of violating any criminal drug statute while on the workplace, he or she will be subject to discipline up to and including termination. Alternatively, the Agency may require the employee to successfully finish a drug abuse program sponsored by an approved private or governmental institution.
6. As a condition of employment or continued employment on any federal government grant, the law requires all employees to abide by this policy.

THE POLICY STATED HEREIN IS BEING ADOPTED BY THIS AGENCY IN COMPLIANCE WITH THE DRUG-FREE WORKPLACE ACT.


President
Tennessee District Attorneys General Conference

8-4-16
Date

I hereby acknowledge that I have read and fully understand the Drug-Free Workplace Policy.

Social Security No.

Employee Signature

Date



Department of Human Resources - Technical Services Division

BENEFICIARY DESIGNATION FOR LEAVE BALANCES AND LAST WAGES

Part I: EMPLOYEE INFORMATION

Name: _____ Social Security Number: _____

Employee I.D. Number: _____

Part II: BENEFICIARY DESIGNATION FOR PAYMENT OF ANNUAL, SICK, AND COMPENSATORY LEAVE BALANCES

I, _____, Pursuant to TCA 8-50-808, designate the person or persons listed below to receive, upon my death, a lump sum payment for any annual, sick, or compensatory leave balances.

(Employee Signature) (Date)

Leave Balance Beneficiary Information (If additional space is needed please attach a second page).

Name (First, Middle, Last)	Phone #	Address	Relationship	Sex	Birth Date	Social Security #

Part III: BENEFICIARY DESIGNATION FOR PAYMENT OF LAST WAGES

I, _____, designate the person or persons listed below to receive payment for any wages or salary due to me at the time of my death. I understand if I fail to designate a beneficiary or beneficiaries, a sum not exceeding \$10,000 will be paid out to my surviving spouse, but if none, then to my surviving children in equal percentages. If I do not have a spouse nor children, my last wages will be granted to my estate.

(Employee Signature) (Date)

Last Wages Beneficiary Information (If additional space is needed please attach a second page).

Name (First, Middle, Last)	Phone #	Address	Relationship	Sex	Birth Date	Social Security #

State of Tennessee, County of _____

_____ personally appeared before me this _____ day of _____, 20____ and made oath that he/she executed the foregoing instrument.

Notary Public

My Commission Expires: _____

Southeast Financial Federal Credit Union is a FULL SERVICE financial institution created for the specific purposes of promoting thrift, providing financial services for its members, providing a source of credit for its members at a reasonable rate of interest, and investing any surplus funds not required for loans to members. Employees can join Southeast Financial Federal Credit Union by filling out a membership application and returning it to the credit union with a copy of your driver's license and an opening deposit of a minimum of \$5.00. A packet on Southeast Financial Federal Credit Union is available from the Conference Office. You can also find more information on the Credit Union at their website at www.southeastfinancial.org.

To see all options available through the Credit Union, visit the website.

To Enroll in a Southeast Financial Federal Credit Union account:

Fill out the 2 page application

Make note on the application to inform (Your Name) at (phone number) when account is set up

Make a copy of your driver's license

Send a check for minimum of \$5.00

Mail to address listed on the application- Southeast Financial Credit Union
P.O. Box 331788
Nashville, TN 37203

To Add Your Credit Union Account to Payroll for Direct Deposit:

Go To Employee Self Service

Payroll and Compensation

Direct Deposit

Add Account

Fill in your Routing and Account Number and select either 1) Exact amount you want sent to the account every pay period or 2) the percentage of your check you want deposited into the account.

The credit union is now handled as a direct deposit. Credit Union members can go to Edison Self Service and add a direct deposit to their account or change the amounts deposited

Membership Application

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account.

Member/Owner Information

Member Name	Date of Birth
SS#/ITIN	EIN
Home Phone	Email Address*
Driver's License #/State/Expiration Date	Mother's Maiden Name
Residential Address	Mailing Address (if different)
Apt #/City/State/Zip	Apt #/City/State/Zip
Employer	Work Phone

* As a benefit of your Southeast Financial membership you'll receive email updates notifying you about current specials and upcoming events. We'll also let you know about identity scams and provide tips to keep your account safe. You may opt out of these emails at any time, using the link at the bottom of each email.

Account Ownership

Individual
 Joint
 Trust
 UTMA
 Custodian/Guardian
 DBA

Membership Eligibility

<input type="checkbox"/> Employed by or retiree of SFCU sponsor company	<input type="checkbox"/> Member of qualifying organization
<input type="checkbox"/> Qualified by family member	Relationship to you

Please indicate the type(s) of account(s) you wish to open/change

<input type="checkbox"/> Share Savings	<input type="checkbox"/> Silver Plus Checking	<input type="checkbox"/> IRA
<input type="checkbox"/> Basic Checking	<input type="checkbox"/> Share Certificate	<input type="checkbox"/> ATM/VISA® Check Card
<input type="checkbox"/> LifeTools Checking (see below)	<input type="checkbox"/> Money Market	<input type="checkbox"/> Overdraft Protection
<input type="checkbox"/> Club Checking	<input type="checkbox"/> Christmas Club Account	<input type="checkbox"/> HSA - Checking Account

Qualifications for LifeTools Checking

In order to maintain a LifeTools Checking Account with FREE Bill Payer, the following services must remain open and active at all times:

Direct Deposit (payroll, social security, and other regularly recurring direct deposits)
 Debit Card
 eStatements
 Bill Payer

Identity Theft Protection

Credit Union membership includes two low-cost identity theft protection product options:

MemberSecureSM: \$1.98 monthly
 IdentitySecureSM: \$9.95 monthly

Multiple Owners

Designate the ownership of the accounts and responsibility for the services requested.

Joint Owner Trustee Custodian/Guardian Authorized Signatory Only Beneficiary/POD

Name	Date of Birth
SS#/ITIN	EIN
Home Phone	Email Address
Driver's License #/State/Expiration Date	Mother's Maiden Name
Residential Address	Mailing Address (if different)
Apt #/City/State/Zip	Apt #/City/State/Zip
Employer	Work Phone

Joint Owner Trustee Custodian/Guardian Authorized Signatory Only Beneficiary/POD

Name	Date of Birth
SS#/ITIN	EIN
Home Phone	Email Address
Driver's License #/State/Expiration Date	Mother's Maiden Name
Residential Address	Mailing Address (if different)
Apt #/City/State/Zip	Apt #/City/State/Zip
Employer	Work Phone

Business/DBA Accounts

Please answer the following questions pertaining to the Unlawful Internet Gambling Reinforcement Act.

Does your business engage in gambling services of any kind?
 Yes
 No

Does your business engage in online/Internet gambling services?
 Yes
 No

I have answered the above questions truthfully about the business referred to on this Account Application and agree to notify Southeast Financial Credit Union should the business's involvement in online/Internet gambling change.

Member Signature	Date
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Signatures and Agreements

Please read carefully before signing.

INCLUDE A VALID DRIVER'S LICENSE COPY FOR ALL SIGNERS *~*~*

TIN Certification, Backup Withholding Information, and Citizenship

I am subject to backup withholding Exempt I am not a United States citizen or a resident (complete W-8BEN form)

By signing below, I certify, in accordance with the IRS W-9 instructions provided by the Credit Union and under penalties of perjury, that the Taxpayer Identification Number shown is correct and that I am not, unless designated above, subject to backup withholding as a result of a failure to report all dividends or interest, or because the IRS has notified me that I am no longer subject to backup withholding. Furthermore, my signature certifies that I am a U.S. Person, including a U.S. Resident Alien.

<input type="text"/>	<input type="text"/>
Member Signature	Date

Authorization

By signing below, I/we agree to the Terms and Conditions, Electronic Fund Transfers, and Funds Availability disclosures, Privacy Model disclosure, Substitute Check disclosure, Overdraft Privilege disclosure, Schedule of Products and Fees, if applicable, and to any amendment that the Credit Union makes from time to time, which are incorporated herein. I/we understand that the Terms and Conditions and applicable disclosures may be accessed via our website, www.southeastfinancial.org. I/we acknowledge the actual/electronic receipt of a copy of the Terms and Conditions and disclosures applicable to the accounts and benefits requested herein. If an access card or EFT service is requested and provided, I/we agree not to use the card(s) until I/we have read and understand the agreement governing its use. I/we authorize Southeast Financial Credit Union to request and obtain one or more credit reports about me/us from one or more credit reporting agencies for the purpose of considering my/our application for the Account, reviewing or collecting any account opened by me/us, or any other legitimate business purpose. I/we authorize Southeast Financial Credit Union to disclose information about my/our account to a credit reporting agency if my/our account is closed because I/we have abused it. The Internal Revenue Service does not require my/our consent to any provisions of this document other than the certifications required to avoid backup withholding.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Member Signature	Date	Joint Owner/Other Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Joint Owner/Other Signature	Date	Authorized Signatory	Date

LifeTools Checking Cancellation Agreement

I/We understand that, as a condition of receiving a LifeTools Checking Account with FREE Bill Payer, I/we must actively maintain the agreed upon account services. If, for any reason, my/our direct deposits are discontinued, debit card is cancelled, eStatements are cancelled, or Bill Payer account is inactive for a period of two consecutive months, the LifeTools Checking Account will automatically be converted to a Regular Checking Account and Bill Payer will be cancelled. The Credit Union is not required to notify me of this change.

If applicable, I/we understand that, by cancelling my/our LifeTools Checking Account, all the benefits of the LifeTools Checking Account will be forfeited.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Member Signature	Date	Joint Owner/Other Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Joint Owner/Other Signature	Date	Authorized Signatory	Date

For Credit Union Use Only:

<input type="text"/>	<input type="text"/>	<input type="text"/>
Membership Verification	Processed Date	Credit Score
<input type="text"/>	<input type="text"/>	<input type="text"/>
Check Verification	Opened/Changed by	Account Number and suffix(es)

Southeast Financial
credit union

membership and account application

www.southeastfinancial.org

Southeast Financial Credit Union
P.O. Box 331788
Nashville, TN 37203
615-743-3700 • 800-521-9653



rev111210



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

EMPLOYEE INSURANCE CHECKLIST — STATE PLAN

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, Tennessee 37243 • 615.741.3590 or 800.253.9981

DO NOT submit this form to Benefits Administration. This form must be completed during an employee's initial enrollment period. After completion, place this form in the employee's insurance or personnel file at the time of processing. Place a check mark after each action has been completed.

EMPLOYEE INFORMATION
NAME EDISON ID AGENCY

ELIGIBILITY AND ENROLLMENT
[] Explain the eligibility criteria for employees and dependents.
[] Enrollment must be completed within 31 days of your eligibility date.
[] Advise of the importance of enrolling during the initial enrollment period.
[] Explain the changes which can be made during the fall annual enrollment period.

INSURANCE PRODUCTS
Health Options: [] Partnership PPO, [] Standard PPO, [] HealthSavings CDHP
Life Options: [] Basic Term Life, [] Voluntary Term Life, [] Voluntary Accidental Death
Other: [] Dental, [] Vision, [] Long-term Care, [] Flexible Benefits

MATERIALS TO BE PROVIDED
[] Provide Edison login, password and employee self service (ESS) instructions.
[] If the Edison password is not set up timely to complete ESS, provide an enrollment application.
[] Provide the web address to locate the summaries of benefits and coverage.
[] Provide the web address to the TennCare notice.
[] Provide a copy of the eligibility and enrollment guide and HIPAA privacy notice.
[] Explain the marketplace letter and applicable provider materials.
[] Explain monthly premiums, including employee deduction and employer contribution.
[] Explain the benefits available through the Employee Assistance Program (EAP).
[] Provide the phone number and web address for the long-term care vendor.
[] Explain flexible medical, limited purpose, dependent care, transportation and parking reimbursement accounts.
[] Explain the deferred compensation choices and provide enrollment form or the web address to enroll.

EMPLOYEE SIGNATURE

AGENCY BENEFITS COORDINATOR SIGNATURE

DATE

DATE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is held annually in the fall. Check the www.healthcare.gov website for more information and deadlines.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Benefits Administration.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name State of Tennessee		4. Employer Identification Number (EIN) 62-6001445	
5. Employer address 19th Floor Wm Snodgrass Tower 312 Rosa L Parks Avenue		6. Employer phone number	
7. City Nashville	8. State TN	9. ZIP code 37243	
10. Who can we contact about employee health coverage at this job? Benefits Administration			
11. Phone number (if different from above) 615.532.6045		12. Email address benefits.info@tn.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.
 - Some employees. Eligible employees are:
 - Full-time employees regularly scheduled to work at least 30 hours per week
 - Seasonal or part-time employees with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year, (July–June) [per state law, will not apply to employees hired on or after July 1, 2015]
 - All other individuals cited in state statute, approved as an exception by the State Insurance Committee, or defined as full time employees for health insurance purposes by federal law
 - With respect to dependents:
 - We do offer coverage. Eligible dependents are:
 - Your spouse (legally married)
 - Natural or adopted children
 - Stepchildren
 - Children for whom you are the legal guardian
 - Children for whom the plan has qualified medical child support orders
 - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.**

a. How much would the employee have to pay in premiums for this plan? \$81

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$84

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (mm/dd/yyyy): 01/01/2017

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTICE TO TENNCARE ENROLLEES

Are You or Your Dependents Insured by TennCare?

Regular full-time employees of participating agencies of state government, local education agencies and local government agencies and their dependants are eligible for health insurance through a state-sponsored medical plan.

If you and/or your dependents are currently enrolled in TennCare you are required to contact your caseworker at the Department of Human Services within 10 days of your date of employment. You need to report your new job, salary and that you have access to medical insurance with your employer. If you have elected to sign up for state-sponsored medical insurance you will need to provide your DHS caseworker with the date your coverage will begin and the name of the insurance carrier.

TennCare could determine that you would still be eligible to continue the TennCare coverage. **If TennCare cancels your coverage or the coverage of your dependents at some future date, you will have 60 days from the termination date to apply to your employer for coverage on the state-sponsored plan.** You may also contact the State Division of Insurance at 1-800-253-9981 for instruction on how to apply after TennCare has cancelled your coverage.

Tennessee Code Annotated 71-5-118

It is now a felony offense to obtain TennCare coverage under fraudulent means. Violators, if convicted, can be sent to prison.

It is now a felony offense for a person to knowingly obtain, attempt to obtain or aid and abet any other person to obtain, by fraudulent, means any coverage provided to TennCare enrollees.

In addition to any penalties for a felony offense, any person committing the offense and violating the law may be disqualified from participating in the TennCare Program as an enrollee.

STATE GROUP INSURANCE PROGRAM

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review this
notice carefully.**

**PARTNERS
FOR HEALTH**



Department of Finance and Administration.
Authorization Number 317308. August 2015.
20,000 copies. This public document was
promulgated at a cost of \$0.11 per copy.

PROTECTING YOUR HEALTH INFORMATION

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information (PHI), with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your PHI. You have the right to approve or refuse the release of specific information outside of the State Group Insurance Program except when the release is required or authorized by law or regulation. The State Group Insurance Program must follow the privacy practices contained in this notice from its effective date of April 14, 2003, as amended on September 13, 2013, until this notice is changed or replaced.

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 or condition or related health care services. We are required by law to make sure your protected health information is kept private; give you this privacy notice; and follow the terms of the current privacy notice.

The State Group Insurance Program reserves the right to change the privacy practices and the terms of this notice at any time, as permitted by law. Any changes made in these privacy practices will be effective for all PHI that is maintained including information created or received before the changes were made. Changes will be posted on the Benefits Administration website and we will tell you how you can receive a revised notice in annual enrollment materials.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of The State Group Insurance Program and the plan groups as listed below. Your PHI may be used or disclosed by and within each plan as well as the State Group Insurance Program third-party "business associates" (contractors) as needed for your treatment, payment of benefits or other health care plan operations.

**The State Insurance Plan
The Local Education Plan
The Local Government Plan
The Medicare Supplement Plan**

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed for treatment, payment and health care operations. For example:

TREATMENT: Your PHI may be used or disclosed in order to provide, coordinate or manage your health care. It may be disclosed to a doctor, hospital or other health care provider.

PAYMENT: Your PHI may be used or disclosed to pay claims for services which are covered under your health insurance.

HEALTH CARE OPERATIONS: Your PHI may be used or disclosed in the course of the operation of the State Group Insurance Program to determine eligibility, establish enrollment, collect or refund premiums, conduct quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines.

Your PHI may be disclosed in order to coordinate and manage your care, contact health care providers with information about your treatment alternatives, as well as services that do not include treatment, but may improve your health or reduce your health care costs. Disclosure may be necessary in order to 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, training, accreditation, conducting and

arranging legal services and other necessary health care operations related to your plan coverage.

UNDERWRITING: Your PHI may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or benefits. If the contract is not issued, your PHI will not be used or further disclosed for any other purpose, except as required by law. In addition, we cannot use or disclose genetic information for underwriting purposes.

COMMUNICATION: Your PHI may be used 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. For example, your name and address will be used to send you information about the plans or services we offer or that we believe will be of benefit to you.

RESEARCH: Your PHI may be disclosed for research purposes when authorized by law.

AUTHORIZATION: You may provide written authorization to use your PHI or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time; however, that revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your PHI will be disclosed to individuals who have the authority by law to act on your behalf. In addition, unless you object, your PHI may be disclosed by us to a family member, friend or other person as necessary to help with your health care or with payment for your health care. The HIPAA rules also authorize limited disclosures in emergency situations if you are unable to consent and your health care provider determines such disclosures to be in your best interest.

PLAN SPONSORS: Your PHI may be disclosed to your plan sponsor in order to perform plan administration functions. Please see your plan document for a full description of the uses and disclosure the plan sponsor may make of your medical information in such circumstances.

AS REQUIRED BY LAW: Your PHI may be used or disclosed as required by state or federal law. These disclosures may include requirements to disclose information to health oversight agencies, to civil and criminal authorities and funeral directors relating to the death of a covered person, and in emergencies related to a crime. Under limited circumstances (i.e. court order, warrant or grand jury subpoena), PHI may be disclosed to law enforcement officials. In addition, your PHI may be disclosed to law enforcement officials concerning a suspect, fugitive, material witness, crime victim or missing person. Your PHI may be disclosed to law enforcement officials or correctional institutions regarding an inmate or other person in lawful custody, in certain circumstances.

COURT OR ADMINISTRATIVE ORDER: Your PHI may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: Your PHI may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. PHI may be disclosed when necessary to assist law enforcement officials to capture any individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: PHI of Armed Forces personnel may be disclosed to military authorities under certain circumstances. PHI may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence and other national security activities.

YOUR INDIVIDUAL RIGHTS

INSPECT AND COPY: In most cases, you have the right to view or obtain copies of your information. Your request must be made in writing and you will be charged a fee for the cost of copying your records.

ACCOUNTING: You have the right to ask for a list of disclosures of your PHI made by us or a third-party business associate for any reason other than treat-

ment, payment, health care operations and other activities as listed in this notice after April 14, 2003. Your request must be in writing and there may be a reasonable cost-based charge.

RESTRICTION: You have the right to request restrictions on our use or disclosure of your PHI. We are not required to agree to such requests. Any agreement to restrictions on the use and disclosure of your PHI must be in writing and signed by a person authorized to make such an agreement on behalf of The State Group Insurance Program. We will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATION: You have the right to request confidential communications about your PHI by alternative means or alternative locations. You must inform us that confidential communication by alternative means or to alternative location is required to avoid endangering you. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. We must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premium and pay claims under your health plan option.

AMENDMENT: You have the right to make a written request that we amend your PHI. Your request must explain why the information should be amended. We may deny your request if the information you seek to amend was not created by us or for certain other reasons. If your request is denied, we will provide a written explanation of the denial. If you disagree, you may submit a written statement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

BREACH: You have the right to be notified in the event of a breach of your unsecured PHI. (Unsecured PHI means PHI that has not been encrypted or otherwise coded so that it cannot be readily viewed by others.)

NOTICE: You may request a copy of this notice at any time by contacting the privacy office. This notice is also available on our website in its entirety at tn.gov/finance

QUESTIONS AND COMPLAINTS

If you want more information concerning The State Group Insurance Programs' privacy practices or have questions or concerns, please contact the privacy office.

If you are concerned that The State Group Insurance Program has violated your privacy rights, or you disagree with a decision made about access to your medical information, or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us or the U.S. Department of Health and Human Services using the contact information provided below.

The State Group Insurance Program supports your right to protect the privacy of your PHI. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

The Privacy Office
State of Tennessee
Benefits Administration
19th Floor William R. Snodgrass
Tennessee Tower
312 Rosa L. Parks Avenue
Nashville, Tennessee 37243
PH: 615.741.4517
FAX: 615.253.8556

Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909



DEPENDENT ELIGIBILITY

Definitions and Required Documents



TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship AND a document proving joint ownership
		Proof of Marital Relationship <ul style="list-style-type: none"> Government issued marriage certificate or license Naturalization papers indicating marital status
		Proof of Joint Ownership <ul style="list-style-type: none"> Bank Statement issued within the last six months with both names; or Mortgage Statement issued within the last six months with both names; or Residential Lease Agreement within the current terms with both names; or Credit Card Statement issued within the last six months with both names; or Property Tax Statement issued within the last 12 months with both names; or The first page of most recent Federal Tax Return filed showing “married filing jointly” (if married filing separately, submit page 1 of both returns)
		If just married in the current calendar year, a marriage certificate only is acceptable proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate; or
		Certificate of Report of Birth (DS-1350); or
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Court documents signed by a judge showing that the participant has adopted the child; or
		International adoption papers from country of adoption; or
		Papers from the adoption agency showing intent to adopt
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse and birth certificate of the child showing the relationship to the spouse; or
		Any legal document that establishes relationship between the stepchild and the spouse or the member
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a Qualified Medical Child Support Order (QMCSO)	Court documents signed by a judge; or
		Medical support orders issued by a state agency

Never send original documents. Please mark out or black out any social security numbers and any personal financial information on the copies of your documents BEFORE you return them.



**PARTNERS
FOR HEALTH**

State Group
Insurance Program

**2017
Eligibility and
Enrollment
Guide**

State and Higher Education Employees

If you need help...

Contact your agency benefits coordinator. He or she has received special training in our insurance programs. For additional information about a specific benefit or program, refer to the chart below.

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 — M-F, 8-4:30	tn.gov/finance partnersforhealthtn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness and Nurse Advice Line	Healthways	888.741.3390 — M-F, 8-8	partnersforhealthtn.gov (wellness tab)
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	mybenefits.metlife.com/ StateOfTennessee
Vision Insurance	EyeMed Vision Care	855.779.5046 — M-Sat, 7:30-10 Sun, 10-7	eyemedvisioncare.com/stoftn
Life Insurance	Securian (Minnesota Life)	866.881.0631 — M-F, 7-6	lifebenefits.com/stateoftn
Long-term Care Insurance	MedAmerica	866.615.5824 — M-F, 8:30-6	ltc-tn.com
OTHER PROGRAMS			
Edison	TN Department of Finance & Administration	password reset for higher education 800.253.9981 — M-F, 8-4:30; state call Edison help desk at 866.376.0104 — M-F, 7-4:30	https://www.edison.tn.gov
Flexible Benefits medical & dependent care parking & transportation (state employees only)	Payflex Benefits Administration	855.288.7936 — M-F, 7-7; Sat, 9-2 800.253.9981 — M-F, 8-4:30	stateoftn.payflexdirect.com tn.gov/finance

Enrollment forms and handbooks...

All enrollment forms and handbooks referenced in this guide are located on our website at tn.gov/finance or you can get a copy from your agency benefits coordinator.

Online resources...

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

Follow us on social media...



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TN Department of Finance and Administration,
Authorization No. 317374, October 2016.
This public document was promulgated at a cost of \$0.42 per copy.

INTRODUCTION

Overview

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

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

If you are eligible, you may enroll in health, dental, vision, life and long-term care coverages. Flexible spending accounts are also available.

For More Information

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

You can also find information that explains benefit details on the Benefits Administration website. This includes brochures and handbooks for health, pharmacy, dental, vision, life and long-term care. Plan documents, summaries of benefits and coverage and sample life insurance certificates are also available.

Authority

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

State Insurance Committee

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

Certain state and federal laws and regulations, which may be amended or the subject of court rulings, apply to the group insurance program. These laws, regulations and court rulings shall control over any inconsistent language in this guide.

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

The following employees are eligible to enroll in coverage:

- Full-time employees regularly scheduled to work at least 30 hours per week
- All other individuals cited in state statute, approved as an exception by the State Insurance Committee or defined as full-time employees for health insurance purposes by federal law

Employees NOT Eligible to Participate in the Plan

Individuals who do not meet the employee eligibility rules outlined above, are ineligible UNLESS they otherwise meet the definition of an eligible employee under applicable state or federal laws or by approval of the State Insurance Committee. As an example, the following individuals are normally ineligible but might qualify for coverage if they meet the federal definition of a full-time employee under the Patient Protection and Affordable Care Act.

- Individuals performing services on a contract basis
- Individuals in positions that are temporary appointments

Dependent Eligibility

If you enroll in health, vision or dental coverage, you may also enroll your eligible dependents. You or your spouse must be enrolled in voluntary term life in order to add a child term rider to the coverage. You do not have to be enrolled in long-term care to enroll your eligible dependents.

The following dependents are eligible for coverage:

- Your spouse (legally married)
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian
- Children for whom the plan has qualified medical child support orders

All dependents must be listed by name during enrollment. Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart for the types of proof you must provide. A dependent can only be covered once within the same plan, but can be covered under two separate plans (state, local education or local government). Dependent children are eligible for coverage through the last day of the month of their 26th birthday.

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

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

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/disability)
- Live-in companions who are not legally married to the employee

Enrollment and Effective Date of Coverage

As a new employee, your eligibility date is your hire date. You must complete enrollment within 31 days after your hire date. Coverage starts on the first day of the month after you complete one full calendar month of employment.

If you are a part-time employee who has completed one full calendar month of employment and you gain full-time status, your coverage will start the first day of the month after gaining full-time status. Application must be made within 31 calendar days of the date of the status change, but you should submit your enrollment request as soon as possible to avoid the possibility of double premium deductions.

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

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

A dependent's coverage starts on the same date as yours unless newly acquired. Application to add a newly acquired dependent must be submitted within 60 days of the acquire date. Family coverage based on enrolling newly acquired dependent children due to birth, adoption or legal custody must begin on the first day of the month in which the event occurred and the children shall be eligible for coverage on the date they were acquired. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption. If enrolled in single coverage and adding a newly-acquired spouse, you may choose to begin family coverage on the first day of the month in which your spouse was acquired or the first day of the following month. Depending on the date you choose, your newly acquired spouse will be covered beginning with the acquire date (date of marriage) or the first day of the following month.

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

Choosing a Premium Level (Tier)

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

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

Family Coverage — Coverage other than employee only is considered family coverage.

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

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

Premium Payment

For state and higher education employees, the state pays about 80 percent of the cost of your health insurance premium if you are in a positive pay status or on approved family medical leave. If you are approved for workers compensation and receiving lost-time pay, the state pays the entire health insurance premium. Insurance premiums are taken from the paycheck you get at the end of each month to pay for the next month's coverage. Voluntary coverages, such as dental, get no state support, and you must pay the total premium.

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

Premiums are not prorated. You must pay the premium for the entire month in which the effective date occurs.

Pre-tax Premiums — State employee premiums for health, dental and vision are paid before income or Social Security tax is deducted. Pre-tax premiums reduce an employee's taxable income because they are taken out before taxes are withheld.

Adding New Dependents

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

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

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

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

If you have single coverage

- The new dependent can enroll if they have a qualifying event under the special enrollment provisions or during the annual enrollment period.

If you have family coverage

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

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

Updating Personal Information

State employees can update information, such as home address, in Edison or by contacting their agency human resource offices. Higher education employees can also update information in Edison or by contacting their agency benefits coordinators to report address changes. Higher education employees may also call 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 your address and phone number current with your employer.**

Annual Enrollment Period

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

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

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

Canceling Coverage

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

- You lose eligibility for the state group insurance program (e.g., changing from full-time to part-time)
- You experience a special qualifying event, family status change or other qualifying event as approved by Benefits Administration

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

When canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for adopted children ends when the legal obligation ends. Insurance continued for a disabled dependent child ends when he/she is no longer disabled or at the end of the 31-day period after any requested proof is not given.

For a divorce or legal separation, you cannot remove your spouse unless your spouse or the court gives permission, until occurrence of one of the following:

- The final divorce decree is entered
- The order of legal separation is entered
- The petition is dismissed
- The parties reach agreement
- The court modifies or dissolves the injunction against making changes to insurance

You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you lose eligibility or you experience an event that results in you becoming newly eligible for coverage under another plan. There are no exceptions. You have 60 days from the date that you and/or your dependents become newly eligible for other coverage

to turn in an application and proof to your agency benefits coordinator. The required proof is shown on the application. Events that might result in becoming newly eligible for coverage elsewhere are:

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

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

- The last day of the month before the eligibility date of other coverage
- The last day of the month that the event occurred
- The last day of the month that documentation is submitted (to cancel prepaid dental)

Transferring Between Plans

Members eligible for coverage under more than one state-sponsored plan may transfer between the state, local education and local government plans. You may apply for a transfer during the plan's designated enrollment period with an effective date of January 1 of the following year. In no case may you transfer to another state-sponsored plan and remain on your current plan as the head of contract.

If You Don't Apply When First Eligible

If you do not enroll in health coverage when you are first eligible, you must wait for the annual enrollment period. You can also apply during the year through special enrollment due to certain life events.

Special Enrollment Provisions

The Health Insurance Portability and 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, dental and vision coverage.

An employee experiencing one of the events below may enroll in employee only or family coverage. Previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible) may also be enrolled.

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

You must make the request within 60 days of acquiring the new dependent. You must also submit proof, as listed on the enrollment application, to show:

- The date of the birth
- The date of placement for adoption
- The date of marriage

The above events are ONLY subject to special enrollment IF you want to use the event to enroll yourself or you already have coverage and want to add other previously eligible dependents at the same time as the new dependent. If you already have coverage and only want to add a newly acquired dependent, this is treated as a regular enrollment change.

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

- Day on which the event occurred if enrollment is due to birth, adoption or placement for adoption
- Day on which the event occurred or the first day of the next month if enrollment is due to marriage

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

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

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

You must submit proof as required to show ALL of the following:

- A qualifying event has occurred
- You and/or your dependents were covered under another group health plan at the time of the event
- You and/or your dependents may not continue coverage under the other plan

If enrolling due to loss of coverage under another plan, options for coverage start dates are:

- The day after the loss of other coverage, or
- The first day of the month following loss of other coverage

Important Reminders

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

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION OF EMPLOYMENT

Extended Periods of Leave

Family and Medical Leave Act (FMLA)

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

Leave Without Pay — Health Insurance Continued

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

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages. The \$20,000 basic term life and the \$40,000 basic accidental death coverages provided at no cost to all eligible employees will remain in effect. You may reinstate coverage when you return to work. If canceled for nonpayment, you must wait for the next annual enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year.

To Reinstate Coverage After You Return

You must submit an application to your agency benefits coordinator within 31 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 31 days of your return to work, you must wait for the next annual enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year. Coverage goes into effect the first of the next month after you return to work.

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

Reinstatement for Military Personnel Returning from Active Service

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

- The first day of the month, which includes the date discharged from active duty
- The first of the month following the date of discharge from active duty

- The date returning to active payroll
- The first of the month following return to the employer's active payroll

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

Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave.

Leave Due to a Work-related Injury

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

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

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

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

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration.

- State employees: If your last day worked is the last day of the month, your coverage will end on the last day of the following month. If your last day worked is any date other than the last day of the month, your coverage will end on the last day of the current month.
- Higher education employees: Coverage will end on the last day of the month following the month you terminate employment.

A COBRA notice to continue health, dental and vision coverage will be mailed to you. Life insurance conversion notices will also be mailed, if applicable.

In the event that your spouse is also insured as a head of contract under either the state, local education or local government plan, you have the option to transfer to your spouse's contract as a dependent. Application must be made within one full calendar month of your termination of employment.

Continuing Coverage through COBRA

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

- Coverage is lost due to a qualifying event (refer to the COBRA brochure on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

Benefits Administration will send a COBRA packet to you. It will be sent to the address on file within 7-10 days after your coverage ends. Make sure your correct home address is on file with your agency benefits coordinator. You have 60 days

from the date coverage ends or the date of the COBRA notice, whichever is later, to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. If you do not receive a letter within 30 days after your insurance ends, you should contact Benefits Administration.

Continuing Coverage at Retirement

Members whose first employment with the state began prior to July 1, 2015, who meet the eligibility rules may continue health insurance at retirement for themselves and covered dependents until eligible for Medicare. For service retirement a minimum of ten years employment is required. To continue coverage as a retiree, you must submit an application within one full calendar month of the date active coverage ends. A member cannot have retiree coverage and keep active coverage as an employee in the same plan. Information on the eligibility requirements can be found in the guide to continuing insurance at retirement available on the Benefits Administration website. Employees whose first employment with the state began on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement.

One way to save money for healthcare expenses when you retire is to enroll in the HealthSavings CDHP, which includes a health savings account (HSA). Please see the available benefits section for details.

Coverage for Dependents in the Event of Your Death

If You Are an Active Employee

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

If You Are a Covered Retiree

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

If You Die in the Line of Duty

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

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

If You Are Covered Under COBRA

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

AVAILABLE BENEFITS

Health Insurance

You have a choice of three health insurance options:

- Partnership Preferred Provider Organization (PPO) (with or without the Partnership Promise)
- Standard PPO
- HealthSavings Consumer-driven Health Plan (CDHP) (with or without the Partnership Promise)

You also have a choice of three insurance carrier networks:

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

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

Each healthcare option:

- Provides the **same comprehensive health insurance coverage**
- Offers the **same provider networks**
- Covers **in-network preventive care** (like annual well visits and routine screenings) **at no cost to you**
- Covers **maintenance** prescription drugs without having to first meet a deductible
- Has a deductible
- Has out-of-pocket maximums to limit your costs

There are some differences between the PPOs and the CDHP.

With the PPOs

- You pay a higher monthly premium but have a lower deductible
- You pay fixed copays for doctor office visits and prescription drugs without first having to meet your deductible

With the CDHP

- You pay a lower monthly premium but have a higher deductible
- You pay the full discounted network cost for **ALL** healthcare expenses, including pharmacy, until you meet your deductible
- You have a tax free health savings account (HSA) which can be used to cover your qualified medical expenses, including your deductible

Partnership Promise

Both the Partnership PPO and the HealthSavings CDHP reward you with lower costs when you agree to complete simple steps for better health. These steps are called the Partnership Promise.

Partnership PPO

If you enroll in this option and agree to meet the Partnership Promise, you will pay \$50 to \$100 less in monthly premiums compared to the No Partnership Promise PPO.

HealthSavings CDHP

If you enroll in this option and agree to meet the Partnership Promise, the state will deposit \$500 for employee only coverage or \$1,000 for family coverage into your health savings account.

By agreeing to the Partnership Promise, you (and your covered spouse, if applicable) are making a specific commitment to do the following steps within 120 days of the day your insurance coverage begins:

- Complete the online Healthways Well-Being Assessment (WBA)
- Get a biometric screening at a worksite location or from your doctor (you can use screening results from a doctor's visit within the last 12 months)

Note: to access the WBA and physician screening form, visit partnersforhealthtn.gov and click on the Partnership Promise link for more information.

The Partnership Promise is an annual commitment. When you sign the enrollment application or enroll through Edison employee self-service (ESS) you are agreeing to fulfill the Partnership Promise steps each year. You will not be required to sign a new promise each year. You and all eligible family members must enroll in the same healthcare option. Your covered spouse, if applicable, must also agree to the Partnership Promise. Children are not required to complete the steps.

Should you or your spouse fail to complete the requirements, you are not eligible for the Partnership Promise PPO discounted premium or state HSA funds for the Promise Healthsavings CDHP in 2018.

Health Savings Account

If you enroll in the HealthSavings CDHP, a health savings account (HSA) will be set up for you. You can contribute pre-tax money to your HSA through payroll deduction to cover your qualified medical expenses, including your deductible. The HSA is managed by PayFlex, a company selected and contracted by the state.

Benefits of a HSA

- The money you save in the HSA (both yours and any employer contributions) rolls over each year and collects interest. You don't lose it at the end of the year.
- You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses.
- The money is yours! You take your HSA with you if you leave or retire.
- The HSA offers a triple tax advantage on money in your account:
 1. Both employer and employee contributions are tax free
 2. Withdrawals for qualified medical expenses are tax free
 3. Interest accrued on HSA balance is tax free
- The HSA can be used to pay for qualified medical expenses that may not be covered by your health insurance plan (like vision and dental expenses, hearing aids, contact lens supplies, acupuncture and more) with a great tax advantage.

- It serves as another retirement savings account option. Money in your account can be used tax free for health expenses even after you retire. And, when you turn 65, it can be used for non-medical expenses. But non-medical expenses will be taxed.

Contribution Limits

- IRS guidelines allow total tax-free annual contributions up to \$3,400 for individuals and \$6,750 for families in 2017.
- At age 55 and older, you can make an additional \$1,000/year contribution (\$4,400 for individuals or \$7,750 for families).

Restrictions

You cannot enroll in the HealthSavings CDHP if you are enrolled in another plan, your spouse’s plan or any government plan (e.g., Medicare A and/or B, Medicaid).

If you are eligible for VA medical benefits and did not receive benefits during the preceding three months, you can enroll in and make contributions to your HSA. If you receive VA benefits in the future, then you are NOT entitled to contribute to your account for another three months. However, if your veteran’s hospital care or medical service was for a service-connected disability, you may contribute to your HSA. Veterans are responsible for determining their eligibility. Restrictions may apply. Go to IRS.gov to learn more.

Basic Features of the Health Options

	PPOs (Partnership & Standard)	HealthSavings CDHP
Covered Services	Each option covers the same set of services	
Preventive Care — routine screenings and preventive care	Covered at 100% (no deductible)	
Employee Contribution — premium	Higher than the HealthSavings Plan	Lower than the PPOs
Deductible — the dollar amount of covered services you must pay each calendar year before the plan begins reimbursement	Lower than the HealthSavings Plan	Higher than the PPOs
Physician Office Visits — includes specialists and behavioral health and substance abuse services	You pay fixed copays without having to first meet your deductible	You pay the discounted network cost until the deductible is met, then you pay coinsurance
Non Office Visit Medical Services — hospital, surgical, therapy, ambulance, advanced x-rays	You pay the discounted network cost until the deductible is met, then you pay coinsurance	
Prescription Drugs	You pay fixed copays without having to first meet your deductible	You pay for the medication at the discounted network cost until your deductible is met — then you pay coinsurance until you meet the out-of-pocket maximum
Out-of-Pocket Maximum — The most you pay for covered services; once you reach the out-of-pocket maximum, the plan pays 100%	Higher than the HealthSavings Plan	Lower than the PPOs
Health Savings Account	None	If you agree to complete the Partnership Promise requirements, the state will contribute \$500 for single coverage and \$1,000 for family coverage to help offset the deductible — your contributions are pre-tax

Member Cost at a Glance — In-Network Comparison

EMPLOYEE ONLY	PARTNERSHIP PPO		STANDARD PPO		HEALTHSAVINGS CDHP	
Deductible	\$500		\$1,000		\$1,500	
Out-of-Pocket Maximum (medical and pharmacy)	\$3,600		\$4,000		\$2,500	
Medical Coinsurance	10%		20%		20%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	\$183	\$223	\$130	\$170	\$84	\$124
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT	- \$50 premium discount =		None		\$500 deposit to your HSA	
	\$133	\$173				

EMPLOYEE + CHILD(REN)	PARTNERSHIP PPO		STANDARD PPO		HEALTHSAVINGS CDHP	
Deductible	\$750		\$1,500		\$3,000	
Out-of-Pocket Maximum (medical and pharmacy)	\$5,400		\$6,000		\$5,000	
Medical Coinsurance	10%		20%		20%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	\$250	\$290	\$197	\$237	\$127	\$167
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT	- \$50 premium discount =		None		\$1,000 deposit to your HSA	
	\$200	\$240				

EMPLOYEE + SPOUSE	PARTNERSHIP PPO		STANDARD PPO		HEALTHSAVINGS CDHP	
Deductible	\$1,000		\$2,000		\$3,000	
Out-of-Pocket Maximum (medical and pharmacy)	\$7,200		\$8,000		\$5,000	
Medical Coinsurance	10%		20%		20%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	\$380	\$460	\$275	\$355	\$177	\$257
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT	- \$100 premium discount =		None		\$1,000 deposit to your HSA	
	\$280	\$360				

EMPLOYEE + SPOUSE + CHILD(REN)	PARTNERSHIP PPO		STANDARD PPO		HEALTHSAVINGS CDHP	
Deductible	\$1,250		\$2,500		\$3,000	
Out-of-Pocket Maximum (medical and pharmacy)	\$9,000		\$10,000		\$5,000	
Medical Coinsurance	10%		20%		20%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	\$446	\$526	\$340	\$420	\$219	\$299
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT	- \$100 premium discount =		None		\$1,000 deposit to your HSA	
	\$346	\$426				

Monthly Premiums for Active Employees

ALL REGIONS				
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS	EMPLOYER SHARE
PARTNERSHIP PROMISE PPO				
Employee Only	\$133	\$133	\$173	\$572
Employee + Child(ren)	\$200	\$200	\$240	\$857
Employee + Spouse	\$280	\$280	\$360	\$1,200
Employee + Spouse + Child(ren)	\$346	\$346	\$426	\$1,486
NO PARTNERSHIP PROMISE PPO				
Employee Only	\$183	\$183	\$223	\$572
Employee + Child(ren)	\$250	\$250	\$290	\$857
Employee + Spouse	\$380	\$380	\$460	\$1,200
Employee + Spouse + Child(ren)	\$446	\$446	\$526	\$1,486
STANDARD PPO				
Employee Only	\$130	\$130	\$170	\$572
Employee + Child(ren)	\$197	\$197	\$237	\$857
Employee + Spouse	\$275	\$275	\$355	\$1,200
Employee + Spouse + Child(ren)	\$340	\$340	\$420	\$1,486
HEALTHSAVINGS CDHP (PROMISE OR NO PROMISE)				
Employee Only	\$84	\$84	\$124	\$572
Employee + Child(ren)	\$127	\$127	\$167	\$857
Employee + Spouse	\$177	\$177	\$257	\$1,200
Employee + Spouse + Child(ren)	\$219	\$219	\$299	\$1,486

2017 Benefit Comparison

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum. CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

HEALTHCARE OPTION AND ACTUARIAL VALUE	PARTNERSHIP PPO 83.9%		STANDARD PPO 78.2%	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
PREVENTIVE CARE — OFFICE VISITS				
<ul style="list-style-type: none"> Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) Adult annual physical exam Annual well-woman exam Immunizations as recommended by CDC Annual hearing and non-refractive vision screening Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force 	No charge	\$45 copay	No charge	\$50 copay
OUTPATIENT SERVICES				
Primary Care Office Visit <ul style="list-style-type: none"> Family practice, general practice, internal medicine, OB/GYN and pediatrics Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider Including surgery in office setting and initial maternity visit 	\$25 copay	\$45 copay	\$30 copay	\$50 copay
Specialist Office Visit <ul style="list-style-type: none"> Including surgery in office setting 	\$45 copay	\$70 copay	\$50 copay	\$75 copay
Behavioral Health and Substance Abuse ^[2]	\$25 copay	\$45 copay	\$30 copay	\$50 copay
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance	
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance	
Telehealth	\$15 copay	N/A	\$15 copay	N/A
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	\$25 copay primary; \$45 copay specialist	\$45 copay primary; \$70 copay specialist	\$30 copay primary; \$50 copay specialist	\$50 copay primary; \$75 copay specialist
Chiropractors <ul style="list-style-type: none"> Limit of 50 visits per year 	Visits 1-20: \$25 copay Visits 21-50: \$45 copay	Visits 1-20: \$45 copay Visits 21-50: \$70 copay	Visits 1-20: \$30 copay Visits 21-50: \$50 copay	Visits 1-20: \$50 copay Visits 21-50: \$75 copay
PHARMACY				
30-Day Supply	\$7 copay generic; \$40 copay preferred brand; \$90 copay non-preferred	copay plus amount exceeding MAC	\$14 copay generic; \$50 copay preferred brand; \$100 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (Retail-90 network pharmacy or mail order)	\$14 copay generic; \$80 copay preferred brand; \$180 copay non-preferred	N/A - no network	\$28 copay generic; \$100 copay preferred brand; \$200 copay non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from Retail-90 network pharmacy or mail order) ^[3]	\$7 copay generic; \$40 copay preferred brand; \$160 copay non-preferred	N/A - no network	\$14 copay generic; \$50 copay preferred brand; \$180 copay non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min \$50; max \$150	N/A - no network	10% coinsurance; min \$50; max \$150	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE				
Convenience Clinic	\$25 copay	\$45 copay	\$30 copay	\$50 copay
Urgent Care Facility	\$45 copay	\$70 copay	\$50 copay	\$75 copay
EMERGENCY ROOM				
Emergency Room Visit	\$150 copay (services subject to coinsurance may be extra)		\$175 copay (services subject to coinsurance may be extra)	

HEALTHSAVINGS CDHP 83.9% (promise) 77% (no promise)	
IN-NETWORK	OUT-OF-NETWORK ^[1]
No charge	40% coinsurance
20% coinsurance	
20% coinsurance	N/A
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance plus amount exceeding MAC
20% coinsurance	N/A - no network
10% coinsurance without first having to meet deductible	N/A - no network
20% coinsurance	N/A - no network
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	

Using Edison ESS

When you use ESS in Edison to enroll in your benefits, Internet Explorer 11 is your best choice. You may not be able to enroll in your benefits if you use the Chrome browser or any mobile devices. Although not recommended, other browsers might work. All of your information may not be on the enrollment screens, which could mean that you are not enrolled in your choices. If these issues cannot be resolved, you will need to use the recommended browser.

Passwords

- For **higher education employees**, if you are using the Edison system for the first time or are having trouble logging in, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps or call the Benefits Administration service center.
- For **state employees**, if you have trouble logging in to Edison, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps to reset your password or call the Edison help desk at 866.376.0104.

Note: The names of four health insurance options are shortened in Edison. Please check the chart below before making your selection.

HEALTH INSURANCE OPTION NAME	NAME AS IT APPEARS IN EDISON
Partnership Promise PPO	Partners Promise
No Partnership Promise PPO	No Partners Promise
Promise HealthSavings CDHP	Promise CDHP
No Promise HealthSavings CDHP	No Promise CDHP

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

COVERED SERVICES	PARTNERSHIP PPO		STANDARD PPO	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
Hospital/Facility Services • Inpatient care; outpatient surgery ^[4] • Inpatient behavioral health and substance abuse ^{[2] [4]}	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care ^[4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient ^[4] ; outpatient • Skilled nursing facility ^[4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care ^[4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies ^[4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ^[4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
DEDUCTIBLE				
Employee Only	\$500	\$1,000	\$1,000	\$2,000
Employee + Child(ren)	\$750	\$1,500	\$1,500	\$3,000
Employee + Spouse	\$1,000	\$2,000	\$2,000	\$4,000
Employee + Spouse + Child(ren)	\$1,250	\$2,500	\$2,500	\$5,000
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED				
Employee Only	\$3,600	\$4,000	\$4,000	\$4,500
Employee + Child(ren)	\$5,400	\$6,000	\$6,000	\$6,750
Employee + Spouse	\$7,200	\$8,000	\$8,000	\$9,000
Employee + Spouse + Child(ren)	\$9,000	\$10,000	\$10,000	\$11,250
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT				
For individuals who agree to complete the Partnership Promise	premium discount (reflected in premium chart): \$50 for employee only and employee+child(ren) coverage; \$100 for employee+spouse and employee+spouse+child(ren) coverage		N/A	

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. **For PPO Plans**, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For CDHP Plans**, the out-of-pocket maximum amount can be met by one or more persons.

- [1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge.
- [2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization (PA) is required.
- [3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.
- [4] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

HEALTHSAVINGS CDHP	
IN-NETWORK	OUT-OF-NETWORK ^[1]
20% coinsurance	40% coinsurance
20% coinsurance	
100% covered up to MAC (after the deductible has been met)	
20% coinsurance	40% coinsurance
20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
20% coinsurance	40% coinsurance
N/A - no network	40% coinsurance
\$1,500	\$3,000
\$3,000	\$6,000
\$3,000	\$6,000
\$3,000	\$6,000
\$2,500	\$4,500
\$5,000	\$9,000
\$5,000	\$9,000
\$5,000	\$9,000
State contribution to HSA: \$500 for employee only; \$1,000 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

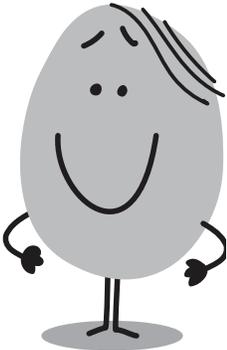
What is actuarial value?

Insurance plans have actuarial value — on average for plan members as a whole, a percentage of total costs for covered benefits that a plan will pay for. (Members pay the rest through copays, deductibles and coinsurance.) The higher the percentage or actuarial value, the more the plan pays on average for the group.

HEALTHCARE OPTION	ACTUARIAL VALUE
Partnership PPO	83.9%
Promise HealthSavings CDHP	83.9%
Standard PPO	78.2%
No Promise HealthSavings CDHP	77.0%

ALEX, your confidential, online benefits expert, can help you compare your insurance options based on your own situation. Be sure you are using the most current version of Flash software.

Visit ALEX on partnersforhealthtn.gov. He will ask you questions that may help you choose your benefits.



Dental Insurance

Dental coverage is available to all state and higher education employees and their dependents. You must pay 100 percent of the premium if you elect this coverage. Two options are available—a prepaid plan and a dental preferred provider organization (DPPO) plan.

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

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

Prepaid Plan (Cigna)

- Must select and use a general dentist from the prepaid dental plan list for each covered family member — the network is Cigna Dental Care (HMO)
- 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

DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider — the network is PDP
- \$1,500 calendar year benefit maximum per person
- Deductible applies for basic, major and out-of-network dental care
- You or your dentist will file claims for covered services
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of \$1,250 for orthodontia

Monthly Premiums for Active Members

	PREPAID PLAN	DPPO PLAN
Employee Only	\$12.99	\$22.37
Employee + Child(ren)	\$26.97	\$51.44
Employee + Spouse	\$23.02	\$42.32
Employee + Spouse + Child(ren)	\$31.65	\$82.80

Dental Insurance Benefits at a Glance

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

COVERED SERVICES	CIGNA PREPAID OPTION		METLIFE DPO OPTION	
	GENERAL DENTIST	SPECIALIST DENTIST	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	none		\$25 single; \$75 family, per policy year ^[1]	\$100 single; \$300 family, per policy year ^[1]
Annual Maximum Benefit	none		\$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	\$10 copay ^[2]		no charge	20% of MAC
Periodic Oral Evaluation	no charge		no charge	20% of MAC
Routine Cleaning – Adult	no charge		no charge	20% of MAC
Routine Cleaning – Child	no charge	\$15 copay	no charge	20% of MAC
X-ray — Intraoral, Complete Series	no charge	\$5 copay	no charge	20% of MAC
Amalgam (silver) Filling — 2 Surfaces Permanent	\$8 copay	\$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	\$125 copay	\$600 copay	20% of MAC	40% of MAC
Major Restorations — Crowns (porcelain fused to high noble metal)	\$275 copay, plus lab fees ^[3]		50% of MAC ^[4]	
Extraction of Erupted Tooth (minor oral surgery)	\$15 copay	\$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	\$100 copay	\$120 copay	50% of MAC	
Dentures — Complete Upper	\$310 copay, plus lab fees ^[3]		50% of MAC ^[4]	
Orthodontics	\$140 monthly copay for treatment ^[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	\$3,360 treatment fee only ^[6]		\$1,250 ^[5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge (maximum amount of charge agreed to by dentist)

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

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

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

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

[4] A 6-month waiting period applies.

[5] The orthodontics lifetime maximum is for a dependent member enrolled in the state group dental insurance program even if the member has been covered under different employing agencies.

[6] Additional copays apply for specific orthodontic procedures.

Vision Insurance

Vision coverage is available to all state and higher education employees and dependents. You must pay 100 percent of the premium if you elect this coverage. Two options are available — 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. See the benefit chart on the following page to compare benefits in both plans.

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.

General Limitations and Exclusions

The following services are not covered under the vision plan:

- Treatment of injury or illness covered by workers' compensation or employer's liability laws
- Cosmetic surgery and procedures
- Services received without cost from any federal, state or local agency
- Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility
- Services by a vision provider beyond the scope of his or her license
- Vision services for which the patient incurs no charge
- Vision services where charges exceed the amount that would be collected if no vision coverage existed

Note: If you receive vision services and materials that exceed the covered benefit, you will be responsible for paying the difference for the actual services and materials you receive.

EyeMed offers some additional discounts which include:

- 40% off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- 15% off conventional contact lenses after the benefit has been used
- 20% off non-covered items such as lens cleaner, accessories and non-prescription sunglasses

Monthly Premiums for Active Members

	BASIC	EXPANDED
Employee Only	\$3.35	\$5.86
Employee + Child(ren)	\$6.69	\$11.72
Employee + Spouse	\$6.35	\$11.14
Employee + Spouse + Child(ren)	\$9.83	\$17.23

Vision Insurance Benefits at a Glance

Here is a comparison of discounts, copays and allowed amounts under the vision options. Copays represent what the member pays. Allowance and percentage discount represent the cost the carrier will cover.

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	\$0 copay	\$10 copay
Retinal Imaging Benefit	none	up to \$39 copay
Frames	\$50 allowance; 20% discount off balance above the allowance	\$115 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass) <ul style="list-style-type: none"> • Single, bifocal, trifocal, lenticular • Standard progressive Lens • Premium progressive Lens 	\$50 allowance; 20% off balance over \$50	\$15 copay \$55 copay discount on no-line bifocals ^[1] \$55+(20% off retail price-\$120 allowance) for other ^[1]
Eyeglass Lens Options (upgrades) <ul style="list-style-type: none"> • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium anti-reflective • All other eyeglass lens options 	20% discount off all options	maximum copayments: \$45 copay \$30 copay; \$0 for children 18 and under discount applied \$15 copay \$10 copay \$25 copay 20% off retail price discount applied 20% discount
Exam for Contact Lenses (fitting and evaluation)	15% discount off retail price	up to \$60 copay
Contact Lenses ^[2] <ul style="list-style-type: none"> • Elective <ul style="list-style-type: none"> • Conventional • Disposable • Medically necessary ^[3] 	\$50 allowance; 15% off balance over \$50 \$50 allowance \$150 allowance	\$130 allowance; 15% off balance over \$130 \$130 allowance covered at 100%
LASIK/Refractive Surgery (for select providers)	15% discount off retail price or 5% off promotional price	15% discount off retail price or 5% off promotional price
Out-of-Network Benefits <ul style="list-style-type: none"> • All eye exams • Frames • Eyeglass lenses <ul style="list-style-type: none"> • Single vision • Lined bifocal • Lined trifocal • Elective contacts (conventional or disposable) • Medically necessary contacts ^[3] • Lens options-UV, polycarbonate, photochromic/transitions plastic 	up to \$30 allowance up to \$50 allowance (frames and lenses combined) \$25 allowance \$75 allowance	up to \$45 allowance up to \$70 allowance up to \$30 allowance up to \$50 allowance up to \$65 allowance up to \$50 allowance up to \$100 allowance up to \$5 allowance
Frequency <ul style="list-style-type: none"> • Eye exam • Eyeglass lenses and contacts • Frames 	once every calendar year per person once every calendar year per person once every two calendar years per person	once every calendar year per person once every calendar year per person once every two calendar years per person

[1] Copays for premium progressive lens are subject to change

[2] Instead of eyeglass lenses

[3] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

Employee Assistance Program

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

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

The EAP offers seminars on various topics of interest at locations across the state. Visit the here4tn.com website for more information.

All services are confidential. Obtain prior authorization as required. Services can be easily accessed by calling Optum Health — available 24 hours a day, 365 days a year. You may participate in EAP services on work time with your supervisor's approval.

You and your eligible dependents may get up to five counseling sessions per episode. Services are available at no cost if eligible for health insurance coverage under the plan, even if enrollment is waived. If you need assistance beyond the EAP, you will be referred to your insurance carrier's behavioral health and substance abuse benefits.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is free to all members, their eligible spouses and dependents.

24/7 Nurse Advice Line

The nurse advice line gives you medical information and support, 24/7, at no cost to you. Whether you have questions about a new diagnosis or you aren't sure about an urgent situation, the nurse advice line is there when you need it. Call day or night to talk to a nurse about:

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

Working with a Health Coach

Coaching offers you professional support to create and meet goals for better health. Calls are private and scheduled when it is convenient for you. For more information about working with a coach, see the frequently asked questions section of the ParTNers for Health website.

Healthways Well-Being Connect

Well-Being Connect provides you with online tools and resources like healthy recipes, meal plans and exercise trackers. Choose from a variety of online health improvement focus areas and keep track of your progress to reach your personal goals. Registration is easy. Simply go to partnersforhealthtn.gov, click on the "My Wellness Login" button and follow the registration instructions.

Healthways Well-Being Assessment (WBA)

The online Well-Being Assessment (WBA) is a questionnaire that summarizes your overall health and offers steps you can take for better health. By completing the confidential online assessment, you will learn more about how your lifestyle habits affect your overall well-being. Once you complete the assessment, you will view your results and create your personal well-being plan, which will help you set goals and focus on areas where you can make improvements. Visit the wellness program page on the ParTNers for Health website for more information.

Weekly Health Tips by Email

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

Wellness and Fitness Center Discounts

Additional wellness and fitness center discounts are available through the ParTNers for Health Wellness Program and Employee Assistance Program (EAP) services. Our carriers BlueCross BlueShield and Cigna also offer fitness and other discounts for health insurance plan members.

Life Insurance

Basic Group Term Life and Accidental Death and Dismemberment

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

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

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

Voluntary Accidental Death and Dismemberment

You and your dependents (spouse and children) may enroll in this coverage. It is in addition to the basic accidental death coverage and you must pay a premium. Benefits are paid for dismemberment if the loss occurs within 90 days of the accident, as long as you or your dependent is covered on the date of the accident and meet the criteria. Coverage amounts are based on salary and age. The maximum benefit for you is \$60,000.

Voluntary Term Life Insurance

You and your dependents (spouse and children) may enroll in this coverage whether or not you enroll in health coverage. A premium is required. For employee guaranteed issue coverage, you must enroll during the first 31 calendar days of employment with the state. The effective date of coverage is the first of the month after you have completed three full calendar months of employment. If you do not enroll when first eligible, you can apply for coverage during the annual enrollment period by answering health questions.

You may select up to five times your annual base salary (subject to a maximum of \$500,000) if you apply when first eligible. You may apply for up to seven times your annual base salary (subject to a maximum of \$500,000), but evidence of good health is required. The minimum coverage level is \$5,000.

Your spouse may apply for \$5,000, \$10,000 or \$15,000 of term life insurance at any age. Spouses below age 55 may apply for increments of \$5,000, subject to an overall maximum of \$30,000. Spouses must be performing normal duties of a healthy person of similar age and gender and not have been hospitalized, advised to seek medical treatment or received disability benefits within six months prior to the application to enroll date for coverage to be issued without answering any additional health questions. A spouse who does not meet the previous criteria may apply for coverage by answering specific health questions which the insurance company will use to decide if coverage will be allowed. You do not have to enroll in this coverage in order for your spouse to participate.

Children may be covered under either a \$5,000 or a \$10,000 term rider. The rider is added to either your contract or your spouse's contract, but not both. These amounts will cover all eligible dependent children who meet the dependent definition. Coverage for children is guaranteed issue.

The voluntary term life insurance provides a death benefit and the premiums increase with age. It also offers an advance benefit rider, which allows part of the life insurance proceeds if an insured encounters a terminal illness.

Flexible Benefits Spending Reimbursement Accounts

State and higher education employees (excludes off-line employees) are eligible for the flexible benefits plan. It is designed to help you decrease your taxable income and increase your take-home pay. Authorized under Sections 125 and 132 of the Internal Revenue Code, it allows you to pay certain expenses from your pre-tax rather than after-tax income. The maximum amount you can contribute to a flex benefits account is set by the IRS and the limits are subject to change yearly.

Unless you have an approved family status change, you cannot enroll in or cancel a medical or dependent care reimbursement account in the middle of a calendar year.

Medical Reimbursement Account

You may set up a FSA to pay for medical expenses that are not already covered by insurance, such as the deductible or copayment amounts, contact lenses or glasses, certain non-cosmetic dental procedures, prescription drugs or their copayment amounts, hearing aids and other qualified expenses. Over-the-counter medications are not a reimbursable expense unless your doctor writes a prescription.

If you enroll in the HealthSavings CDHP, you do not qualify for a flexible spending account for medical expenses. You can still have a limited purpose FSA to use for dental and vision expenses.

Limited Purpose Account

While anyone can enroll in a limited purpose FSA, those who are enrolled in the HealthSavings CDHP with a health savings account may find it particularly attractive since they may not enroll in the medical FSA option. You can use the limited purpose FSA to pay for certain dental and vision costs not covered by insurance.

Dependent Care Reimbursement Account

The dependent care reimbursement account lets you use tax-free dollars to pay for certain dependent-care costs such as after-school care, baby-sitting fees, adult or child daycare and preschool. To qualify, the care must be necessary to allow you to work and, if you are married, to allow your spouse to work or attend school full-time. The amount you can set aside for a dependent care reimbursement account depends on your tax filing status.

Transportation and Parking Reimbursement Accounts

State employees are eligible for transportation and parking reimbursement accounts. These accounts let you use tax-free dollars to pay for your transportation to and from work as well as work-related parking costs. You may enroll in a transportation or parking reimbursement account at any time.

Long-term Care Insurance

Qualified state and higher education employees, their eligible dependents (spouse and children ages 18 through 25), retirees, parents and parents-in-law are eligible to enroll in long-term care coverage. This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness or an accident may bring on this need.

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

As a new employee, you have 90 days to enroll and have guaranteed issue of coverage. You may sign-up for coverage by completing the enrollment form enclosed in the enrollment kit, over the phone by speaking with customer service or online via the insurance carrier's website. Your spouse, eligible dependent children, parents and parents-in-law may also apply for coverage; however, they must provide information about their health status and will be subject to medical underwriting review for approval to enroll. After the initial guaranteed issue period, you may still apply for coverage, but will also be subject to the same medical underwriting review for approval to enroll.

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

OTHER INFORMATION

Coordination of Benefits

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

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

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.

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

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

Subrogation

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

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

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

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses the plan has already paid for, you may be subject to collections activity.

On-the-job Illness or Injury

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

Fraud, Waste and Abuse

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

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

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

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

How You Can Help

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

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

To File an Appeal

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

You should direct any specific questions regarding initial levels of appeal (the internal appeal process) to the insurance carrier. Other appeal questions may be directed to the Benefits Administration appeals coordinator at 615.741.4517 or 866.576.0029.

Administrative Appeals

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

Benefit Appeals

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

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

Appealing to the Insurance Company

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

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

Pursuing Further Action

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

LEGAL NOTICES

Information in this Guide

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

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

Discrimination

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.

Member Privacy

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

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

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

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

Medicare Part D

Medicare eligible retirees have access to a Medicare supplement plan. The supplemental plan does not include pharmacy benefits and retirees should enroll in a Medicare Part D plan for prescription drug benefits. For further information, refer to the notice of creditable coverage which is available on the Medicare supplement page of the Benefits Administration website.

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

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

Claims

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

Coinsurance

Coinsurance is the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service.

Consumer-Driven Health Plan (CDHP)

A consumer-driven health plan (CDHP) is a type of medical insurance or plan that typically has a higher deductible and lower monthly premiums. Typically, you take responsibility for covering minor or routine healthcare expenses until your deductible is met. Once you meet your deductible, coinsurance applies.

Copay

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

Deductible

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

Drug List

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

Drug Tiers

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

Fully Insured Plan

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

Generic Drug (Tier One)

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

Guaranteed Issue

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

Health Insurance Portability and Accountability Act (HIPAA)

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

In-Network Care

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

Maximum Allowable Charge (MAC)

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

Meeting Your Deductible

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

Network

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

Non-Preferred Brand Drug (Tier Three)

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

Out-of-Network Care

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

Out-of-Pocket Maximum

An out-of-pocket maximum is the most you will pay for services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services. A separate out-of-pocket maximum applies to in-network pharmacy in the standard and partnership options.

Preferred Brand Drug (Tier Two)

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

Preferred Provider Organization (PPO)

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

Premium

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

Preventive Care

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

Primary Care Physician

Primary care physician (also known as PCP) refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician's assistants and nurse midwives (licensed healthcare facility only) may also be considered primary-type providers when working under the supervision of a primary care physician.

Self-Insured Plan

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

Special Enrollment Provision

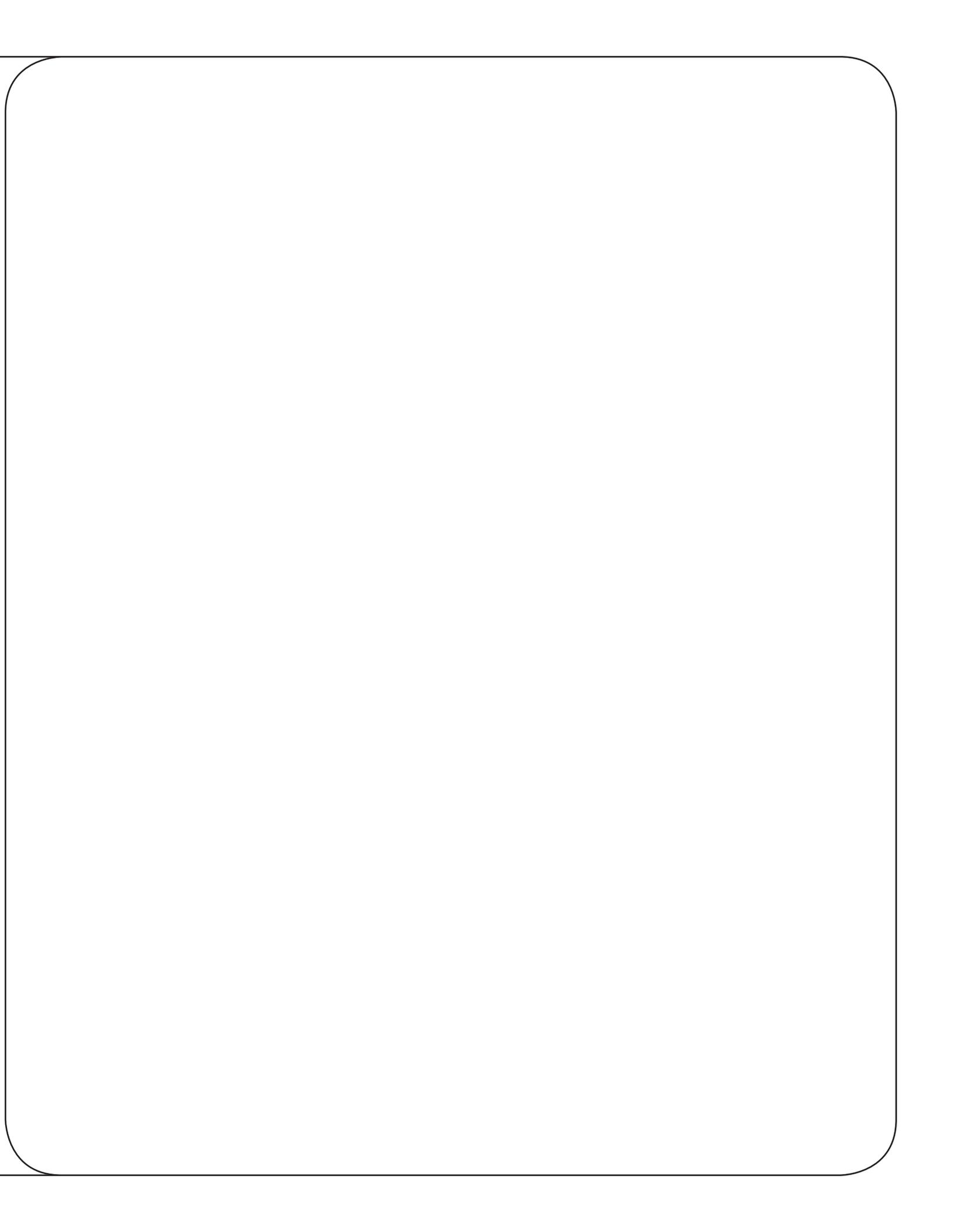
A rule that allows persons to request enrollment beyond the initial eligibility period due to certain life events.

Special Qualifying Event

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

The Plan

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





STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
19TH FLOOR, 312 ROSA L. PARKS AVENUE • WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

ENROLLMENT CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196



PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

Form with columns: TYPE OF ACTION (Add, Change, Terminate coverage), COVERAGE AFFECTED (Health, Dental, Vision), PARTICIPANTS AFFECTED (Employee, Spouse, Child(ren)), REASON FOR THIS ACTION (New Hire, Termination, etc.), Life Event (Marriage, Newborn, etc.), Special Enrollment (Death, Divorce, etc.)

PART 2: EMPLOYEE INFORMATION

Form with fields: FIRST NAME, MI, LAST NAME, DATE OF BIRTH, GENDER, MARITAL STATUS, SOCIAL SECURITY NUMBER, EMPLOYING AGENCY, EMPLOYER GROUP, YOUR CURRENT STATUS, HOME ADDRESS, CITY, ST, ZIP CODE, COUNTY

PART 3: HEALTH COVERAGE SELECTION

Form with columns: SELECT AN OPTION (Partnership PPO, HealthSavings CDHP, Standard PPO), LOCAL ED & GOV ONLY MAY ALSO CHOOSE (Limited PPO, Local HealthSavings CDHP), EMPLOYEE HSA CONTRIBUTION (STATE ONLY), SELECT A CARRIER (BlueCross BlueShield, Cigna), REGION WHERE YOU LIVE OR WORK (East, Middle, West), SELECT A HEALTH PREMIUM LEVEL (employee only, employee + child(ren), etc.)

PART 4: DENTAL COVERAGE SELECTION

Form with columns: SELECT A PLAN (MetLife DPPO, Cigna Prepaid DHMO), SELECT A DENTAL PREMIUM LEVEL (employee only, employee + child(ren), etc.)

PART 5: VISION COVERAGE SELECTION

Form with columns: SELECT A PLAN (Basic Plan, Expanded Plan), SELECT A VISION PREMIUM LEVEL (employee only, employee + child(ren), etc.)

PART 6: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

Table with columns: NAME (FIRST, MI, LAST), DATE OF BIRTH, RELATIONSHIP, GENDER, ACQUIRE DATE *, SOCIAL SECURITY NUMBER, HEALTH, DENTAL, VISION

*The acquire date is the date of marriage, birth, adoption or guardianship. Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).

PART 7: EMPLOYEE AUTHORIZATION

Accept I confirm that all of the information above is true. If I chose the Partnership Promise PPO or Promise HealthSavings CDHP, then I agree to the terms and conditions of the Partnership Promise for the plan year indicated on page 4. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my benefits coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.
Refuse I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

Form with fields: EMPLOYEE SIGNATURE, DATE, HOME PHONE (REQUIRED), EMAIL ADDRESS (REQUIRED)

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

Form with fields: ORIGINAL HIRE DATE, COVERAGE BEGIN/END DATE, POSITION NUMBER, EDISON ID, NOTES TO BENEFITS ADMINISTRATION, AGENCY BENEFITS COORDINATOR SIGNATURE, DATE, PPACA Eligible, 1450 Eligible

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.

Dependent Eligibility Definitions and Required Documents

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship AND a document proving joint ownership
		Proof of Marital Relationship <ul style="list-style-type: none"> • Government issued marriage certificate or license • Naturalization papers indicating marital status
		Proof of Joint Ownership <ul style="list-style-type: none"> • Bank Statement issued within the last six months with both names; or • Mortgage Statement issued within the last six months with both names; or • Residential Lease Agreement within the current terms with both names; or • Credit Card Statement issued within the last six months with both names; or • Property Tax Statement issued within the last 12 months with both names; or • The first page of most recent Federal Tax Return filed showing “married filing jointly” (if married filing separately, submit page 1 of both returns) or form 8879 (electronic filing)
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate; or
		Certificate of Report of Birth (DS-1350); or
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Court documents signed by a judge showing that the participant has adopted the child; or
		International adoption papers from country of adoption; or
		Papers from the adoption agency showing intent to adopt
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; or
		Any legal document that establishes relationship between the stepchild and the spouse or the member
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a qualified medical child support order (QMCSO)	Court documents signed by a judge; or
		Medical support orders issued by a state agency
Disabled dependent	A dependent of any age (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent’s disability must have begun before age 26 and while covered under a state-sponsored plan.	Documentation will be provided by the insurance carrier at the time incapacitation is determined

Revised 1/2016

Never send original documents. Please mark out or black out any social security numbers and any personal financial information on the copies of your documents BEFORE you return them.

NAME	EDISON ID	OR	SSN
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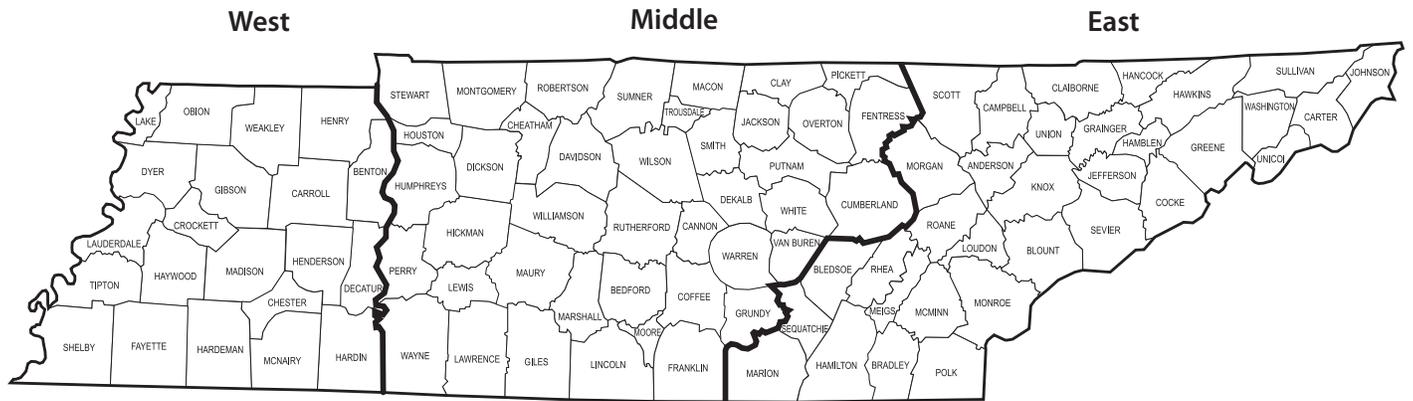
Special Enrollment Qualifying Events

The federal law, Health Insurance Portability Accountability Act (HIPAA), allows you and your dependents to enroll in health coverage under certain conditions. Exceptions will also be made for you or your dependents if you lose health coverage offered through your spouse's or ex-spouse's employer. You or your dependents may also be eligible to enroll in dental and vision coverage when lost with another employer. If you are adding dependents to your existing coverage, you and your dependents may transfer to a different carrier or healthcare option, if eligible. Premiums are not prorated. If approved, you must pay premium for the entire month in which the effective date occurs.

Identify the qualifying event(s) which caused the loss of other coverage for you and/or your eligible dependent(s). You must submit this page with the appropriate required documentation, proof of prior coverage and a completed enrollment application. Application for enrollment must be made within 60 days of the loss of insurance coverage or within 60 days of a new dependent's acquire date.

QUALIFYING EVENT	DOCUMENTATION REQUIRED	EFFECTIVE DATE
<input type="checkbox"/> Death of spouse or ex-spouse	Copy of death certification and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> 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 what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Legal separation	Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause)	Written documentation from the employer or the insurance company on company letterhead providing the names of covered participants, date coverage ended, reason for the loss of eligibility and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of coverage due to exhausting lifetime benefit maximum	Written documentation from the insurance company on company letterhead providing the names of covered participants, date coverage ended, stating that the lifetime maximum has been met and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Loss of TennCare (does not include a loss due to failure to pay premiums)	Written documentation from TennCare providing the names of covered participants, date coverage ended and the reason why coverage ended	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary)	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Employer eliminated contribution to spouse's, ex-spouse's or dependent's insurance coverage (total contribution, not partial)	Written documentation from the employer on company letterhead providing names of covered participants, date contribution amount changed, date coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
<input type="checkbox"/> Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage	Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended, reason why coverage ended and what coverage was lost (i.e., medical, dental, vision)	Day after loss of coverage OR first day of the month following loss of other coverage
When a new dependent is acquired, a non-covered employee may use the event to enroll in employee only or family coverage. If the employee is already enrolled, they may add the new dependent and previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible). Required documentation is listed below. Employees only requesting to add a new dependent should follow regular enrollment procedures.		
<input type="checkbox"/> Acquires a new dependent — spouse	Copy of marriage certificate	Date of marriage OR first day of the month following marriage
<input type="checkbox"/> Acquires a new dependent — newborn	Copy of birth certificate for newborn	Date of birth
<input type="checkbox"/> Acquires a new dependent — adoption/ legal custody	Copy of adoption documents	Date of adoption or legal custody

Counties and Regions For Health Plans



Active employees can select the region where they either live or work. COBRA participants must select the region where they live.

Out of state residents: If you do not live in Tennessee, you will be eligible to enroll in the middle region options.

INSTRUCTIONS

Please complete the entire form and do not leave anything blank. Leaving a section blank can cause a delay in processing your request.

To add, change or terminate health, dental or vision coverage during the annual enrollment period, follow these instructions for each section in Part 1:

TYPE OF ACTION — mark the box indicating that you want to add, change or terminate coverage

COVERAGE AFFECTED — mark all that apply

PARTICIPANTS AFFECTED — mark all that apply

REASON FOR THIS ACTION — indicate reason for action – if making changes during annual enrollment period mark “Other” and write in AEP

Please make sure the rest of the form is filled out completely and be sure to sign and date the form. If you are an active employee, return your completed form to your agency benefits coordinator.

2017 PARTNERSHIP PROMISE

Members and covered spouses must:

- Complete the online Healthways Well-Being Assessment® (health questionnaire) between January 1 and March 15, 2017
- Complete a biometric health screening by July 15, 2017
- Actively participate in coaching, if you are called
 - » Coaching includes disease management [diabetes, chronic obstructive pulmonary disease (COPD), asthma, heart failure and congestive heart disease (CHD)] and/or case management administered by BlueCross BlueShield, Cigna and Optum
- Keep your contact information current with your employer, or if a covered spouse, with Healthways

New employees and newly covered members:

New plan members are required to complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date. New plan members include new employees hired on or after January 1, 2017, and their covered spouses, as well as any new member who enrolls in the Partnership Promise PPO or Promise HealthSavings CDHP on or after January 1, 2017, due to a special qualifying event. Children enrolled in the health plan are not required to complete the Partnership Promise. Visit our website at partnersforhealthtn.gov for more information about the Partnership Promise.

A person who knowingly provides false information to maintain benefits may have to pay a higher premium to stay in the Partnership Promise PPO or would not qualify for state HSA funds if in the Promise HealthSavings CDHP. In addition, the state insurance plans have the right to recover the cost of benefits from any member who has received these benefits through false information.

Enrollment in the Partnership Promise PPO and the Promise HealthSavings CDHP. By choosing a plan that requires the Partnership Promise, you and your dependent spouse (if applicable), have the opportunity to qualify for a premium discount or HSA funds by completing the Partnership Promise requirements each year that you are enrolled. If you do not fulfill the requirements, you will not get the premium discount in the Partnership Promise PPO or the HSA funds from the state if enrolled in the Promise HealthSavings CDHP. During the annual enrollment period each year, you may select another health insurance option. If you do not do so, you will continue to be enrolled in your current plan, if eligible.

Requirements of the Partnership Promise PPO and the Promise HealthSavings CDHP. You will be informed of the requirements of the Partnership Promise on or before the annual enrollment period each year. The benefits of the Partnership Promise are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our Partners for Health Wellness Program at 888.741.3390. They will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.

Non-Completion of Partnership Promise requirements. Members who do not complete the requirements of the Partnership Promise will be sent written notification and will have the opportunity to respond to the notice.

**Group Term Life and Accidental Death and Dismemberment
Insurance Program Benefits**
For Employees of the State of Tennessee

NEW JOB

New Guarantee Issue Opportunities



Underwritten by Minnesota Life Insurance Company



What's Inside

The State of Tennessee is proud to work with Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. to provide Group Term Life and Accidental Death and Dismemberment (AD&D) insurance benefits. These programs offer you an affordable way to provide protection for your family.

Before enrolling in a voluntary plan you should consider *"How much life insurance do I need?"* and *"How much will it cost?"*

This booklet provides information on the state provided life insurance and voluntary options available to you. Enrollment in the basic plan is automatic. Instructions for enrolling in the voluntary plans are given in this booklet. Enrolling in the voluntary plans is easy and can be done in three simple steps:

Step 1 - Review your coverage options

Step 2 - Calculate your costs

Step 3 - Enroll

QUESTIONS?

Visit the **www.LifeBenefits.com/StateofTN** or call Group Customer Service at **1-866-881-0631** or e-mail **LifeBenefits@securian.com**.

Basic Term Life and AD&D insurance

Coverage – Employees and dependents receive the following coverage for Basic Term Life and AD&D Insurance through the State of Tennessee.

If your base annual salary is:	Basic Employee Term Life	Basic AD&D			
		Employee only	Spouse only	Spouse and Child	
				Spouse	Child
Less than \$15,000	\$20,000	\$40,000	\$24,000	\$16,000	\$4,000
\$15,000 - \$17,499	\$22,000	\$44,000	\$26,000	\$18,000	\$4,000
\$17,500 - \$19,999	\$25,000	\$50,000	\$30,000	\$20,000	\$5,000
\$20,000 - \$22,499	\$30,000	\$60,000	\$36,000	\$25,000	\$5,000
\$22,500 - \$24,999	\$33,500	\$67,000	\$40,000	\$27,000	\$6,000
\$25,000 - \$27,499	\$37,000	\$74,000	\$44,000	\$30,000	\$7,000
\$27,500 - \$29,999	\$40,500	\$81,000	\$49,000	\$32,000	\$8,000
\$30,000 - \$32,499	\$44,000	\$88,000	\$53,000	\$35,000	\$9,000
\$32,500 - \$34,999	\$47,500	\$95,000	\$57,000	\$38,000	\$9,000
\$35,000 and over	\$50,000	\$100,000	\$60,000	\$40,000	\$10,000

Basic Dependent Term Life – Spouse and child(ren) from live birth to age 26: \$3,000. You must be enrolled in the State of Tennessee Group Health Insurance family plan to be eligible for this coverage.

Reductions – The amount of the employee’s Basic Group Term Life and the amount of the employee’s and spouse’s Basic AD&D coverage will begin to decrease when the employee reaches age 65; to 65 percent at age 65; to 45 percent at age 70; and to 30 percent at age 75. The Basic Dependent Term Life is not reduced.

Employees not enrolled in the State of Tennessee Group Health Insurance plan are limited to \$20,000 Basic Term Life and \$40,000 Basic AD&D.

Base Annual Salary is based on a normal work week, exclusive of overtime, bonuses or other special compensation.

Annual Calculation of Coverage Level – In September of every year, the salary and age of each employee as of the current September 1 are reviewed to determine the appropriate coverage level and premium rate for each employee. All changes are effective on the following October 1.

Voluntary Group Term Life insurance

Below are the options available to you under the Voluntary Group Term Life insurance plan through the State of Tennessee.

Coverage type	Coverage options	Additional information
Voluntary Employee Term Life insurance	\$5,000 increments	<ul style="list-style-type: none"> Maximum coverage is the lesser of seven times annual base salary or \$500,000
Voluntary Spouse Term Life insurance		<ul style="list-style-type: none"> Spouse is not eligible if he or she is also eligible for employee coverage
Spouse under age 55	\$5,000, \$10,000, \$15,000, \$20,000, \$25,000 or \$30,000	<ul style="list-style-type: none"> Maximum coverage is \$30,000 Always requires proof of good health
Spouse age 55 or older	\$5,000, \$10,000 or \$15,000	<ul style="list-style-type: none"> Maximum coverage is \$15,000 Always requires proof of good health
Voluntary Child Term Life Rider	\$5,000 or \$10,000	<ul style="list-style-type: none"> Children are eligible from live birth to 26 years of age A child may only be covered by one parent Employee or spouse must have Voluntary Term Life coverage for the Voluntary Child Term Life Rider to be elected

Guaranteed coverage opportunities - No proof of good health required

Initial Eligibility (within 31 days of eligibility)

Voluntary Employee Term Life Insurance: Up to 5X base annual earnings

Voluntary Child Term Life Rider: All guaranteed

Annual Enrollment

Voluntary Employee Term Life Insurance: Employees currently participating may increase coverage by \$5,000 as long as the resulting total does not exceed 5x base annual salary (as of September 1) or \$500,000 whichever is less.

Elections exceeding these amounts require Proof of Good Health. Applicants previously declined coverage must also provide Proof of Good Health.

Voluntary Child Term Life Rider: All guaranteed

Voluntary AD&D insurance

Coverage options – State of Tennessee employees may elect Employee Only, or Employee and Family coverage for Voluntary AD&D insurance.

If your base annual salary is:	Employee only	Family coverage		
		Spouse only	Spouse and Child	
		(No children)	Spouse	Child
Less than \$3,000	\$6,000	\$4,000	\$2,000	\$1,000
\$3,000 - \$3,999	\$9,000	\$5,000	\$3,000	\$1,000
\$4,000 - \$4,999	\$12,000	\$7,000	\$4,000	\$2,000
\$5,000 - \$5,999	\$15,000	\$9,000	\$5,000	\$2,000
\$6,000 - \$6,999	\$18,000	\$11,000	\$7,000	\$2,000
\$7,000 - \$7,999	\$21,000	\$13,000	\$8,000	\$3,000
\$8,000 - \$8,999	\$24,000	\$15,000	\$10,000	\$3,000
\$9,000 - \$9,999	\$27,000	\$17,000	\$11,000	\$3,000
\$10,000 - \$12,499	\$32,000	\$19,000	\$13,000	\$3,000
\$12,500 - \$14,999	\$38,000	\$23,000	\$15,000	\$4,000
\$15,000 - \$17,499	\$44,000	\$26,000	\$18,000	\$4,000
\$17,500 - \$19,999	\$50,000	\$30,000	\$20,000	\$5,000
\$20,000 and over	\$60,000	\$36,000	\$25,000	\$5,000

How much does coverage cost?

The State of Tennessee automatically enrolls you in the Basic Term Life and Basic AD&D insurance programs. The State pays for \$20,000 Basic Term Life and \$40,000 Basic AD&D (reduced amounts if age 65 or greater).

If you enroll in the State’s medical insurance program, you pay 100 percent of the premium for Basic Term Life insurance in excess of \$20,000, Basic AD&D insurance in excess of \$40,000, and Basic Dependent Term Life/AD&D. You also pay 100 percent of the premium if you enroll in the Voluntary Group Term Life and/or Voluntary AD&D programs.

Basic Term Life and AD&D and Voluntary AD&D insurance employee monthly cost by employee annual base salary bands

	Less than \$3,000	\$3,000 - \$3,999	\$4,000 - \$4,999	\$5,000 - \$5,999	\$6,000 - \$6,999
Emp Basic Term/AD&D	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Family Basic Term/AD&D	\$1.27	\$1.27	\$1.27	\$1.27	\$1.27
Emp Vol AD&D	\$0.21	\$0.32	\$0.42	\$0.53	\$0.63
Family Vol AD&D	\$0.35	\$0.50	\$0.67	\$0.85	\$1.02
	\$7,000 - \$7,999	\$8,000 - \$8,999	\$9,000 - \$9,999	\$10,000 - \$12,499	\$12,500 - \$14,999
Emp Basic Term/AD&D	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Family Basic Term/AD&D	\$1.27	\$1.27	\$1.27	\$1.27	\$1.27
Emp Vol AD&D	\$0.74	\$0.84	\$0.95	\$1.12	\$1.33
Family Vol AD&D	\$1.20	\$1.37	\$1.55	\$1.79	\$2.14
	\$15,000 - \$17,499	\$17,500 - \$19,999	\$20,000 - \$22,499	\$22,500 - \$24,999	\$25,000 - \$27,499
Emp Basic Term/AD&D	\$0.42	\$1.04	\$2.08	\$2.81	\$3.54
Family Basic Term/AD&D	\$1.72	\$2.40	\$3.53	\$4.32	\$5.11
Emp Vol AD&D	\$1.54	\$1.75	\$2.10	\$2.10	\$2.10
Family Vol AD&D	\$2.45	\$2.80	\$3.36	\$3.36	\$3.36
	\$27,500 - \$29,999	\$30,000 - \$32,499	\$32,500 - \$34,999	\$35,000 and over	
Emp Basic Term/AD&D	\$4.26	\$4.99	\$5.72	\$6.24	
Family Basic Term/AD&D	\$5.91	\$6.70	\$7.49	\$8.05	
Emp Vol AD&D	\$2.10	\$2.10	\$2.10	\$2.10	
Family Vol AD&D	\$3.36	\$3.36	\$3.36	\$3.36	

“Family” includes both employee and dependent coverage.

All rates subject to change.

Underwritten by Minnesota Life Insurance Company

Voluntary Employee and Spouse Term Life insurance rates effective January 1, 2016

Rates per \$1,000 per month

Age	Rate
Under 30	\$0.046
30 - 34	\$0.050
35 - 39	\$0.061
40 - 44	\$0.093
45 - 49	\$0.158
50 - 54	\$0.266
55 - 59	\$0.415
60 - 64	\$0.646
65 - 69	\$1.072
70 - 74	\$1.495
75 - 79	\$2.297
80 & Over	\$4.150

Rates increase with age. Age is as of January 1 each year.

Voluntary Term Life rider rates

One monthly premium covers all eligible children.

Coverage options:

\$5,000 - \$0.50 per month

\$10,000 - \$1.00 per month

All rates are subject to change.

Voluntary Group Term Life exclusions

Suicide - If an insured, whether sane or insane, dies by suicide within two years of the effective date of any increase in coverage, Securian's liability with respect to such increase will be limited to an amount equal to the premiums paid and attributable to such increase.

Calculate your costs for Voluntary Term Life

Use these examples as your guide to calculating the life insurance costs for you and your spouse for Voluntary Term Life.

Example:

Employee age 38, chooses \$150,000 in coverage

$$\frac{\$150,000}{\text{Coverage amount}} \div \frac{\$1,000}{\text{Coverage units}} = \frac{150}{\text{Coverage units}} \times \frac{\$.061}{\text{Monthly rate}} + \frac{\$.30}{\text{Administrative cost}} = \frac{\$9.45}{\text{Monthly cost}}$$

Spouse age 34, chooses \$20,000 in coverage

$$\frac{\$20,000}{\text{Coverage amount}} \div \frac{\$1,000}{\text{Coverage units}} = \frac{20}{\text{Coverage units}} \times \frac{\$.050}{\text{Monthly rate}} + \frac{\$.30}{\text{Administrative cost}} = \frac{\$1.30}{\text{Monthly cost}}$$

Now just fill in the blanks!

$$\frac{\$}{\text{Coverage amount}} \div \frac{\$1,000}{\text{Coverage units}} = \frac{\quad}{\text{Coverage units}} \times \frac{\$}{\text{Monthly rate}} + \frac{\$.30}{\text{Administrative cost}} = \frac{\$}{\text{Monthly cost}}$$

Enroll

Computer Enrollment For Voluntary Group Term Life

It's easy to enroll/designate your beneficiary online!

Log on

Log on to **LifeBenefits.com** with the ID and password provided below.

Enter your information

Follow the instructions on the site to enroll for insurance coverage for you and your spouse and children if desired, and to designate your beneficiary. After submitting your information, please print a copy of your application for your records.

Clean up

Clear your personal information before leaving the computer.

Log on to the enrollment website with the ID and password below.

You will be prompted to change your password the first time you log-on.

YOUR ID: The letters **TN** followed by your Edison ID number

YOUR PASSWORD: Your password is your eight-digit date of birth (MMDDYYYY) followed by the last four digits of your social security number

If you do not have access to a computer or the internet, forms are available by calling Securian at **1-866-881-0631** or from your Human Resources Department.

TO ENROLL for Voluntary AD&D please log into Edison and complete your enrollment or utilize a paper form. Consult with your Agency Benefits Coordinator in your Human Resources Office on the appropriate method to use for enrollment.

What features does my plan provide?

Beyond paying a benefit in the event of your death, your group life insurance plan has other important features.

Conversion – If you are no longer eligible for coverage as an active employee you may convert your life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Continue (port) – If you are no longer eligible for coverage as an active employee, you may continue (port) your Voluntary Group Term Life insurance under the group plan. Insurance will be on a direct bill basis. Continued (ported) coverage ends at the end of the year you reach age 70. Rates are the same as those paid by active employees.

Accidental Death and Dismemberment (AD&D) – Provides beneficiaries with additional financial protection if an insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere.

No premiums if you become disabled – If you become totally disabled according to the terms of your certificate, life insurance premiums may be waived.

Early benefit payments if diagnosed as terminally ill – If an insured person becomes terminally ill with a life expectancy of 12 months or less, you may request early payment of up to 100 percent of the life insurance amount Basic and Voluntary Life combined.

Child Continuation and notification requirements – Once a child reaches age 26 and you wish to convert that child coverage, Securian must be contacted within 31 days. Also, you must notify Securian when the last child covered under the Voluntary Term Life reaches age 26.

HOW MUCH LIFE INSURANCE DO I NEED?

Check out our life insurance calculator at LifeBenefits.com/insuranceneeds.

LifeSuite services

Securian and Benefits Administration offer these services to you as a State of Tennessee employee eligible for basic term life insurance.

These services are available to you with no additional fee or enrollment required. We encourage you to visit the websites to become familiar with the services, and use them if and when you need them.

Travel Assistance Services

RedpointWTP, LLC provides travel assistance services to you and your dependents. The services are available 24/7/365 for emergency assistance, transport services, and pre-trip resources, when traveling 100 or more miles away from home. Visit **LifeBenefits.com/Travel** or call **1-855-516-5433** when traveling in the U.S. and Canada. From other locations, you can call collect to **+1-415-484-4677**.

Legacy Planning Resources

Securian provides you, and your spouse and dependents, access to a variety of information and resources to help when organizing important financial documents as well as working through end-of-life issues. Our legacy planning resources support you as you consider your final wishes or those of a loved one.

In addition, information guides individuals through the process of planning or pre-planning final arrangements. Our Express Assignment™ funeral home assignment service, available to insureds, reduces concern about paying funeral expenses. For more information, visit LegacyPlanningResources.com.

Beneficiary Financial Counseling

Financial counseling services are offered by PricewaterhouseCoopers LLP (PwC) to beneficiaries who receive at least \$20,000 in policy benefits. PwC is a professional services firm with decades of experience in personal financial education and counseling. The counseling services are designed to help families make sound financial decisions at a difficult time. PwC advisors do not sell insurance or investment products. There is no fee to the beneficiary for this service.

If you have specific questions about Travel Assistance or Legacy Planning, please call or visit the websites listed above.

Services provided by RedpointWTP, LLC and PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life Insurance Company or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services. To learn more, visit the appropriate website.



Underwritten by Minnesota Life Insurance Company
400 Robert Street North
St. Paul, MN 55101

ACT NOW!

**To enroll for
guaranteed coverage!**

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.

This product is offered under policy form series 13-31526 (Basic life), 12-31463 (Voluntary life) and 13-31554 (Voluntary AD&D). If there are any differences between these materials and the policy or certificate, the policy and certificate govern.

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STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

TYPE OF REQUEST

- New Enrollment
- Beneficiary Add/Change

Effective date of designation:

Enrolled in health coverage:

- Yes
- No

If yes, type of health coverage:

- Employee only
- Employee + dependents

This application is to be used to designate a beneficiary for basic life insurance coverages. Individuals who elect **NOT** to enroll in health insurance will be provided with basic term life and basic accident coverage with the premium being provided by the State of Tennessee. These amounts of coverage **CANNOT** be increased.

Individuals who **DO** elect health coverage will also receive the same state support; however, the amount of coverage will increase as your salary increases, with additional premiums deducted from your paycheck. If enrolling in health coverage, covered dependents will also receive life insurance benefits; however, the amount of coverage is different from that of an employee.

Please refer to the eligibility and enrollment guide for further information.

EMPLOYEE INFORMATION

NAME	SOCIAL SECURITY NUMBER	EDISON ID (IF KNOWN)	
EMPLOYING DEPARTMENT/AGENCY	DEPT ID	DATE OF HIRE	DATE OF BIRTH
WORK ADDRESS	CITY	STATE	ZIP CODE
HOME ADDRESS	CITY	STATE	ZIP CODE
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DAYTIME PHONE NUMBER	

AUTHORIZATION

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic accident coverage only. Unless I enroll in family health insurance, coverage is provided to the employee only (not spouse or child). If I enroll in family health insurance coverage, my covered dependents will also be enrolled in basic life coverage; however dependents do not elect a beneficiary as the benefit will automatically default to me as the employee. I further understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death.

I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

Upon termination of employment, I may convert my basic term life coverage to an individual policy with the insurance company. Payment of monthly premiums directly to the insurance company will be my responsibility.

I confirm that all information that I have provided on this application is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.

EMPLOYEE SIGNATURE

DATE

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

NAME		EDISON ID	OR	SSN	
PRIMARY BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%)					TOTAL
CONTINGENT BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR CONTINGENT BENEFICIARY (MUST BE 100%)					TOTAL

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.



STATE OF TENNESSEE GROUP INSURANCE PROGRAM

VOLUNTARY ACCIDENTAL DEATH ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

TYPE OF REQUEST		ACTION FOR ENROLLMENT CHANGE	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Terminate Coverage	
<input type="checkbox"/> Employee only	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Add/Change Beneficiary	
<input type="checkbox"/> Employee + dependents	<input type="checkbox"/> Update Dependent Eligibility	<input type="checkbox"/> Change Coverage Type to: <input type="checkbox"/> Single <input type="checkbox"/> Family	
<input type="checkbox"/> Enrollment Change	Effective Date of Change: _____		

EMPLOYEE INFORMATION					
FIRST NAME	MI	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY NUMBER	EMPLOYING AGENCY		DAYTIME PHONE NUMBER	EDISON ID	
HOME ADDRESS			CITY	ST	ZIP CODE

DEPENDENT INFORMATION						
NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			

* The acquire date is the date of marriage, birth, adoption or guardianship.
Proof of a dependent's eligibility must be submitted with this application for all new dependents.

AUTHORIZATION	
<p>I confirm that all the above information is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.</p> <p>I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.</p> <p>I understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death. Dependents do not elect a beneficiary as the benefit will automatically default to me as the employee.</p>	
EMPLOYEE SIGNATURE _____	DATE _____

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

NAME		EDISON ID	OR	SSN	
PRIMARY BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%)					TOTAL
CONTINGENT BENEFICIARY DESIGNATION					
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
NAME		PHONE NUMBER	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENT OF BENEFIT
HOME ADDRESS			CITY	STATE	ZIP CODE
TOTAL FOR CONTINGENT BENEFICIARY (MUST BE 100%)					TOTAL

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.

Optional Group Term Life Insurance Enrollment

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Group Administration Department • 400 Robert Street North • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: State of Tennessee

POLICY NUMBER: 34175

Reason for Enrollment: New Hire Family Status Change Date of Family Status Change _____ Annual Enrollment

1. Complete sections A, B, and F.
2. If you are electing coverage on your dependents, complete sections C, D, and/or E.

If you have questions, please contact Minnesota Life at 1-866-881-0631.

A. EMPLOYEE INFORMATION

First name _____ Middle initial _____ Last name _____

Email address _____

Street address _____ City _____ State _____ Zip code _____

Date of birth _____ Social Security number _____ Date of employment _____ Gender
 Male Female

Total amount of insurance requested (\$5,000 increments to a maximum of 7 times base annual salary or \$500,000, whichever is less. Up to 5 times base annual salary is guaranteed if elected within 30 days of hire. Electing 6x or 7x base salary will require you to complete the separate Evidence of Insurability form.)

\$ _____ Check this box for the \$5,000 Annual Enrollment increase ONLY

B. EMPLOYEE BENEFICIARY INFORMATION

Primary beneficiary(ies) designation (include full name and address) <i>The person or persons named will receive the benefits.</i>	Relationship	Share % (Primary beneficiaries must total 100%)
---	--------------	---

Contingent beneficiary(ies) designation (include full name and address) <i>If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).</i>	Relationship	Share % (Contingent beneficiaries must total 100%)
---	--------------	--

PLEASE NOTE: If you do not designate a beneficiary, any death proceeds would be paid out at State of TN's plan default:

1. Spouse
2. Child(ren)
3. Parent(s)
4. Estate of Insured

C. SPOUSE INFORMATION

First name _____ Middle initial _____ Last name _____

Email address _____

Has your spouse been hospitalized, advised to seek medical treatment, or received disability benefits in the past six months? Yes No

Date of birth _____ Social Security number _____ Gender
 Male Female

Total amount of Spouse Optional Term Life insurance requested

- \$5,000
 \$10,000
 \$15,000
 \$20,000 (Spouse under age 55 only)
 \$25,000 (Spouse under age 55 only)
 \$30,000 (Spouse under age 55 only)

D. SPOUSE BENEFICIARY DESIGNATION (if no beneficiary is designated, employee will be the default beneficiary for spouse coverage)

Primary beneficiary(ies) designation (include full name and address) <i>The person or persons named will receive the benefits.</i>	Relationship	Share % (Primary beneficiaries must total 100%)
---	--------------	---

Contingent beneficiary(ies) designation (include full name and address) <i>If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).</i>	Relationship	Share % (Contingent beneficiaries must total 100%)
---	--------------	--

E. CHILDREN INFORMATION (Employee is the beneficiary of child coverage)

List of names and dates of birth for your eligible children:

Total amount of insurance requested

\$5,000 \$10,000

F. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for supplemental insurance coverage.

I authorize the State Group Insurance Plan to release to Minnesota Life on behalf of myself and all family members information (name, address, Social Security number, age, gender, salary, enrollment effective/termination dates) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The State Group Insurance Plan will not condition treatment, payment, or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X			

EMPLOYEE ASSISTANCE PROGRAM BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS



Welcome!

Optum Health is the company contracted by the state group insurance program to provide behavioral health services, which include both employee assistance and substance abuse treatment for all state group insurance program participants and eligible dependents. All services are strictly confidential and can be accessed by calling 855.HERE4TN (855.437.3486) 24 hours a day, seven days a week.

Employee Assistance Program Eligibility

All EAP services must be preauthorized. The chart below defines eligibility for employee assistance program services. You and your eligible dependents may receive up to five counseling sessions per episode at no cost to you. All services are confidential. The EAP can provide support and resources for:

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

State Plan	All full-time state and higher education employees and eligible dependents, under-65 retirees and COBRA participants.
Local Education and Local Government Plans	All employees, under-65 retirees and COBRA participants enrolled in a state-sponsored healthcare option. An employee's eligible dependents may receive EAP services even if the dependents are not enrolled in health coverage.

Online Resources

Here4TN.com provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, on-line training courses, search for available providers and access a map of your provider's location, as well as obtain driving directions. It also provides the ability to review claims information online. No password is required to access the site. Personalized information and tools are available when you register.

Behavioral Health and Substance Abuse Eligibility

You and your dependents must be enrolled in health coverage to be eligible for behavioral health and substance abuse services. No matter which healthcare option you have selected, you have convenient and confidential access to behavioral health and substance abuse benefits. Your cost depends on your particular healthcare option (see grid on reverse side). Subject to clinical necessity, services generally include:

- Outpatient assessment and treatment
- Individual and group treatment
- Inpatient assessment and treatment
- Alternative care such as partial hospitalization and intensive outpatient treatment
- Treatment follow-up and aftercare

Certain services are specifically excluded under the terms and conditions of the state group insurance program. For more information, contact Optum or refer to the *Plan Document*, available on the publications page of the Benefits Administration website at tn.gov/finance or from your agency benefits coordinator.

Obtaining Behavioral Health or Substance Abuse Services

To receive the maximum benefit coverage for your care, you must use a network provider and obtain preauthorization as required. You can call Optum toll free at 855.HERE4TN any time, day or night, to speak confidentially with a trained professional for a referral. Although you may see an out-of-network provider without a referral, your coinsurance and copayments will be higher and you will be responsible for charges above the maximum allowable charge (MAC). You may also be at risk of having inpatient benefits totally denied if Optum determines that services are not clinically necessary.

2017 Copays, Coinsurance, Deductibles and Out-of-Pocket Maximums

Table 1: Outpatient Behavioral Health and Substance Abuse Treatment

Member copay/coinsurance amounts. Outpatient services are not subject to a deductible in the PPOs. Costs do apply to the annual out-of-pocket maximum. ^{[1], [2]}

Healthcare Option	In-Network	Out-of-Network
Partnership PPO	\$25	\$45
Standard PPO	\$30	\$50
Limited PPO	\$35	\$55
HealthSavings CDHP	20%	40%
Local HealthSavings CDHP	30%	50%

Table 2: Inpatient Behavioral Health and Substance Abuse Treatment

Member coinsurance amounts. Services are subject to a deductible and eligible expenses apply to the annual out-of-pocket maximum. ^{[1], [2]}

Healthcare Option	In-Network	Out-of-Network
Partnership	10%	40%
Standard	20%	40%
Limited	30%	50%
HealthSavings CDHP	20%	40%
Local HealthSavings CDHP	30%	50%

Table 3: Deductibles ^[3]

	In-Network	Out-of-Network
Partnership PPO		
Employee only	\$500	\$1,000
Employee + children	\$750	\$1,500
Employee + spouse	\$1,000	\$2,000
Employee + spouse + children	\$1,250	\$2,500
Standard PPO		
Employee only	\$1,000	\$2,000
Employee + children	\$1,500	\$3,000
Employee + spouse	\$2,000	\$4,000
Employee + spouse + children	\$2,500	\$5,000
Limited PPO		
Employee only	\$1,600	\$3,000
Employee + children	\$2,200	\$4,000
Employee + spouse	\$2,500	\$4,600
Employee + spouse + children	\$3,200	\$6,000
HealthSavings CDHP		
Employee only	\$1,500	\$3,000
Employee + children	\$3,000	\$6,000
Employee + spouse	\$3,000	\$6,000
Employee + spouse + children	\$3,000	\$6,000
Local HealthSavings CDHP		
Employee only	\$2,000	\$4,000
Employee + children	\$4,000	\$8,000
Employee + spouse	\$4,000	\$8,000
Employee + spouse + children	\$4,000	\$8,000

Table 4: Out-of-Pocket Maximums ^[3]

	In-Network	Out-of-Network
Partnership PPO		
Employee only	\$3,600	\$4,000
Employee + children	\$5,400	\$6,000
Employee + spouse	\$7,200	\$8,000
Employee + spouse + children	\$9,000	\$10,000
Standard PPO		
Employee only	\$4,000	\$4,500
Employee + children	\$6,000	\$6,750
Employee + spouse	\$8,000	\$9,000
Employee + spouse + children	\$10,000	\$11,250
Limited PPO		
Employee only	\$6,600	\$10,000
Employee + children	\$13,200	\$20,000
Employee + spouse	\$13,200	\$20,000
Employee + spouse + children	\$13,200	\$20,000
HealthSavings CDHP		
Employee only	\$2,500	\$4,500
Employee + children	\$5,000	\$9,000
Employee + spouse	\$5,000	\$9,000
Employee + spouse + children	\$5,000	\$9,000
Local HealthSavings CDHP		
Employee only	\$3,500	\$5,000
Employee + children	\$7,000	\$10,000
Employee + spouse	\$7,000	\$10,000
Employee + spouse + children	\$7,000	\$10,000

^[1] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy.

^[2] Prior authorization is required for psychological testing, electroconvulsive therapy, applied behavior analysis and transcranial magnetic stimulation. When using out-of-network providers, benefits for clinically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge (MAC). If services are not clinically necessary, no benefit will be provided.

^[3] Deductibles and out-of-pocket maximums are for medical services, pharmacy and behavioral health and substance abuse treatment services combined. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

State and Higher Education

2017 Monthly Premiums for Active Employees

ALL REGIONS				
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS	EMPLOYER SHARE
PARTNERSHIP PROMISE PPO				
Employee Only	\$133	\$133	\$173	\$572
Employee + Child(ren)	\$200	\$200	\$240	\$857
Employee + Spouse	\$280	\$280	\$360	\$1,200
Employee + Spouse + Child(ren)	\$346	\$346	\$426	\$1,486
NO PARTNERSHIP PROMISE PPO				
Employee Only	\$183	\$183	\$223	\$572
Employee + Child(ren)	\$250	\$250	\$290	\$857
Employee + Spouse	\$380	\$380	\$460	\$1,200
Employee + Spouse + Child(ren)	\$446	\$446	\$526	\$1,486
STANDARD PPO				
Employee Only	\$130	\$130	\$170	\$572
Employee + Child(ren)	\$197	\$197	\$237	\$857
Employee + Spouse	\$275	\$275	\$355	\$1,200
Employee + Spouse + Child(ren)	\$340	\$340	\$420	\$1,486
HEALTHSAVINGS CDHP (PROMISE OR NO PROMISE)				
Employee Only	\$84	\$84	\$124	\$572
Employee + Child(ren)	\$127	\$127	\$167	\$857
Employee + Spouse	\$177	\$177	\$257	\$1,200
Employee + Spouse + Child(ren)	\$219	\$219	\$299	\$1,486

HEALTH PREMIUMS—ACTIVE

2017 Monthly Premiums

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	\$12.99	\$22.37
Employee + Child(ren)	\$26.97	\$51.44
Employee + Spouse	\$23.02	\$42.32
Employee + Spouse + Child(ren)	\$31.65	\$82.80
COBRA PARTICIPANTS		
Employee Only/Single	\$13.25	\$22.82
Employee + Child(ren)	\$27.51	\$52.47
Employee + Spouse	\$23.48	\$43.17
Employee + Spouse + Child(ren)	\$32.28	\$84.46
COBRA DISABILITY PARTICIPANTS		
Employee Only/Single	\$19.49	\$33.56
Employee + Child(ren)	\$40.46	\$77.16
Employee + Spouse	\$34.53	\$63.48
Employee + Spouse + Child(ren)	\$47.48	\$124.20
RETIREE PARTICIPANTS		
Retiree Only	\$14.29	\$28.88
Retiree + Child(ren)	\$29.67	\$66.41
Retiree + Spouse	\$25.33	\$54.64
Retiree + Spouse + Child(ren)	\$34.80	\$106.91

2017 Monthly Premiums

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	\$3.35	\$5.86
Employee + Child(ren)	\$6.69	\$11.72
Employee + Spouse	\$6.35	\$11.14
Employee + Spouse + Child(ren)	\$9.83	\$17.23
COBRA PARTICIPANTS		
Employee Only/Single	\$3.42	\$5.98
Employee + Child(ren)	\$6.82	\$11.95
Employee + Spouse	\$6.48	\$11.36
Employee + Spouse + Child(ren)	\$10.03	\$17.57
COBRA DISABILITY PARTICIPANTS		
Employee Only/Single	\$5.03	\$8.79
Employee + Child(ren)	\$10.04	\$17.58
Employee + Spouse	\$9.53	\$16.71
Employee + Spouse + Child(ren)	\$14.75	\$25.85
RETIREE PARTICIPANTS		
Retiree Only	\$3.35	\$5.86
Retiree + Child(ren)	\$6.69	\$11.72
Retiree + Spouse	\$6.35	\$11.14
Retiree + Spouse + Child(ren)	\$9.83	\$17.23

2017 Partnership Promise Requirements

THESE REQUIREMENTS ARE FOR MEMBERS OF¹:

- ✓ The Partnership Promise PPO (including covered spouses)
- ✓ Promise HealthSavings CDHP (including covered spouses)

THE REQUIREMENTS:



Complete the online Healthways Well-Being Assessment™ (WBA) by **March 15, 2017**.

- The Well-Being Assessment must be completed between **January 1 and March 15, 2017**. Go to www.partnersforhealthtn.gov and click on “My Wellness Login” to get started.



Complete a biometric health screening by **July 15, 2017**.

- **At a work site screening:** You can see a complete list of worksite screening locations on the ParTNers for Health website, www.partnersforhealthtn.gov, in **January 2017**.
- **From your health care provider:** Healthways will accept results from a doctor’s visit between **July 16, 2016 and July 15, 2017**. Go to www.partnersforhealthtn.gov, click on “Complete Your Biometric Screening” in the Quick Links box and follow the directions to print a Physician Screening Form*. Follow the instructions on the form and return the completed form to Onsite Health Diagnostics (OHD) by the **July 15** deadline.

**You must use the form provided by Onsite Health Diagnostics (OHD).*



Actively participate in Disease Management or Case Management coaching, **if you are called**.

- Lifestyle Management coaching will be voluntary in 2017.



Keep your contact information current with your employer; or, if you are a covered spouse, keep your contact information current with Healthways, **if it changes**.

NOTE: New employees and newly covered members (as of 1/1/17) who enroll in the Partnership Promise PPO or the Promise HealthSavings CDHP must complete the online Well-Being Assessment and biometric screening within 120 days of their insurance coverage effective date to fulfill the 2017 Partnership Promise.

¹ The benefits of the Partnership Promise are open to all plan members. If you think you might be unable to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 888.741.3390, and they will work with you and/or your physician, if you wish, to find an alternate way for you to meet the Promise.

2017 Benefit Comparison— State and Higher Education

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum. CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

HEALTHCARE OPTION AND ACTUARIAL VALUE	PARTNERSHIP PPO 83.9%		STANDARD PPO 78.2%		HEALTHSAVINGS CDHP 83.9% (promise) 77% (no promise)	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
PREVENTIVE CARE — OFFICE VISITS						
<ul style="list-style-type: none"> Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) Adult annual physical exam Annual well-woman exam Immunizations as recommended by CDC Annual hearing and non-refractive vision screening Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force 	No charge	\$45 copay	No charge	\$50 copay	No charge	40% coinsurance
OUTPATIENT SERVICES						
Primary Care Office Visit <ul style="list-style-type: none"> Family practice, general practice, internal medicine, OB/GYN and pediatrics Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider Including surgery in office setting and initial maternity visit 	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance
Specialist Office Visit <ul style="list-style-type: none"> Including surgery in office setting 	\$45 copay	\$70 copay	\$50 copay	\$75 copay	20% coinsurance	40% coinsurance
Behavioral Health and Substance Abuse ^[2]	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance		20% coinsurance	40% coinsurance
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance		20% coinsurance	
Telehealth	\$15 copay	N/A	\$15 copay	N/A	20% coinsurance	N/A
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	20% coinsurance	40% coinsurance
Allergy Injection with Office Visit	\$25 copay primary; \$45 copay specialist	\$45 copay primary; \$70 copay specialist	\$30 copay primary; \$50 copay specialist	\$50 copay primary; \$75 copay specialist	20% coinsurance	40% coinsurance
Chiropractors <ul style="list-style-type: none"> Limit of 50 visits per year 	Visits 1-20: \$25 copay Visits 21-50: \$45 copay	Visits 1-20: \$45 copay Visits 21-50: \$70 copay	Visits 1-20: \$30 copay Visits 21-50: \$50 copay	Visits 1-20: \$50 copay Visits 21-50: \$75 copay	20% coinsurance	40% coinsurance
PHARMACY						
30-Day Supply	\$7 copay generic; \$40 copay preferred brand; \$90 copay non-preferred	copay plus amount exceeding MAC	\$14 copay generic; \$50 copay preferred brand; \$100 copay non-preferred	copay plus amount exceeding MAC	20% coinsurance	40% coinsurance plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	\$14 copay generic; \$80 copay preferred brand; \$180 copay non-preferred	N/A - no network	\$28 copay generic; \$100 copay preferred brand; \$200 copay non-preferred	N/A - no network	20% coinsurance	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) ^[3]	\$7 copay generic; \$40 copay preferred brand; \$160 copay non-preferred	N/A - no network	\$14 copay generic; \$50 copay preferred brand; \$180 copay non-preferred	N/A - no network	10% coinsurance without first having to meet deductible	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min \$50; max \$150	N/A - no network	10% coinsurance; min \$50; max \$150	N/A - no network	20% coinsurance	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE						
Convenience Clinic	\$25 copay	\$45 copay	\$30 copay	\$50 copay	20% coinsurance	40% coinsurance
Urgent Care Facility	\$45 copay	\$70 copay	\$50 copay	\$75 copay	20% coinsurance	40% coinsurance
EMERGENCY ROOM						
Emergency Room Visit	\$150 copay (services subject to coinsurance may be extra)		\$175 copay (services subject to coinsurance may be extra)		20% coinsurance	

2017 Benefit Comparison— State and Higher Education

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

COVERED SERVICES	PARTNERSHIP PPO		STANDARD PPO		HEALTHSAVINGS CDHP	
	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]	IN-NETWORK	OUT-OF-NETWORK ^[1]
Hospital/Facility Services • Inpatient care; outpatient surgery ^[4] • Inpatient behavioral health and substance abuse ^{[2] [4]}	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care ^[4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient ^[4] ; outpatient • Skilled nursing facility ^[4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance		20% coinsurance	
Hospice Care ^[4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (after the deductible has been met)	
Equipment and Supplies ^[4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ^[4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
DEDUCTIBLE						
Employee Only	\$500	\$1,000	\$1,000	\$2,000	\$1,500	\$3,000
Employee + Child(ren)	\$750	\$1,500	\$1,500	\$3,000	\$3,000	\$6,000
Employee + Spouse	\$1,000	\$2,000	\$2,000	\$4,000	\$3,000	\$6,000
Employee + Spouse + Child(ren)	\$1,250	\$2,500	\$2,500	\$5,000	\$3,000	\$6,000
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED						
Employee Only	\$3,600	\$4,000	\$4,000	\$4,500	\$2,500	\$4,500
Employee + Child(ren)	\$5,400	\$6,000	\$6,000	\$6,750	\$5,000	\$9,000
Employee + Spouse	\$7,200	\$8,000	\$8,000	\$9,000	\$5,000	\$9,000
Employee + Spouse + Child(ren)	\$9,000	\$10,000	\$10,000	\$11,250	\$5,000	\$9,000
PARTNERSHIP PROMISE DISCOUNT/DEPOSIT						
For individuals who agree to complete the Partnership Promise	premium discount: \$50 for employee only and employee+child(ren) coverage; \$100 for employee+spouse and employee+spouse+child(ren) coverage		N/A		State contribution to HSA: \$500 for employee only; \$1,000 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. For PPO Plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. For CDHP Plans, the out-of-pocket maximum amount can be met by one or more persons.

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

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization (PA) is required.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

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

Covered Dental Services

Here is a comparison of deductibles, copays and your share of coinsurance for 2017 under the dental options. Costs represent what the member pays.

COVERED SERVICES	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
	GENERAL DENTIST	SPECIALIST DENTIST	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	none		\$25 single; \$75 family, per policy year ^[1]	\$100 single; \$300 family, per policy year ^[1]
Annual Maximum Benefit	none		\$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	\$10 copay ^[2]		no charge	20% of MAC
Periodic Oral Evaluation	no charge		no charge	20% of MAC
Routine Cleaning – Adult	no charge		no charge	20% of MAC
Routine Cleaning – Child	no charge	\$15 copay	no charge	20% of MAC
X-ray — Intraoral, Complete Series	no charge	\$5 copay	no charge	20% of MAC
Amalgam (silver) Filling — 2 Surfaces Permanent	\$8 copay	\$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	\$125 copay	\$600 copay	20% of MAC	40% of MAC
Major Restorations — Crowns (porcelain fused to high noble metal)	\$275 copay, plus lab fees ^[3]		50% of MAC ^[4]	
Extraction of Erupted Tooth (minor oral surgery)	\$15 copay	\$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	\$100 copay	\$120 copay	50% of MAC	
Dentures — Complete Upper	\$310 copay, plus lab fees ^[3]		50% of MAC ^[4]	
Orthodontics	\$140 monthly copay for treatment ^[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	\$3,360 treatment fee only ^[6]		\$1,250 ^[5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge (maximum amount of charge agreed to by dentist)

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

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

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

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

[4] A 6-month waiting period applies.

[5] The orthodontics lifetime maximum is for a dependent member enrolled in the state group dental insurance program even if the member has been covered under different employing agencies.

[6] Additional copays apply for specific orthodontic procedures.

Covered Vision Services

Here is a comparison of discounts, copays and allowed amounts for 2017 under the vision options. Copays represent what the member pays. Allowances and percentage discounts represent the cost the carrier will cover.

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	\$0 copay	\$10 copay
Retinal Imaging Benefit	none	up to \$39 copay
Frames	\$50 allowance; 20% discount off balance above the allowance	\$115 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass) <ul style="list-style-type: none"> • Single, bifocal, trifocal, lenticular • Standard progressive Lens • Premium progressive Lens 	\$50 allowance; 20% off balance over \$50	\$15 copay \$55 copay discount on no-line bifocals ^[1] \$55+(20% off retail price-\$120 allowance) for other ^[1]
Eyeglass Lens Options (upgrades) <ul style="list-style-type: none"> • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium anti-reflective • All other eyeglass lens options 	20% discount off all options	maximum copayments: \$45 copay \$30 copay; \$0 for children 18 and under discount applied \$15 copay \$10 copay \$25 copay 20% off retail price discount applied 20% discount
Exam for Contact Lenses (fitting and evaluation)	15% discount off retail price	up to \$60 copay
Contact Lenses ^[2] <ul style="list-style-type: none"> • Elective <ul style="list-style-type: none"> • Conventional • Disposable • Medically necessary ^[3] 	\$50 allowance; 15% off balance over \$50 \$50 allowance \$150 allowance	\$130 allowance; 15% off balance over \$130 \$130 allowance covered at 100%
LASIK/Refractive Surgery (for select providers)	15% discount off retail price or 5% off promotional price	15% discount off retail price or 5% off promotional price
Out-of-Network Benefits <ul style="list-style-type: none"> • All eye exams • Frames • Eyeglass lenses <ul style="list-style-type: none"> • Single vision • Lined bifocal • Lined trifocal • Elective contacts (conventional or disposable) • Medically necessary contacts ^[3] • Lens options-UV, polycarbonate, photochromic/transitions plastic 	up to \$30 allowance up to \$50 allowance (frames and lenses combined) \$25 allowance \$75 allowance	up to \$45 allowance up to \$70 allowance up to \$30 allowance up to \$50 allowance up to \$65 allowance up to \$50 allowance up to \$100 allowance up to \$5 allowance
Frequency <ul style="list-style-type: none"> • Eye exam • Eyeglass lenses and contacts • Frames 	once every calendar year per person once every calendar year per person once every two calendar years per person	once every calendar year per person once every calendar year per person once every two calendar years per person

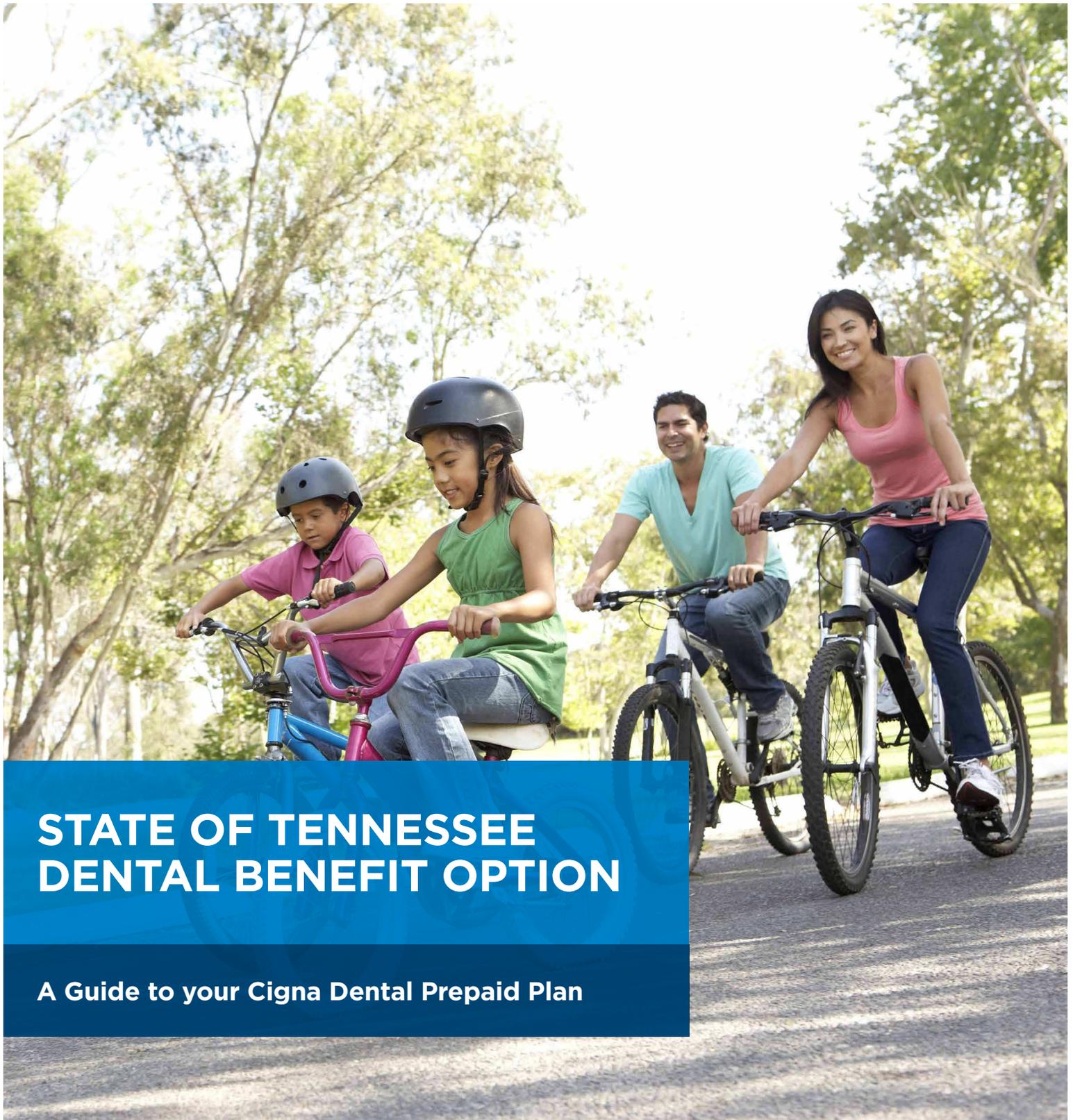
[1] Copays for premium progressive lens are subject to change

[2] Instead of eyeglass lenses

[3] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

EyeMed offers some additional discounts which include:

- > 40% off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- > 15% off conventional contact lenses after the benefit has been used
- > 20% off non-covered items such as lens cleaner, accessories and non-prescription sunglasses



STATE OF TENNESSEE DENTAL BENEFIT OPTION

A Guide to your Cigna Dental Prepaid Plan

Sponsored by the State of Tennessee | 2017

**PARTNERS
FOR HEALTH**



Together, all the way.®



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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IMPORTANT PLAN INFORMATION

We are pleased to provide information about the prepaid dental plan. This plan offers a full range of benefits through a network of plan dentists. Cigna Dental Care® is providing your prepaid dental benefit plan.¹

Important details

You must select a network general dentist, who will manage your overall dental care. Covered family members can choose their own network general dentists – near home, work or school. Our nationwide Cigna Dental Care network is one of the largest in the United States. If you need assistance in selecting a dentist, contact Cigna at **800.997.1617**.

- ▶ You will pay the copay amount listed on your Patient Charge Schedule for covered dental services performed by your network dentist.
- ▶ If your network general dentist does not perform the specialty care procedure you need, he/she can direct you to a participating network specialist.
- ▶ Procedures not listed on your Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- ▶ Preauthorization of payment is not required for specialty referrals for pediatric and orthodontic services.
- ▶ **Remember:** If you seek covered services from a dentist who does not participate in the Cigna Dental Care network, your plan will not pay except in the case of an emergency, or as required by law.

Participation Requirements:

An agency must be participating in the State of Tennessee Sponsored Group Health Plan in order to qualify for participation in the State of Tennessee Voluntary Dental Program. Employee, Retiree and/or Dependent participation in the State Sponsored Group Health Plan is not required to participate in the State Dental Program. Employee or Retiree participation in the Prepaid Dental Program is required for participation of eligible Dependents. Participation by those enrolled in the Prepaid Dental Program is on a calendar year basis, and enrollment may only be dropped by the Members during the Annual Enrollment Period for the beginning of the next calendar year or due to a special qualifying event. We will also allow dropping of prepaid if there is no participating general dentist within 40 mile radius of home.

What's covered

You can save money on a wide range of services, including:

- › **Preventive care** – cleanings, fluoride, sealants, bitewing x-rays, full-mouth x-rays and more.
- › **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam).
- › **Major services** – crowns, bridges, dentures, root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more.
- › **Specialty care** – provided at the specialist copay listed on your Patient Charge Schedule only when performed by your network specialist dentist.
- › **Orthodontic care** – all plans include coverage for braces for children and adults.² Check your plan materials. Plan materials can be found at Cigna.com/sites/stateoftn.
- › **General anesthesia** – when medically necessary.
- › **Temporomandibular joint (TMJ)** – diagnosis and treatment procedures, including cone beam x-ray and appliance.

Alternate coverage provisions may apply for covered services if noted on your Patient Charge Schedule. For more details review your enrollment materials at Cigna.com/sites/stateoftn.

Plan features:

- › **No deductibles** – you don't have to reach a certain level of out-of-pocket expenses before your insurance kicks in.
- › **No dollar maximums** – you don't have to worry about your coverage running out after your covered expenses reach a certain dollar amount.
- › There are **no claim forms** to file and **no waiting periods** for coverage.
- › Coverage for dental conditions that exist at the time you enroll in the plan are not excluded if they are otherwise covered under your Patient Charge Schedule. Treatment in progress is generally excluded.³
- › There is a \$10 office visit fee associated with your plan.

Savings you can see

MONTHLY PAYROLL DEDUCTIONS FOR 2017			
Employee	\$12.99	Retiree	\$14.29
Employee + spouse	\$23.02	Retiree + spouse	\$25.33
Employee + child(ren)	\$26.97	Retiree + child(ren)	\$29.67
Employee + family	\$31.65	Retiree + family	\$34.80



YOUR QUESTIONS ANSWERED

Q: How does the Cigna Dental Prepaid Plan work?

A: When you sign up in the Cigna Dental Prepaid Plan, you must select a network general dentist, who will handle your dental care needs. You then receive a Patient Charge Schedule, or PCS, that lists the specific dental procedures covered by the plan and the amount you would pay the dentist (your copays). These copays apply only when you receive treatment from the dentists or dental specialists in our Cigna Dental Care DHMO Network.

If a dental procedure is not listed on your PCS, it is not covered and you will have to pay according to the dentist's regular fees. If you receive a covered service from a dentist who does not participate in the Cigna Dental Care DHMO network, your dental benefits may not be covered at all.¹ You can take your PCS to dental appointments to discuss treatment options and costs with your dentist (but it is not required).

Q: How do I choose a dentist when I sign up for the plan? Can I change my network dentist later on?

A: When you enroll in the Cigna Dental Prepaid Plan, you are required to select and visit a network general dentist (provider) for your dental care needs. You can find a network dentist by visiting **Cigna.com/sites/stateoftn** or go to your personalized website at **myCigna.com** after you sign up. If you need help finding a dentist, you can call the customer service number below and request to have a list of providers mailed, emailed or faxed to you. You can change your network dentist at any time; changes go into effect the first of the following month. Remember, if you visit a non-network dentist, your treatment may not be covered at all.

If you'd like to speak with someone, call customer service at **800.997.1617**. You can also follow the phone prompts to use our automated Dental Office Locator. The automated system will speak the names of the dentists in your area, mail, email or fax a list of dentists to you.

Q: If I'm new to the Cigna Dental Prepaid Plan, can I keep my current dentist?

A: That depends. If your current dentist participates in the Cigna Dental Care DHMO Network, you can choose him/her as your network general dentist. You can look online at **Cigna.com/sites/stateoftn** to find out, or ask your dental office directly. Sometimes, Cigna's online Dental Office Directory may show that your dental office is not accepting new patients even when their office says they are. If this happens, please contact customer service at **800.997.1617** for assistance.

Q: Do I need a referral to visit a dental specialist?

A: Yes. If you require specialty care, your network general dentist will refer you to a network dental specialist – and handle any paperwork. Referrals are required for all network specialists, except orthodontists and pediatric dentists. Prior authorization may be required for certain types of specialty care and there may be a different copay.

Q: Do I need to show my ID card when I arrive at the dentist's office?

A: No. ID cards are not required to use the plan. When you call to schedule your appointment, just let your selected network dental office know that you are covered under the Cigna Dental Prepaid Plan. If for some reason the dental office does not see your name on its list of Cigna DHMO patients, they can call us to verify. You can also call customer service at **800.997.1617** if you need more help.

Q: When do I have to pay the dentist?

A: That depends on the financial arrangement between you and your network dentist. We encourage you to discuss costs and payment arrangements for dental treatment with your dentist before you receive care. Most dentists will work with their patients to arrange payment plans for more costly treatments.

Q: Will my network dentist submit a claim to Cigna after I receive treatment?

A: No. There are no claim forms required when receiving care from a network dentist.

Q: Are braces covered?

A: Yes. A maximum benefit of 24 months of interceptive and/or comprehensive orthodontic treatment is covered as shown in the Patient Charge Schedule. Cases beyond 24 months may require additional payments by the patient, which are based on the dentist's contracted fee and may be different from the copay listed in the patient charge schedule. If you or your family member started treatment before you joined the Cigna Dental Prepaid Plan (called "orthodontics in progress"), this treatment² is excluded.

Q: What if I have a dental emergency and can't get treatment from my DHMO network dentist?

A: Emergency services: If you are out of your service area or unable to contact your network general dentist, you may receive emergency services by any licensed dentist for unexpected but necessary services. Emergency services are limited to relieving severe pain, controlling excessive bleeding and eliminating serious and sudden ("acute") infection. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care and you should return to your network general dentist for these procedures.

Emergency care out of your service area: For emergency covered services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency covered services and your Patient Charge, up to a total of \$50 per incident (this amount may vary by state). To request reimbursement, send the dentist's itemized statement to Cigna Dental at the address listed for your state on your plan materials.

Emergency care after hours: There is a copay listed on your PCS for emergency care received after regularly scheduled office hours. This copay will be in addition to other copays that may apply.



HOW TO FIND A DENTIST

It's easy to find a Cigna network dentist or specialist.

Before you enroll, you can check to see if your dentist is in the Cigna Dental Care DHMO network. Here's how.

Visit myCigna.com

Enter the below information

User ID: Dhmo01

Password: Stateoftn1

Click **"Login"**

Once you have logged into myCigna.com

Step 1

Click on **"Find a Dentist"** at the top of the screen.

Step 2

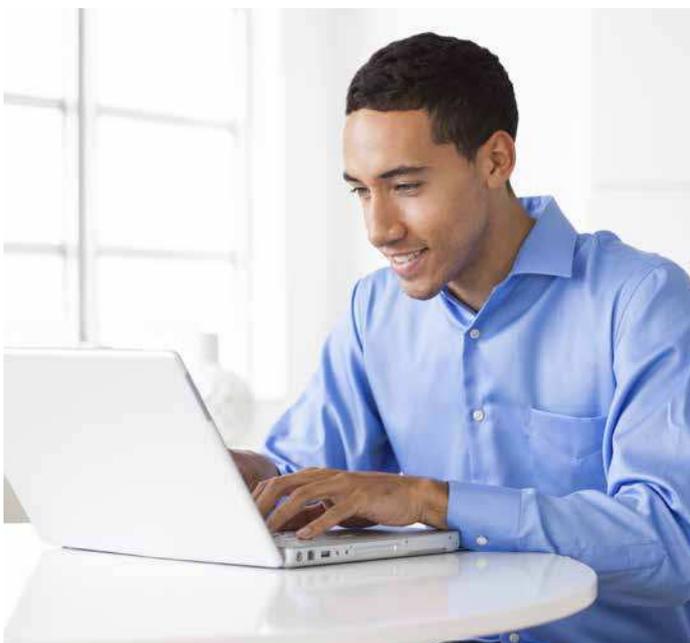
Next, enter the **GEOGRAPHIC LOCATION** you want to search - city, state or ZIP code.

Step 3

If you want to narrow your search, you can also type in **key words**, like dentist name, specialist type or office name. Then, click **"Search."**

Step 4

From the **Search Results** page, you can further refine your results - by distance, specialty, years in practice and additional languages. Click on a dentist's name for more details, including multiple locations listing with map view.



Once you're enrolled, register for myCigna.com to find a dentist, access your claims, compare the cost of procedures and so much more.

It's easy to set up.

Visit **myCigna.com** or download the myCigna Mobile App today:

- › **Select** "Register"
- › **Enter** your name, address and date of birth
- › **Confirm** your identity with your Cigna ID number, Social Security number, or with the myCigna security questionnaire
- › **Create** a user ID and password
- › **Review** then select "Submit"

Already have an ID but haven't visited in a while? That's ok! If you don't remember your ID or password, just click "forgot user ID" or "forgot password" on the registration page, and we'll help you out.



You can also find a dentist 24/7/365 by calling the number on your ID card, or 800.997.1617.

- › Use the Dental Office Locator via Speech Recognition.
- › Speak with a customer service representative, who can send you a customized network directory listing via email.
- › Ask coworkers. Then tell us which office you choose. Each covered family member can select his/her own network general dentist.

Under your plan, you have coverage for **hundreds** of dental procedures. This overview shows you a small sampling of covered services and what you will pay compared to your estimated **cost without coverage**. See savings below. You can find a full list of dental procedures on the Patient Charge Schedule available at Cigna.com/sites/stateoftn.

SAMPLING OF COVERED PROCEDURES	WHAT YOU'LL PAY ⁴		
	COST WITH CIGNA DENTAL CARE		ESTIMATED COST WITHOUT DENTAL COVERAGE
	GENERAL DENTIST	SPECIALIST	
Adult cleaning (two per calendar year, additional cleaning \$45)	\$0	\$0	\$70–\$136 each
Child cleaning (two per calendar year, additional cleaning \$45)	\$0	\$15	\$53–\$102 each
Periodic oral evaluation	\$0	\$0	\$40–\$76
Comprehensive oral evaluation	\$0	\$20	\$62–\$118
Topical fluoride (two per calendar year)	\$0	\$0	\$28–\$53
X-rays – (bitewings) 2 films	\$0	\$0	\$33–\$63
X-rays – panoramic film	\$0	\$20	\$84–\$161
Sealant – per tooth	\$10	\$10	\$42–\$80
Amalgam filling (silver colored) – 2 surfaces	\$8	\$10	\$118–\$226
Composite filling (tooth-colored) – 1 surface, Anterior	\$25	\$25	\$120–\$231
Molar root canal (excluding final restoration)	\$125	\$600	\$852–\$1,640
Periodontal (gum) scaling and root planing – 1 quadrant	\$45	\$60	\$179–\$344
Periodontal (gum) maintenance	\$45	\$45	\$109–\$209
Removal/extraction of erupted tooth	\$15	\$70	\$120–\$231
Removal/extraction of impacted tooth	\$100	\$120	\$370–\$712
Crown – porcelain fused to high noble metal	\$200	\$200	\$849–\$1,634
Occlusal appliance, by report (for treatment of TMJ)	\$330	\$455	\$640–\$1,233

EXCEPTIONS

PROCEDURE	LIMIT
Exams	Two per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Crowns and inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Adjustments	Four within the first 6 months after installation
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months

Referrals are required for specialty care services. Specialty treatment plans require payment authorization for services to be covered under your plan, except for Pediatrics, Orthodontics and Endodontics. You should verify with your Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna before treatment begins. The copays on your PCS also apply to covered network specialist care. If you go to a network specialist, there may be a different copay.

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's usual fees. There is no coverage for:

- › Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- › Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- › To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- › Services for the charges which the person is not legally required to pay
- › Charges which would not have been made if the person had no insurance
- › Due to injuries which are intentionally self-inflicted
- › Services not listed on the PCS
- › Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)⁵
- › Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- › Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- › Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- › Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- › General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- › Prescription medications
- › Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion
- › Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect
- › Surgical implant of any type unless specifically listed on your PCS
- › Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards
- › Procedures or appliances for minor tooth guidance or to control harmful habits
- › Services and supplies received from a hospital
- › The completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage²
- › Consultations and/or evaluations associated with services that are not covered
- › Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- › Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- › Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- › Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- › Services performed by a prosthodontist
- › Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- › Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service
- › Infection control and/or sterilization
- › Services to correct congenital malformations, including the replacement of congenitally missing teeth
- › The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- › Crowns, bridges and/or implant supported prosthesis used solely for splinting
- › Resin bonded retainers and associated pontics

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

This document outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.



HOW TO ENROLL AND HOW TO SELECT A DENTIST

Enroll today

Make sure that you don't miss your opportunity to enroll for this important benefit. All you need to do is:

1. Review your plan materials and consider your family's needs.
2. Contact your agency's benefits coordinator for enrollment instructions.
3. Select a network general dentist for yourself and every member of your family who you are enrolling. Each family member may choose a different network dentist. You may change your network dentist at any time during the plan year. Changes will become effective the first of the following month. If care is needed prior to that 1st of the month after the selection, call 800.997.1617 and a Cigna customer service representative will contact your dental office and ask for an exception and an immediate appointment.

Select a general dentist

1. Complete the Dentist Selection Form below. Be sure to include the seven-digit Dental facility ID# for the Plan general dentist you select. The list of DHMO Plan dentists is available at **Cigna.com/sites/stateoftn** or at **myCigna.com**, via our mobile app, by calling customer service at **800.997.1617** or in the printed directory. To receive the most benefits from the Cigna Dental Prepaid Plan you must select and use a network general dentist.
2. Once completed return the signed form to the following address:

Cigna Dental Prepaid Program
Attn: Celeste Sims
1000 Corporate Centre Drive, #500
Franklin, TN 37067

Dentist Selection Form

State of Tennessee PrePaid Plan - 2017

Please check one box to indicate Active or Retiree

Please print

Name _____
Last First Middle

Employee Edison number _____ Phone number _____

Dentist facility number _____ Date _____

Signature _____

If eligible family members have a different dentist selection from yours, list the information below:

First name	MI	Last name (if different)	Dentist facility ID#



NEED MORE? GET MORE?

Cigna Dental Oral Health Integration Program®

What is the Cigna Dental Oral Health Integration Program?

It's a program that reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. There's no additional cost for the program - if you qualify, you get reimbursed!

Do I qualify?

If you have a Cigna dental plan, you're eligible for the program. It doesn't matter if you have Cigna health insurance or not. The only requirement is that you're currently being treated by a doctor for:

- › Heart disease
- › Stroke
- › Diabetes
- › Head and neck cancer radiation
- › Maternity
- › Chronic kidney disease
- › Organ transplants

How does it work?

When you visit your dentist, you will pay your usual copay. As a reminder, your copay is the fixed amount you pay for covered services. Next, your dentist will send Cigna your information and we will review the claim and refund your copay for eligible services. Once we receive your claim, you can expect to be reimbursed in about 30 days.

Using the program is as easy as 1, 2, 3!

Together, we can make sure proper dental care is given to those who need it most.

- 1** Participants fill out the Registration Form. This is required only one time per qualifying medical condition. The Registration Form is available on **myCigna.com, Cigna.com** or by calling the number on the ID card or policy.
- 2** Participants mail in the completed form to Cigna at the address listed on the Registration Form.
- 3** Program participants simply visit their dentist for the covered service and pay the dentist their usual copay amount for that procedure. We'll send reimbursement in about 30 days.

SPECIAL NOTICE

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call **866.576.0029** or **615.741.4517**.



1. The terms "DHMO" and "Cigna Dental Prepaid Plan" are used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans and plans with open access features. The Cigna Dental Prepaid Plan for the State of Tennessee Group Insurance Plan may not be available in every state. There are no out-of-network benefits, except where required by law.
2. Refer to your plan materials to see if your plan includes orthodontic coverage. The following orthodontic services are generally not covered: orthodontic treatment already in progress; incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment. Coverage for treatment by a pediatric dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services generally must be obtained from a network general dentist.
3. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under you PCS.
4. NetMinder. DHMO data as of March 2016 and is subject to change. The Ignition Group makes no warranty regarding the performance of the data and the results that will be obtained by using. These are examples used for illustrative purposes only. Your actual costs and plan coverage will vary. Plan limitations and exclusions may apply. See your plan materials for details.
5. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50 percent of the value of your network benefit for those services. Of course, you will pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

Oklahoma residents: DHMO for Oklahoma is an Employer Group Prepaid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided to their patient. They are not agents of Cigna. All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care (DHMO) plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (KS & NB), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Policy forms: HP-POL134 (TN), HP-POL115 (OK). The Cigna name, logo and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.

MetLife

2017 Group Dental Member Handbook
For active employees and retirees

BENEFITS



State of Tennessee

PARTNERS
FOR HEALTH

Revised on 11/1/2016

Welcome!

Why is having a good dental plan so important?

Because a healthier smile can be important to maintaining overall health.

Maintaining good oral health matters. Studies show that those with dental coverage are more likely to visit the dentist¹. And of course staying on top of your care is the key to preventing costly problems that can add up. Plus, going to the dentist regularly can help prevent problems that have been linked to diabetes or heart disease². That's where a good dental plan comes in. The right coverage makes it easier to visit the dentist and helps lower your costs. You get support to keep up with dental cleanings and other preventive care that helps you avoid costly problems and live healthier. Now that's something to smile about.

How can having MetLife Dental insurance benefit you?

By making it easier to get the care you need and lowering your out-of-pocket costs.



Freedom of choice to go to any dentist.

MetLife's Preferred Dentist Program is a Dental PPO plan. So you can visit any licensed dentist, in or out of the network, and receive benefits.

- If you prefer to go to a participating dentist, you can count on our large and constantly growing network. Plus, all participating dentists must meet rigorous selection standards³, so you know you are in good hands.
- Find a participating dentist today at www.mybenefits.metlife.com/StateOfTennessee

For better savings, visit a participating general dentist or specialist. Visits are covered with any dentist you choose even if he or she is out of network, but you'll get the most competitive prices with an in-network provider. With MetLife Dental, you have a large network of providers in the State of Tennessee.

Managing your dental benefits is easy!

- MyBenefits, www.mybenefits.metlife.com/StateOfTennessee, is your secure self-service website. It's available 24/7. You can use the site to get estimates on care or to check coverage and claim status.
- **MetLife Mobile App**⁴ - It's easy. Search "MetLife" at iTunes App Store or Google Play to download the app. Then use your MyBenefits log in information to access these features.⁵
- Call 1-855-700-8001, representatives are available 7:00 a.m. - 10:00 p.m. CT, Monday through Friday.

An agency must be participating in the State of Tennessee Sponsored Group Health Plan in order to qualify for participation in the State of Tennessee Voluntary Dental Program. Employee, retiree and/or dependent participation in the State Sponsored Group Health Plan is not required to participate in the State Dental Program. Employee or Retiree participation in the Preferred Dental Program is required for participation of eligible dependents. Participation by those enrolled in the Preferred Dental Program is on a calendar year basis. Enrollment may only be dropped by the Members during the Annual Enrollment Period for the beginning of the next calendar year or due to a special qualifying event.

¹ 2013 US Survey of Dental Care Affordability and Accessibility; Empirica Research; July 2013.

² American Dental Association; Dentists: Doctors of Oral Health. Accessed April 2016, www.ada.org/en/about-the-ada/dentists-doctors-of-oral-health

³ Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's.

⁴ Certain features of the MetLife Mobile App are not available for all MetLife Dental Plans.

⁵ Before using the MetLife Mobile App, you must register at www.mybenefits.metlife.com/StateOfTennessee from a computer. Registration cannot be done from your mobile device.

2017 State of Tennessee Benefit Summary

Coverage Type	In-Network	Out-of-Network
Type A: Diagnostic and Preventative Services <ul style="list-style-type: none"> Periodic Oral Evaluation: Two oral exams in any calendar year¹ Routine Cleaning: 2 cleanings in any calendar year¹ Full-Mouth X-rays: 1 in 60 consecutive months Bitewing X-rays: 1 in 12 consecutive months Sealants to age 16 Space Maintainers to age 15 	100% of MAC*	80% of MAC*
Type B: Basic Services <ul style="list-style-type: none"> Amalgam & Composite Fillings Periodontal Maintenance: 2 treatments In 1 Year, includes 2 cleanings¹ Periodontics: Non-Surgical/Scaling and Root Planing 	80% of MAC*	60% of MAC*
Type C: Major Services <ul style="list-style-type: none"> Inlays/Onlays/Crowns Implant Services Crown Buildups/Post & Core Dentures, complete or partial 6-month waiting period applies to inlay/onlay restorations, dentures, crowns and implants; 12-month wait applies for initial placement of bridge or denture to replace one or more natural teeth. 	50% of MAC*	50% of MAC*
Orthodontic Services <ul style="list-style-type: none"> Only available for dependent children up to age 19 12-month waiting period 	50% of MAC*	50% of MAC*
Deductible: Type B and C Services only <ul style="list-style-type: none"> Individual Family No single family member will be subject to a deductible greater than the "individual" amount.	\$25.00 \$75.00	\$100.00 \$300.00
Annual Maximum Benefit (per person)	\$1,500	\$1,500
Orthodontia Lifetime Maximum (per person)	\$1,250	\$1,250

¹ Additional oral exams, cleanings and periodontal maintenance allowed if medically necessary and the dentist receives prior authorization from MetLife.

* MAC (or Maximum Allowed Charge) is the lowest of (1) the amount charged by the dentist or (2) the maximum amount that in-network dentists have agreed to accept as payment in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

Monthly Premiums

The following monthly premiums are effective **1/1/2017 – 12/31/2017**. Your premium will be paid through convenient payroll deduction.

Active Employee Premiums		Retiree Employee Premiums	
Employee Only	\$22.37	Retiree Only	\$28.88
Employee + Child(ren)	\$51.44	Retiree + Child(ren)	\$66.41
Employee + Spouse	\$42.32	Retiree + Spouse	\$54.64
Employee + Spouse + Child(ren)	\$82.80	Retiree + Spouse + Child(ren)	\$106.91

In Network Savings* Example

You visit your dentist for a crown, which is a major restorative service.

- MAC: \$716.00
Maximum Allowable Charge In-Network
Maximum Considered Fee Out-of-Network
- Dentist's Usual Fee: \$1,022.00

IN-NETWORK		OUT-OF-NETWORK	
When you receive care from a participating dentist:		When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$1022.00	Dentist's Usual Fee is:	\$1022.00
MAC is:	\$716.00	MAC is:	\$716.00
Your Plan Pays 50% of the \$716.00 MAC:	\$358.00	Your Plan Pays 50% of the \$716.00 MAC:	\$358.00
Your Out-of-Pocket Cost is the MAC Fee minus the amount Your Plan Pays (\$716.00 - \$358.00)	\$358.00	Your Out-of-Pocket Cost is the Dentist's Usual Fee minus the amount Your Plan Pays (\$1022.00 - \$358.00)	\$664.00

In this example, you save **\$306.00** (\$664.00 minus \$358.00)... by using a participating dentist.

*Savings from enrolling in the MetLife Dental Preferred Provider Organization Insurance Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered. Please note: This is a hypothetical example that reviews a porcelain/ceramic crown (D2740). It assumes that the annual deductible has been met.

Important answers to some common questions

How are claims processed?

Dentists may submit your claims for you, so you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.mybenefits.metlife.com/StateOfTennessee or request one by calling 1-855-700-8001.

How do I find a participating dentist?

There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can find the names, addresses, languages spoken and telephone numbers of participating dentists in your area by searching our online *Find a Dentist* feature at www.mybenefits.metlife.com/StateOfTennessee.

Can my dentist apply for participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK (1-866-737-6895) for an application. The website and phone number is for use by dental professionals only.

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. You can ask for a **pretreatment estimate**. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. **We recommend that you request a pre-treatment estimate for services in excess of \$300.** Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9 (1-877-638-3379). You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How does MetLife coordinate benefits with other insurance plans?

The coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

What is “balance billing”?

When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

What is an Explanation of Benefits (EOB)?

An EOB statement is a summary of your processed claim(s) or pretreatment estimate(s), including services rendered, costs and benefits paid.

Do I need an ID card?

No. You are not required to show an ID card to your dentist as proof of coverage. MetLife provides all dental offices, in-network and out-of-network, with access to patient eligibility and benefit information. The information is available online and via a dedicated dental office toll-free number. All you need to do is notify your dentist office that MetLife is your dental provider when scheduling an appointment.

Will switching to the MetLife group dental plan from a non state-sponsored dental plan cause issues if I’m in the middle of a treatment plan?

When moving your dental plan from one carrier to another, some of the most common services that may be affected include orthodontics, endodontics and prosthodontic services. MetLife has transition-of-care guidelines for participants whose dental treatment is in progress during the benefit plan transition to MetLife.

MetLife will credit to each participant the annual or lifetime maximum usage, deductibles and other plan limits used under the prior carrier to the MetLife plan. Any remaining benefits will be paid according to the MetLife plan.

For Orthodontia, MetLife will apply payment history and treatment plan information to the participant’s MetLife dental plan, pro-rating the charges prior to the MetLife effective date and issue benefits from the effective date forward, under the MetLife plan.

Endodontic Treatments, Root canal – A tooth opened prior to, but completed **after** the MetLife effective date will be considered an eligible expense under the MetLife dental plan.

Prosthodontic Treatments, Crowns and Bridgework – Treatment (preparation and impressions) started prior to but placed **after** the MetLife effective date will be considered an eligible expense under the MetLife dental plan.

Partial or Full Denture – Final impressions for appliances completed prior to but delivered **after** the MetLife effective date will be considered eligible expenses under the MetLife dental plan, subject to MetLife plan frequency limits.

What is an Alternate Benefit?

If MetLife determines that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, MetLife will pay benefits based upon the less costly service if such service:

1. Would produce a professionally acceptable result under generally accepted dental standards; and
2. Would qualify as a Covered Service.

Can my dependent child continue insurance beyond age 26?

You may continue coverage for a child who is over age 26 if they are incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Benefits Administration prior to the child’s 26th birthday. Annual proof may also be required.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services performed primarily for cosmetic reasons.
- Replacement of a lost or stolen appliance.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Treatment to restore tooth structure lost from wear.
- Services by a dentist beyond the scope of his or her license.
- Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
- Dental services for which the patient incurs no charge.
- Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
- Services that are deemed to be medical services.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
- Athletic mouth guards.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact your MetLife group representative or your plan administrator for costs and complete details.

Special Notice

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.



State of Tennessee Basic Plan (Effective 1/1/2015)

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam With Dilation as Necessary	\$0 Copay	Up to \$30
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to 85% of Charge	N/A
Premium Contact Lens Fit & Follow-Up	Up to 85% of Charge	N/A
Frames ∞	80% of balance over \$50	Up to \$50 on Frame and Lens
Standard Plastic Lenses		
Single Vision	80% of balance over \$50	
Bifocal	80% of balance over \$50	
Trifocal	80% of balance over \$50	
Lenticular	80% of balance over \$50	
Standard Progressive Lens	80% of balance over \$50	
Premium Progressive Lens	80% of balance over \$50	
Lens Options (paid by the member in addition to the price of the lens)		
UV Treatment	80% of Charge	
Tint (Solid and Gradient)	80% of Charge	N/A
Standard Plastic Scratch Coating	80% of Charge	N/A
Standard Polycarbonate—Adults	80% of Charge	N/A
Standard Polycarbonate—Kids under 19	80% of Charge	N/A
Standard Anti-Reflective Coating	80% of Charge	N/A
Polarized	80% of Charge	N/A
Other Add-Ons and Services	80% of Charge	N/A
Contact Lenses (Contact lens allowance includes materials only) ∞		
Conventional	85% of balance over \$50	Up to \$25
Disposable	Balance over \$50	Up to \$25
Medically Necessary*	Balance over \$150	Up to \$75
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	85% of retail price; 95% of promotional price	N/A
Additional Pairs Discount		
	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency - In & Out-of-Network		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every two calendar years	
Monthly Premium - In & Out-of-Network		
Employee	\$3.35	
Employee + Children	\$6.69	
Employee + Spouse	\$6.35	
Employee + Family	\$9.83	



- You're on the SELECT Network**

**If you are not enrolled and want more information, plus a complete list of providers near you, go to the State of TN website: www.eyemedvisioncare.com/stoftnoe.

If you are currently enrolled, you may visit www.eyemedvisioncare.com/stoftn to register for full access to benefits, providers, claims and ID cards. You can also call 1-855-779-5046.

- For LASIK providers, call 1.877.5LASER6.
- Visit our mobile optimized site or download the new EyeMed iPhone app to view your ID card, see coverage details and find a provider near you.
- Order replacement contact lenses by mail at: www.eyemedcontacts.com†

* If medically necessary as first contact lenses following cataract surgery, or multiple pairs of rigid contact lenses for treatment of keratoconus. General Limitations and Exclusions: Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law. Cosmetic Surgery or procedures for purely cosmetic reasons. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the vision for treatment in any such facility. Services by a vision provider beyond the scope of his or her license. Vision services for which the patient incurs no charge. Vision services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9133TN. This is a snapshot of your benefits. †Plan allowance and discounts do not apply to this service.

∞ Benefit allowances provide no remaining balance for future use within the same benefit frequency.

Get the answers you need

From time to time, you'll have questions about using your EyeMed benefit. So we'll always make it simple to get answers! These frequently asked questions are the perfect place to start. How easy is that?



How can I find a network provider?

Using the benefit at a network provider is easy. Simply visit eyemedvisioncare.com/stoftnoe and search providers near you by entering your zip code or call 1.855.779.5046.



How will my provider verify that I am a member?

An ID card is not required to receive benefits at the provider's office. The provider will search for your eligibility and benefits by your name and then verify your address, date of birth and your subscriber's employer.



How often can I get an eye exam?

You're eligible for an eye exam once every calendar year. You can get standard plastic/glass lenses or contacts once every calendar year and frames once every two calendar years.



Do I need to file a claim?

No, you will not file claims if you use an in-network provider. However, if you do not use a network provider you will need to file an out-of-network claim form. This form, is available at www.eyemedvisioncare.com/stoftn under common questions.



How does the frame allowance work?

If you choose the Basic plan and use a network provider, you will not have to pay anything for your frames if they cost \$50 or less. If the frames are over \$50, you will get a 20% discount on the balance of the monies you owe.



Who do I contact with questions about my claim and how it was paid?

You can contact the EyeMed Customer Care Center at 855-779-5046 with any questions pertaining to your claim. They are available Monday-Saturday from 6:30am to 10:00pm CT and Sunday 10:00am to 7:00pm CT.



How will my provider know if I have used all of my benefits?

An in-network provider will locate your record within the EyeMed system and verify that benefits are available prior to your appointment.



SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam With Dilation as Necessary	\$10 Copay	Up to \$45
Retinal Imaging	Up to \$39	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to \$60	N/A
Premium Contact Lens Fit & Follow-Up	Up to \$60	N/A
Frames ∞	80% of balance over \$115	Up to \$70
Standard Plastic Lenses		
Single Vision	\$15 Copay	Up to \$30
Bifocal	\$15 Copay	Up to \$50
Trifocal	\$15 Copay	Up to \$65
Lenticular	\$15 Copay	Up to \$65
Standard Progressive Lens	\$55 Copay	Up to \$50
Premium Progressive Lens ^Δ	\$75 - \$100	Up to \$50
Tier 1	\$75	Up to \$50
Tier 2	\$85	Up to \$50
Tier 3	\$100	Up to \$50
Tier 4	\$55, 80% of charge less \$120 Allowance	Up to \$50
Lens Options (paid by the member in addition to the price of the lens)		
UV Treatment	\$10 Copay	Up to \$5
Tint (Solid and Gradient)	\$25	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate-Adults	\$30 Copay	Up to \$5
Standard Polycarbonate-Kids under 19	\$0 Copay	Up to \$5
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating ^Δ	\$57 - \$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$70	Up to \$5
Polarized	80% of Charge	N/A
Other Add-Ons and Services	80% of Charge	N/A
Contact Lenses (Contact lens allowance includes materials only.) ∞		
Conventional	85% of balance over \$130	Up to \$50
Disposable	Balance over \$130	Up to \$50
Medically Necessary*	\$0 Copay	Up to \$100
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	85% of retail price; 95% of promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency - In & Out-of-Network		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every two calendar years	
Monthly Premium - In & Out-of-Network		
Employee	\$5.86	
Employee + Children	\$11.72	
Employee + Spouse	\$11.14	
Employee + Family	\$17.23	



- You're on the SELECT Network**

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* If medically necessary as first contact lenses following cataract surgery, or multiple pairs of rigid contact lenses for treatment of keratoconus. General Limitations and Exclusions: Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law. Cosmetic Surgery or procedures for purely cosmetic reasons. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the vision for treatment in any such facility. Services by a vision provider beyond the scope of his or her license. Vision services for which the patient incurs no charge. Vision services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9133TN. This is a snapshot of your benefits.

†Plan allowance and discounts do not apply to this service.

∞ Benefit allowances provide no remaining balance for future use within the same benefit frequency.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and save you money. Welcome to EyeMed.



Benefits Snapshot	With Us (In Network)	Out-of-Network Reimbursement
Exam with dilation as necessary (every calendar year)	\$10 copay	Up to \$45
Frames (every 2 calendar years)	80% of balance over \$115	Up to \$70
Single Vision, Bifocal & Trifocal lenses (every calendar year) or Contacts (every calendar year)	\$15 copay Balance over \$130	Up to \$30 Up to \$50

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

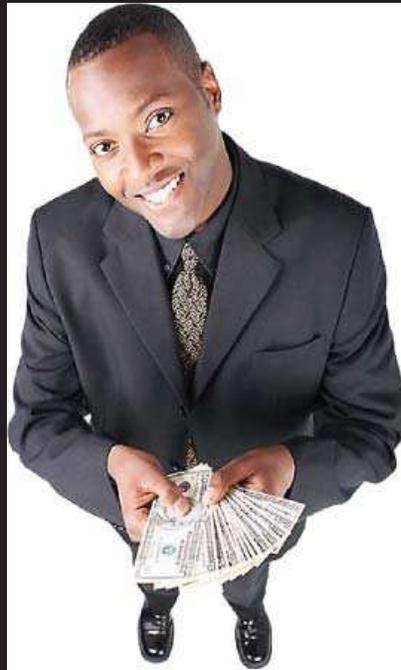
**75%
SAVINGS
with us**

With Us (In Network)		Without Insurance*	
Exam	\$10 copay	Exam	\$106
Frame	\$163 <u>-\$115 allowance</u> \$48 <u>-\$9.60 (20% discount off balance)</u> \$38.40	Frame	\$163
Lens	\$15 copay \$10 UV treatment add-on <u>+\$15 scratch coating add-on</u> \$50	Lens	\$78 \$23 UV treatment add-on <u>+\$25 scratch coating add-on</u> \$126
Total	\$98.40	Total	\$395



FLEXIBLE BENEFITS PLAN

*Medical, Dependent Care,
Transportation and Parking Reimbursement*



It's your money ... plan to keep it!

Enrollment Deadline:

Current Employees - Annual Enrollment/Transfer Period

New Employees - 30 Days from Hire Date

**David H. Lillard, Jr., State Treasurer
Jill Bachus, Director of TCRS**

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Introduction to the Flexible Benefits Plan

The State of Tennessee Flexible Benefits Plan is a program designed to help employees pay less in federal taxes. Authorized under Sections 125 and 132 of the Internal Revenue Code, this program allows you to pay certain specific expenses from your pre-tax rather than after-tax income.

All state employees who receive a regular paycheck are eligible to participate. Any premiums you pay for state group medical or dental insurance will automatically be paid with tax-free salary through the Flexible Benefits Plan and require no action by plan participants.

Use of the plan to pay other eligible expenses is not automatic. In order to pay medical, dependent care, transportation or parking expenses through the Flexible Benefits Plan, you must enroll using Edison. Enrollment from previous years does not continue automatically for medical and dependent care accounts.

Which Expenses are Eligible to be Paid with Tax-Free Salary?

Medical Expenses - You may set up a reimbursement account to pay many of your family's medical expenses that are not already covered by insurance, such as the insurance plan deductible or co-payment amounts, contact lenses or glasses, certain non-cosmetic dental procedures, prescription drugs or their co-payment amount, hearing aids and other qualified expenses.

Dependent Care Expenses - You may set up a reimbursement account to pay qualified child or other dependent care expenses (as defined by the IRS).

Transportation and Parking Expenses - You may set up a reimbursement account to pay for transportation to and from work as well as parking expenses.



How Can the Flexible Benefits Plan Help Me?

Reimbursement requests will be fulfilled within 10 business days, provided the funds are available in the account(s). The reimbursement period may vary depending upon volume.

Flexible Benefits puts more money in your pocket. Unlike other salary reduction plans, such as deferred compensation, the Flexible Benefits Plan frees income and Social Security taxes on these amounts forever rather than just delaying the tax liability.

The following chart illustrates how the program could work to increase your spendable income by saving taxes.

	Without Flexible Benefits	With Flexible Benefits
Monthly Salary	\$2,500.00	\$2,500.00
Insurance	- 150.00	- 150.00
Flexible Benefits Deposit		- 240.00
Taxable Income	\$2,350.00	\$2,110.00
Withholding	- 223.00	- 188.00
Social Security	- 180.00	- 161.00
Medical/Care Expenses	- 240.00	
Remainder to Live On	\$1,707.00	\$1,761.00

Monthly Savings \$54.00
Annual Savings \$648.00

In this example, the savings is like a 3% pay raise!
(Most of us would have to receive an \$80 raise to take home \$54 more.)

How Does It Work?

Each pay period, all eligible tax-free deductions are taken out of your paycheck before federal and Social Security taxes are calculated. After all tax-free deductions have been made, federal income taxes and Social Security taxes are calculated on the reduced amount and the amount paid to you through the reimbursement accounts will not be subject to federal income taxes or Social Security taxes.

Any other taxable payroll deduction amounts are then taken out of your paycheck. The amount remaining in your paycheck is your take-home pay for this period. Since you have paid less in taxes, you will have more money to spend on other things.

What is the Significance of the Plan Year?

The plan year is significant in three ways.

1. Your enrollment cannot be changed during the plan year unless you have a change in family status and you report the change to the plan within 60 days of the event.
2. You must re-enroll in Medical and Dependent Care Accounts each year to continue participation.
3. Only expenses for services incurred during the plan year and your period of coverage may be reimbursed.

The plan year is a calendar year — January 1 through December 31. For those employees hired after the plan year has already begun, the plan begins with the first contribution and ends December 31.

How Can I Enroll?

Worksheets for dependent care and medical expenses are included in Appendix A. The worksheets help you to:

1. Estimate your annual medical and care expenses separately.
2. Use the information from your worksheet to complete enrollment.

You may enroll using the Edison self-service function during the Annual Enrollment and Transfer Period. If you enroll in a reimbursement account, Edison will generate a confirmation statement and send it to you when your election has been processed provided your email address is in Edison.

The Flexible Benefits staff is available for questions Monday through Friday, 8 a.m. to 4:30 p.m. CT, at 1-877-681-0155. Questions may also be directed to Flexible.Benefits@tn.gov.

What if I was Hired After the Annual Enrollment?

If you start to work after the enrollment period, you will have 30 days from your employment date to sign up for Medical and Dependent Care Flexible Benefits Accounts. You may enroll by going to Edison Self-Service, select Benefits, then select Benefit Enrollment. Your period of coverage will begin on the first day of the month after your first deduction occurs.

Can I Change My Enrollment?

Since the funds involved in the Flexible Benefits Plan are tax-free, there are significant IRS requirements that the program and participants must meet:

- ✓ You must file your enrollment decisions before the plan year begins. **Decisions are irrevocable. Once the plan year starts, your contributions cannot be cancelled or changed until the next plan year unless you meet specific requirements.**
- ✓ You may not terminate your contributions or change the amount of your contributions unless you have a significant change in your family status which corresponds with the change you make. See the "Other Information" section for further explanation of family status change.
- ✓ If you have not been reimbursed for your full account balance by March 31 of the following calendar year, you will forfeit all remaining funds. This is known as the "use it or lose it" rule.



Tips to Prevent Forfeiture If You Over-Estimate:

By March 15 of the following year (for you and your family),

- Get eye exams
- Buy a pair of glasses
- Stock up on contacts
- Get your teeth cleaned
- Get physicals
- Fill prescriptions early

Other Tips about Flexible Benefit Accounts:

All expenses claimed must be incurred during your period of coverage. It is not when you pay an expense, but when you incur it that makes it eligible for reimbursement. An expense is "incurred" when you are actually provided with the service that gives you the expense, not when you are formally charged for, billed for or when you pay for the service.

You will receive payment for the amount of your approved expense(s) within 10 business days, provided the funds are available in your reimbursement account. The reimbursement period may vary depending upon volume. The expense must be eligible and the request must be properly filled out and completed. In the event of a disaster that would disable normal processing, the reimbursement period will be placed on hold until normal activities resume.

If your paycheck is deposited directly into your bank account, your reimbursement payments will also be deposited directly to your bank account. If you are not enrolled in the state's direct deposit program, your reimbursement payments will be mailed to you.



Medical Expense Reimbursement Account

The Medical Expense Reimbursement Account is one of the tax-saving options available to state employees through the Flexible Benefits Plan. If you want to enroll in the tax-free reimbursement account for medical expenses, you may enroll using the Edison self-service function during the annual enrollment and transfer period. The Medical Expense Reimbursement Account is generally beneficial to anyone who has predictable out-of-pocket medical expenses for themselves or their dependents.

How It Works

- Use the medical expenses worksheet provided in Appendix A to estimate your out-of-pocket medical expenses for the upcoming plan year. Using these calculations, decide how much to contribute to your account. Be certain the amount is realistic.
- When you incur medical expenses, submit them to your insurance provider or pay for them yourself if they are not covered by insurance. Be sure to save the Explanation of Benefits you receive from your insurance provider and/or the receipts for out-of-pocket medical expenses you incur.
- Submit Reimbursement Request forms to the Flexible Benefits office along with either your Explanation of Benefits (if covered by insurance) or your receipts. The request form and receipts may be faxed to 615-401-6815 or emailed to Flexible.Benefits@tn.gov.
- You will then receive payment for the amount of your approved claimed expense, up to the amount you will contribute to your account during the year.

Contribution Limits

There is no annual minimum contribution. The maximum amount you may contribute to the Medical Reimbursement Account is \$2,500 per year.



Itemizing vs. Reimbursement Account

If you itemize deductions, the IRS allows you to deduct only the amount of eligible medical expenses that exceeds 7.5 percent of your adjusted gross income. The Medical Expense Reimbursement Account allows tax-free reimbursement of 100 percent of eligible medical expenses. Remember that itemizing may only be used for eligible expenses that were paid for during the year, while the Medical Expense Reimbursement Account may only be used for eligible expenses that were incurred during the year.

Filing Claims and Getting Reimbursed

When filing a reimbursement request, please include any applicable receipts. If the expense would normally be covered by insurance, please include a copy of your Explanation of Benefits from your insurance provider. For expenses not covered by insurance, please include copies of the itemized statement or receipt from your service provider. Receipts must include the date of service, name of provider, description of service and amount of charge. Keep the original for your records since request forms and receipts will not be returned. Canceled checks, credit card statements and bank statements are not acceptable as a receipt of the service incurred.

Your maximum amount of reimbursement under the Medical Expense Reimbursement Account is available at all times during your period of coverage, less any prior reimbursement made during that period.

You will have until March 31 of the following year to submit claims for expenses incurred before the end of the current plan year and during your period of coverage.

Eligible Expenses

As a general rule, any categories of expenses that could be deducted on an IRS Form 1040 for medical expenses, except insurance premiums (including long-term care insurance), can be paid for with pre-tax dollars through the Medical Expense Reimbursement Account.

The Medical Expense Reimbursement Account allows you to use tax-free money to pay for medical expenses incurred by you and your family. While everyone has medical expenses, the attractiveness of the reimbursement account depends upon the amount you and your dependents pay out-of-pocket each year.

You may use the account to pay your co-payments and deductible amounts on dental and vision care not covered by insurance, prescription drugs and many other expenses.

For examples of eligible and ineligible expenses, please refer to the Flexible Benefits website at <http://treasury.tn.gov/flex/index.html>.



Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account is another tax-saving options available to state employees through the Flexible Benefits Plan.

Dependent care expenses make up a significant part of many family budgets. The tax-free Dependent Care Reimbursement Account lets you use tax-free dollars to pay for such care if it is necessary to allow you to work and, if you are married, to allow your spouse to work or attend school full-time.



How It Works

- Use the dependent daycare expenses worksheet provided in Appendix A to estimate your out-of-pocket dependent care expenses for the upcoming plan year. Using these calculations, decide how much to contribute to your account.
- When you have incurred dependent care expenses, submit a Reimbursement Request form with a receipt from the care provider. The request form and receipts may be faxed to 615-401-6815 or emailed to Flexible.Benefits@tn.gov.
- You will then receive payment for the amount of your approved claimed expense, provided the funds are available in your account.

Contribution Limits

Depending upon your circumstances, you can contribute up to \$5,000 a year into your Dependent Daycare Reimbursement Account. If you file your income taxes as "head of household," "single" or "married, filing jointly," you may contribute the full \$5,000 a year into your account. If you are married but file a separate federal income tax return, you may deposit a maximum of \$2,500 to your Dependent Daycare Reimbursement Account.

Child Care Tax Credit vs. Reimbursement Account

The child care tax credit will vary depending on your income. For some people, the child care tax credit may offer more tax savings than a Dependent Care Reimbursement Account. As a result, you should carefully review which program is most advantageous to your situation.

You may not use the same expenses for both the tax credit and your Dependent Care Account.

Any amounts contributed to your account will reduce on a dollar-for-dollar basis the annual dollar limit allowed by the IRS in determining expenses eligible for the tax credit. If you place that much money or more in your reimbursement account, the tax credit is unavailable to you.

For more information on the tax credit, call the IRS at 1-800-829-3676 to request Publication 503—Child and Dependent Care Expenses or download the publication from www.irs.ustreas.gov.

Filing Claims and Getting Reimbursed

Once you have incurred eligible expenses, simply submit your receipts from your care provider along with a completed Reimbursement Request form. Receipts must include the date of service, name and address of provider, provider's tax identification number and amount of charge. Canceled checks, credit card statements and bank statements are not acceptable as a receipt of the service incurred.

You will have until March 31 of the following year to submit claims for expenses incurred before the end of the current plan year.

Eligible Expenses

In order to qualify as eligible expenses, the amounts you spend on dependent care must meet the following IRS rules:

- ✓ You may be reimbursed for charges for care services either inside or outside your home for eligible dependents under the age of 13. Services must be for the physical care of the child and must not be provided by a spouse or dependent.
- ✓ You may be reimbursed for charges for the care of a dependent adult or child who is mentally or physically incapable of self-care. To be eligible, services may not be provided by a spouse or dependent and the eligible dependent must regularly spend at least eight hours per day in your household.
- ✓ You may not use the Dependent Care Reimbursement Account to pay for a dependent's healthcare expenses. The account may not be used by a non-custodial parent to pay for child care or child support payments.
- ✓ If you use the Dependent Care Reimbursement Account to pay for care or claim the Child or Dependent Care Tax Credit, you will need to file Form 2441 with your 1040 tax return (or Schedule 2 with your 1040A tax return) to report the name of your care provider to the IRS.



Transportation & Parking Reimbursement Account

The Transportation and Parking Reimbursement Accounts are another tax-saving option available to state employees through the Flexible Benefits Plan.

The tax-free Transportation and Parking Reimbursement Accounts let you use tax-free dollars to pay for your transportation to and from work as well as and work-related parking costs.

How It Works

Unlike Medical and Dependent Care Flexible Benefits Accounts, there is no requirement for new employees to enroll within 30 days of being hired and there is no annual enrollment period for employees. An employee may enroll in a Transportation Account and/or a Parking Account at any time during employment. Employees may enroll by completing a Transportation and Parking Enrollment form. Those forms are available through the agency's Human Resource section or on the Flexible Benefits website.

Contribution Limits

The contribution limits for Transportation and Parking accounts are set by the IRS and typically change each calendar year. Please refer to the Flexible Benefits website at <http://treasury.tn.gov/flex/index.html> for more information.

Filing Claims and Getting Reimbursed

When you have incurred transportation or parking expenses, submit a Transportation and Parking Reimbursement Request Form with a receipt from the service provider that includes the date of service, the name of the provider and the amount charged. Canceled checks, credit card statements and bank statements are not acceptable as a receipt of the service incurred.

Employees who have an available account balance in a Transportation or Parking Flexible Benefits Account as of December 31 will have until June 30th of the following year to claim the remaining funds. However, the expenses must have been incurred within the year just ending. Previous year fund balances unclaimed by June 30th will be rolled to an active current year account of the same type. There is no annual "use it or lose it" rule.



Other Information

Family Status Change

The IRS and your plan specifically define “Family Status Change” as:

- Your marriage, divorce or legal separation;
- Death of a spouse or dependent;
- Birth or adoption of a dependent;
- Termination or commencement of participant's or spouse's employment (termination of a participant's employment occurs after the last working day);
- You or your spouse taking an unpaid leave of absence lasting more than 30 calendar days;
- You or your spouse switching from part-time to full-time employment or from full-time to part-time employment;
- You or your spouse having a significant change in health coverage due to your spouse's employment;
- Ineligibility of a dependent; or
- Bankruptcy court order.



Certain additional status changes such as changes in your residence or work site may qualify you to change your insurance elections.

Should you need to change your deductions because of a family status change, you must complete a Family Status Change form and submit it to the Benefits Administration within 60 days of the qualifying event.

Forms may be obtained from your personnel officer, the Internet at www.tn.gov/flex or from the Flexible Benefits office. Documentation of the change will be required. Any change you request must be consistent with the type of family status change you experience.

If the Family Status Change form is submitted within the 60-day time limit and approved, it will be effective for the remainder of the calendar year. Changes cannot be retroactive (contributions already made to the plan cannot be refunded) except in the event of a death or medical insurance premiums were deducted from your salary while you were receiving temporary disability benefits through workers' compensation (lost time pay).

In order for a change to begin in the paycheck you receive at the end of a month, Benefits Administration must receive your completed form by the 15th of that month and the change must then be approved. If you miss the monthly cutoff date, your change can still begin the next month as long as it complies with the 60-day requirement and is approved.

If you do not submit the change form within 60 days, you will not be allowed to change your elections, which may result in a forfeiture of your insurance premiums or reimbursement of account contributions for the remainder of the year. Everyone will have an opportunity to make new elections for the new plan year.

Does this Hurt My Other Benefits?

- Social Security - Slight impact if below the Social Security wage base
- Deferred Compensation - No Impact
- Retirement - No Impact
- Insurance, Leave or Other Benefits - No Impact

What about Termination or Change in Employment?

- ✓ You may want to accelerate your expenses to use up your account balance before termination. Once you are terminated, no expenses incurred after your last paid date can be reimbursed.
- ✓ Flexible Benefits participation continues for job transfers within state government.
- ✓ Breaks and leaves of absence can cause you to be treated as a terminated employee.
- ✓ Check with your personnel officer for details.

Before You Decide to Enroll:

- ✓ With Medical and Dependent Care Accounts, you must "use it or lose it", but most employees find that they can make optional expenditures such as glasses, contacts, routine dental visits or physical examinations before March 15 of the following year to avoid loss.
- ✓ You cannot withdraw the funds for other purposes and cannot change the annual election without a change in family status.
- ✓ To claim your money, you may submit a claim form and receipts as often as you like, but all claims must be filed by March 31 for the prior calendar year.

Quick Overview of the Flexible Benefits Plan

What is a Flexible Benefits Plan?

It is an employee benefit which will allow you to save taxes by paying certain expenses from your pre-tax income rather than from after-tax income.

What types of expenses are eligible for the Plan?

- Medical
- Dependent Care
- Transportation
- Parking

Who may participate in the Plan?

All state employees who receive a regular paycheck are eligible.

How do I find out more about Flex?

To learn more about Flexible Benefits, visit our website at the address listed below. You may also call Flexible Benefits or your personnel officer.

How do I sign up for Flex?

- New employees have 30 days to enroll.
- Current employees have an annual enrollment period each fall to enroll or change their Medical or Dependent Daycare Accounts. Transportation and Parking accounts can be enrolled in or changed at any time.
- Sign up during annual enrollment using the Edison self-service function.
- Find the enrollment form on our Internet site or contact your personnel officer.

State of Tennessee
Treasury Department
Phone: 1-877-681-0155
Fax: 615-401-6815
www.tn.gov/flex
Flexible.Benefits@tn.gov

APPENDIX A

MEDICAL EXPENSE WORKSHEET

DEPENDENT CARE EXPENSE WORKSHEET

Medical Expense Worksheet

Estimate your annual out-of-pocket medical expenses for the coming plan year on the following worksheet. Be sure to include all members of your immediate family. Remember to estimate conservatively and consider only those expenses you are sure you will incur. Remember, insurance premiums may not be paid through a reimbursement account.

	<u>Last Year's Expenses</u>	<u>This Year's Projected Expenses</u>
1. Medical Expenses:		
Insurance Deductibles	_____	_____
Insurance Co-Payments	_____	_____
Dental Co-Payments orthodontia	_____	_____
Immunizations, Injections and Vaccinations	_____	_____
Routine Examinations and Physicals	_____	_____
Dental Expenses (including crowns, root canals, extractions and non-cosmetic repairs)	_____	_____
Prescription Drugs or Co-Payment Amount	_____	_____
Eyeglasses and Contacts	_____	_____
Hearing Examinations	_____	_____
Transportation to and from Medical Provider	_____	_____
Medically Necessary Nursing Home Care	_____	_____
Non-Cosmetic Surgery (LASIK, etc.)	_____	_____
Other Expenses	_____	_____
2. Total Expenses for the Year:	_____	_____
3. Divide Estimated Total by Your Number of Regular Pay Periods.	_____	_____
4. Enter this amount on your Election Form. This is the amount that will be taken out of each regular paycheck and put into your Medical Expense Reimbursement Account.	_____	_____

Dependent Care Expense Worksheet

Estimate your annual dependent care expenses for the coming plan year on the following worksheet. Remember to estimate conservatively and consider only those weeks when you will have dependent care expenses. For example, if you have a child who will be attending school, your care expenses should be lower while your child is in school. Also, a child must be less than age 13 to take advantage of the Flexible Benefits savings.

	<u>Last Year's Expenses</u>	<u>This Year's Projected Expenses</u>
1. Dependent Care Expenses:		
Infant / Toddler	_____	_____
Preschool	_____	_____
Before-School or After-School Care	_____	_____
Reporting Days (child in school only half a day)	_____	_____
In-Service Days (child not in school)	_____	_____
School Holidays	_____	_____
School Vacations	_____	_____
Sports Camps/Day Camps (excludes overnight camps)	_____	_____
Other Dependent Care	_____	_____
2. Total Dependent Care Expenses for the Year:	_____	_____
3. Divide Estimated Total by Your Number of Regular Pay Periods.	_____	_____
4. Enter this amount on your Election Form. This is the amount that will be taken out of each regular paycheck and put into your Dependent Care Reimbursement Account.	_____	_____

Maximums:

- Married Filing Separately – \$2,500
- Married Filing Jointly – \$5,000
- Single or Head of Household – \$5,000



FLEXIBLE BENEFITS PLAN ENROLLMENT — PLAN YEAR 2016

State of Tennessee • Department of Finance and Administration • Benefits Administration

19th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account

EMPLOYEE INFORMATION					
Last Name		First Name		Middle Initial	Social Security Number
Home Address			City	State	ZIP Code
Department Name			Dept ID / Budget Code	Date Hired	Employee ID (if known)
Work Phone		Payroll Frequency (paychecks per year)		Enrollment Status	
		<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Other _____		<input type="checkbox"/> New Hire	

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your personnel office for additional information or you may call Benefits Administration at 615.741.3590 or 1.800.253.9981.

If you are enrolled in either HealthSavings CDHP, you are not eligible to contribute to the Medical Expense Account; however, you may contribute to the Limited Purpose Account.

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.

Medical Expense Account		Limited Purpose Account		Dependent Care Account	
Maximum allowable annual contribution is \$2,550		Maximum allowable annual contribution is \$2,550		Tax Filing Status (please check one) <input type="checkbox"/> Married, filing separately (maximum \$2,500) <input type="checkbox"/> Married, filing jointly (maximum \$5,000) <input type="checkbox"/> Head of household (maximum \$5,000)	
Box #1 Reduction per regular paycheck	<input type="text"/>	Box #1 Reduction per regular paycheck	<input type="text"/>	Box #1 Reduction per regular paycheck	<input type="text"/>
Box #2 Number of regular paychecks expected	X <input type="text"/>	Box #2 Number of regular paychecks expected	X <input type="text"/>	Box #2 Number of regular paychecks expected	X <input type="text"/>
Box #3 Total plan year dollar amount	= \$0.00	Box #3 Total plan year dollar amount	= \$0.00	Box #3 Total plan year dollar amount	= \$0.00

AUTHORIZATION

- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved family status change.
- I understand that any amount remaining in any reimbursement account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

Employee Signature	Date Signed
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Return this application to your human resource office after making a copy for your records.
 For questions regarding enrollment or a family status change, please call Benefits Administration at 615.741.3590 or 1.800.253.9981.
 For questions regarding reimbursement requests, please call the Department of Treasury at 615.532.3170 or 1.877.681.0155.



FLEXIBLE BENEFITS PLAN ENROLLMENT — TRANSPORTATION AND PARKING

State of Tennessee • Department of Finance and Administration • Benefits Administration
19th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

Complete this form only if you wish to participate in the transportation or parking flex accounts.

EMPLOYEE INFORMATION			
Last Name	First Name	Middle Initial	Social Security Number
Home Address		City	State
Department Name		Dept ID / Budget Code	Employee ID (if known)
Work Phone	Payroll Frequency (paychecks per year) <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Other _____	Enrollment Status <input type="checkbox"/> Enroll <input type="checkbox"/> Change Deduction <input type="checkbox"/> Stop Account	

REIMBURSEMENT ACCOUNT ENROLLMENT

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your personnel office for additional literature or you may call 615.741.3131.

Transportation Reimbursement Account	Parking Reimbursement Account
Maximum allowable contribution is \$130 per month	Maximum allowable contribution is \$255 per month
Monthly Payroll Deduction: If you are paid semi-monthly, this amount will be divided between your paychecks.	Monthly Payroll Deduction: If you are paid semi-monthly, this amount will be divided between your paychecks.
\$ _____	\$ _____

AUTHORIZATION

- Transportation and Parking Accounts do not have an annual enrollment period. I understand the amount selected will remain in effect until I either change the elected amount or notify Benefits Administration to terminate my account.
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file a change in deduction.
- I understand that on June 30, any remaining balance from the previous year will automatically roll into an active account of the same type. If there is not a current account, remaining balances from the previous year will be forfeited.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment application.

Employee Signature	Date Signed
--------------------	-------------

Return this application to your human resource office after making a copy for your records.
For questions regarding enrollment, please call Benefits Administration at 615.741.3590 or 1.800.253.9981.
For questions regarding reimbursement requests, please call the Department of Treasury at 615.532.3170 or 1.877.681.0155.

CONTACT INFORMATION

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 — M-F, 8-4:30	tn.gov/finance partnersforhealthtn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness and Nurse Advice Line	Healthways	888.741.3390 — M-F, 8-8	partnersforhealthtn.gov (wellness tab)
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	mybenefits.metlife.com/ StateOfTennessee
Vision Insurance	EyeMed Vision Care	855.779.5046 — M-Sat, 7:30-10 Sun, 10-7	eyemedvisioncare.com/stoftn
Life Insurance	Securian (Minnesota Life)	866.881.0631 — M-F, 7-6	lifebenefits.com/stateoftn
Long-term Care Insurance	MedAmerica	866.615.5824 — M-F, 8:30-6	ltc-tn.com
Disability — Short- and Long-term	to be determined	to be determined	partnersforhealthtn.gov
Flexible Benefits medical & dependent care parking & transportation (state employees only)	Payflex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
	Benefits Administration	800.253.9981 — M-F, 8-4:30	tn.gov/finance