Plan Design

1. **Why are you making such big changes?**

   The cost of our medical plans is now higher than the total premiums we have coming in, and given the State's unprecedented budget crisis, this situation is not sustainable.

   Broadly speaking, we have two options to contain costs and preserve benefits:

   1. Reduce our need for (and use of) health care by:
   - a. Helping our members get or stay healthy
   - b. Reducing unnecessary use of health care services
   - c. Providing more efficient delivery of care

   2. Make members pay more by:
   - a. Shifting a greater proportion of health care costs to plan members
   - b. Reducing the scope of covered benefits
   - c. Reducing the extent of network coverage

   We think that the **first option** is better for all of us, which is why we designed the Partnership PPO. We are continuing to work hard to minimize the cost shifting and to avoid future reduction in benefits and choice.

2. **Do we have any other alternatives?**

   Unfortunately, no. We implemented the following changes over the past year to control costs until the economy recovered and the State could better afford premium increases:

   - New pharmacy co-pays
   - Reduced co-pays for diabetic drugs and supplies to encourage appropriate use by members with diabetes
   - Elimination of brand-name proton pump inhibitor (PPI) drugs
   - Dependent eligibility verification
   - New pharmacy benefits manager (PBM) contract
   - Regional (as compared to statewide) contracting strategy for claims administrators

   Each of these changes are proven to save costs and did help us to some extent. However, given the severity of the economic downturn and our aging member population, these efforts were simply not sufficient to offset the overall growth in medical costs

3. **Who has been involved in planning the redesign?**

   The Insurance Committees are responsible by law for any changes to benefits. The division of Benefits Administration supports the work of the Committees on a day-to-day basis. Together, these groups have worked hard to develop a new plan design that preserves comprehensive, affordable and dependable coverage for plan members.

   Throughout this process, we consulted and continue to work with many outside partners to get feedback on the redesign. These partners include TSEA, TEA, representatives from local government and other stakeholders as appropriate.

   Based on this feedback and the budget dollars available, the Committees made several key decisions:
   - Members will still be able to go to their primary care doctor and pay a single co-pay
   - Deductibles will not apply to primary care or prescription drugs. The plans will pay for visits to your primary care doctor and your drugs even before you meet your deductible
   - Members will still have a choice with both their health option and their carrier

- We are introducing more premium tiers, going from two (single and family) to a total of four
- Open enrollment period with late applicant fee for employees and dependent spouses
- Elimination of medical underwriting
- Elimination of pre-existing exclusion for dependent children age 26 or younger

4. What is changing?

You can expect these changes:

- You will have the choice of two new PPO (preferred provider organization) health insurance options—the Partnership PPO and Standard PPO
- The current PPO, HMO and POS options are no longer available. The Limited PPO remains for Local Government employees
- Both new health insurance options have deductibles, co-pays and co-insurance
- You will save money if you take an active role in your health
- Premium levels (tiers) have expanded from two to four
- For the first time in many years, you will have to choose a health insurance option during the Annual Enrollment Transfer/Open Enrollment Period, which runs from September 15 through October 15, 2010

5. What is staying the same—or is not going to change?

These plan design features are remaining the same:

- The same types of services, treatments and products covered under your current health insurance will be covered under both of the new options
- You will continue to have a choice of health insurance options and carriers
- Whichever option and carrier you choose, you will still have a large network of doctors and hospitals
- You can continue to cover your spouse and eligible children

6. Are changes to our benefit options legal?

Yes. The new benefit design complies with both state and federal law, including the new national health reform law. For reference, the Insurance Committees are empowered by statute (TCA 8-27-101 et seq.) to change the design of the plan and approve these kinds of policies.

7. Why won't members be able to choose an HMO or POS?

The State simply can no longer afford these options and also keep the same level of coverage. The HMO provides a good example. The premiums for the HMO option have been too low for the last few years. If we were to offer an HMO option, then we would have to "right size" the premium. For State and higher education employees, this means that we would have to raise the member premiums for the HMO by more than 40 percent. Even if we were to offer an HMO option, we would have to include a deductible in the HMO. The same is true for the POS option.

We understand that most people prefer to have even more choices than we will have under the new health insurance options. But providing more choices is costly—and it ultimately means that we will have to cut benefits to be able to offer additional options. Because the main goal was to preserve comprehensive, affordable and dependable benefits, the Insurance Committees decided to adopt a narrower set of choices. They selected two PPO options because PPOs seem to be the best at keeping costs down.

8. Under the new plan designs, there is no state assistance for Local Government Plans, and the agency and employees are totally responsible for premiums. This doesn't seem fair; why is this happening?

Because the State does not contribute to the premiums for local government, the individual agency controls how much the member pays.

9. Can we just increase premiums and keep the current health insurance options?

No. By law, the State pays 80 percent of the premiums for State and higher education employees and their families. The State also pays roughly 45 percent of the premiums for certified instructional employees of local education agencies. If we increase the premiums, then we increase the costs to the State and make the State's budget situation even worse.

10. Why did State Plan members get a premium holiday if the health plans are having financial trouble?

Funding for the State's health insurance options comes from you, through your premiums, and from the State. Our insurance plans must keep a cash surplus to cover unplanned expenses.

Because of the State's budget crisis and the need to save money, the State asked us to use the surplus funds to implement two premium holidays in 2010. In those months, neither the State nor our State Plan members paid any premiums. The premium holidays saved the State approximately $12 million, which helped to minimize the number of layoffs. It also saved our members approximately $3 million.

11. Where did the money come from for the premium holiday?

The insurance plans must keep a cash surplus to cover unplanned expenses. When there is more money in the account than we need, we give it back to plan members and the State. In 2009, we returned this money by not raising premiums, even though our costs increased. In January and February 2010, we returned this money through a premium holiday for State and higher education members. This is especially important given the State's budget crisis.

Note: The premium holiday did not apply for the Local Education and Local Government Plans as there was no cash surplus in either of those separately funded plans.

12. What does it mean for the State to be "self-insured?"

The State's claims are not paid for by an insurance company. Instead, the three insurance plans—the State Plan, the Local Education Plan and the Local Government Plan—are the source of payment for all medical claims and the monthly fees for the insurance carriers. This is what it means to be "self-insured."

Here's how it works. Our insurance plan "bank accounts" contain all of the premiums that are collected each month from the State, plan members and other participating agencies. When a medical or pharmacy claim is paid for you, it is paid out of a central fund or "bank account." This account is used to pay our insurance carriers a small fee each month for the management of a provider network and the processing and payment of medical claims. Again, it's not an insurance company paying claims and fees—it's the State's and your money.

Enrollment & Eligibility

1. Do I have to choose a new health option for 2011?

Yes. If you are currently enrolled in a State health insurance option, you will need to choose either the Partnership PPO or Standard PPO during the Annual Enrollment Transfer/Open Enrollment Period in the

fall. Your benefit choice will be effective January 1, 2011. Remember that Local Government employees are also eligible for the Limited PPO option.

2. When will I choose my new health option?

The Annual Enrollment Transfer/Open Enrollment Period for 2011 will run from September 15 through October 15, 2010.

3. How am I going to find out about all of the details about the new program?

We are committed to providing you with comprehensive communication about the new program:

- **Enrollment Kit**—Current members will receive a comprehensive Enrollment Kit in early September. The Kit will explain your health insurance options and provide instructions on completing your annual enrollment transfer for 2011. The packet will contain a DVD with information about the Partnership PPO and Standard PPO options and how to complete enrollment
- **Call Center and Web Support**—You can call a dedicated ParTNers for Health Call Center 24 hours a day, seven days a week to ask questions at 1-866-741-6464. This website will also provide complete program information at www.partnersforhealthtn.gov.

4. Will there be an Open Enrollment every year?

Open enrollment is not guaranteed after 2010. The Insurance Committees will decide if there will be one in 2011.

5. What does the enrollment kit look like?

The enrollment kit contains a decision guide, an informative DVD, forms and premium information.

6. Where does the enrollment form go after I have filled it out?

Active employees will return the completed enrollment form to their Agency Benefits Coordinator. COBRA participants and Retirees will need to fax or mail the completed enrollment form back to the Benefits Administration Service Center at:

- Fax number (615) 741-8196
- Benefits Administration Service Center
Suite 2600
312 Rosa L Parks Avenue
Nashville, TN 37243

7. Do employees who enroll through Employee Self Service also need to submit the paper form?

No. But, employees who are not currently enrolled or are adding dependents cannot use Employee Self Service and need to fill out the paper form.

8. If a Local Government employee does not enroll, will he or she be defaulted into the Limited PPO since it's the lowest-cost option?

No. Individuals who do not make a selection will be enrolled in the less costly Standard PPO for their region.

9. Why can't members, other than Local Government, be offered or have the PPO limited?

The Limited PPO is a high deductible, catastrophic coverage health plan available only to Local Government Plan members. It was put in place specifically at the request of the Local Government Insurance Committee and was not approved by the State or Local Education Insurance Committees.

10. Can children under age 26 be covered if they are eligible for their own coverage (e.g., with another employer)?

Yes, other available coverage is not a factor.

11. Will incapacitated children be covered beyond age 26?

If they are already enrolled in a plan and incapacitation was prior to age 26, they will be covered.

12. Are children eligible who are on the plan through child tax (e.g., grandchildren)?

We will grandfather any dependent child who previously qualified as a child tax dependent through July 20, 2010, when the policy changed. Moving forward, a dependent is only eligible if a legal obligation is present and there must be proof of a legal guardianship.

13. My dependent child was canceled from my policy in June when he turned 24, but I understand that you are increasing the age limit for adult dependent children. How do I add my dependent child back to my policy?

You will need to complete the dependent section of the enrollment form which will be included in your enrollment kit. Coverage will be effective January 1, 2011. No late applicant fee will apply for these dependents.

14. Do I have to list all of my covered dependents information on the enrollment form?

Yes, you should list all dependents who you want to cover in the dependent section of the form.

15. If I am a late applicant applying through medical underwriting but receive a denial after open enrollment (October 15th), do I have the option of coming into the plan late?

Yes, it will be treated as a qualifying event.

16. Why don't we just have open enrollment without a late applicant fee?

We simply cannot afford to do so. An open enrollment would cost the plans an additional $22.9 million each year. However, we did want to allow late applicants to have access to coverage -- as long as their late applicant fees cover their higher-than-average claims costs.

17. I was enrolled in the State plan but then I dropped my coverage. Am I going to be charged a late fee to enroll again?

Yes.

18. Is the late applicant fee pre-tax for state employees?

Yes.

19. For other participating agencies can the late applicant fee be paid pre-tax?

Yes. It is up to the individual agencies whether the fee may be paid pre- or post-tax.

20. Can an employee count the late applicant fees as out-of-pocket costs for the flexible spending program?

The late applicant fee will be taken out of state employees' paychecks pre-tax, and therefore, the fee will not be eligible for reimbursement in the flexible spending program.

21. An employee was denied coverage through medical underwriting, is he or she still ineligible during open enrollment?

No. Anyone previously denied coverage will be eligible through the open enrollment period, subject to the late applicant fee.

22. Will the late applicant fee amount remain the same each year or will it increase?

We will adjust the late applicant fee each year. We will revise the fee to reflect the actual claims costs of late applicants. The fee could go up, but it could also decrease.

23. Does the late applicant monthly fee and pre-existing condition exclusion apply if I add dependent children up to age 26?

No. The late applicant fee and pre-existing condition exclusion will not apply to dependent children.

24. What happens if an employee doesn't choose a benefit option during the enrollment period?

They will automatically be enrolled in the Standard PPO with the least expensive carrier in their region.

25. Does someone not currently enrolled need to decline coverage during Open Enrollment?

No

26. Is there a map on the enrollment form so members will know which region they are in?

Yes, on the back of the enrollment form in the enrollment kit.

27. I've heard that the State will be dividing up the plans by region. Will the health insurance options have doctors outside the regions?

Yes. The State is awarding separate contracts for carriers to serve what we call the East, Middle and West PPO regions. If you live or work in a PPO region, then you can choose between the options in the area. These regions just identify where our members live and work; they do not mean that the provider networks are limited to these geographic areas. You will always have access to doctors across Tennessee and nationwide.

28. If someone did not receive an enrollment kit, what should they do?

There are three options for getting an enrollment kit:

- Your Agency Benefits Coordinator should have additional enrollment kits
- Call 1-866-741-6464 to request a new kit
- Visit www.partnersforhealthtn.gov to request a new kit or download the printable kit

29. What is the deadline for submitting completed forms?

Employees are encouraged to complete the enrollment forms and return them to their Agency Benefits Coordinator as soon as possible. The deadline for employees is October 15, 2010. Agency Benefit Coordinators must send in the forms, and they must be received by Benefits Administration no later than October 15, 2010.

30. What happens if we hire a new employee after the deadline?

New employees can enroll during their initial eligibility. Annual transfer and open enrollment do not apply to new employees. Depending on their hire date, a new employee would have to complete both the current and new enrollment forms.

31. Will employees hired after August 1 receive an Enrollment Kit?

No, not automatically. The file we pulled is for those enrolled in heath coverage effective August 1. All others will need to be provided this information by their Agency Benefits Coordinator or they can request via call center at 1-866-741-6464 or web at www.partnersforhealthth.gov.

32. Where will the enrollment kits be sent?

Enrollment kits will be sent to the home address on file for the member.

33. How will Agency Benefits Coordinators know who is being enrolled and in which plans?

Information will be available through Edison for the Agency Benefits Coordinators.

34. Two plan members currently have employee + family and want to change to employee only for each. Is this considered a "new" enrollment where they would be charged the monthly fee? Will they be subject to the pre-existing condition clause?

No. This will not be considered a new enrollment since they are currently covered. This is considered a transfer. No late applicant fee or pre-existing exclusion will apply. They will need to indicate this on the enrollment form.

35. If two plan members are married, do they have to take employee + spouse, or can they each sign up for employee only? What if they have children?

You can each enroll in employee only coverage if you like. If two married eligible employees have a child(ren), one of you can choose employee only and the other can choose employee + child(ren).

36. If an employee joins through open enrollment and has a qualifying event that changes the premium level, what amount of the late applicant fee will they pay?

A qualifying event that changes an employee's premium level will override the late applicant fee and the fee will no longer apply.

37. If a qualifying event occurs and only the employee is currently enrolled, can the entire family be enrolled without paying the late applicant fee?

Yes. Anyone can enroll through a qualifying event and not be subject to the late applicant fee.

38. I currently have coverage under my spouse as a dependent. His employer will not allow me to continue in this coverage if I have access to insurance through my job. Since you will hold an open enrollment my coverage through his job will be canceled. Can I sign up and will I have to pay a late applicant fee?

This is considered a special qualifying event. You must apply within 60 days of the loss of coverage by completing an application for special enrollment and an enrollment application. No late applicant fee will apply.

39. Can an employee drop a dependent from coverage in the middle of the plan year?

With the exception of separation or pending divorce an employee can drop a dependent at any time. However, participation in flex benefits does not allow this in mid-year without a family status change. If you cancel your insurance coverage without approval you will pay insurance premiums for the rest of the year.

40. Can an age 65 dependent stay on the State plan? Is state coverage primary over Medicare?

Special circumstances apply to this scenario. Please contact the Benefits Administration Service Center at 1-800-253-9981 for more information and assistance.

41. Do I still have to provide dependent verification information if it's been provided in the past?

If your dependents are currently enrolled in health coverage you do not need to provide verification documents during this enrollment period.

42. How do the pre-existing condition exclusions work for existing members?

Members currently enrolled will not be subject to pre-existing condition exclusions.

43. Do the pre-existing condition exclusions apply to anyone over age 19? What about spouses and children?

The pre-existing condition exclusion applies to any employee or employee's spouse who cannot show proof of prior creditable coverage but does not apply to any dependent children regardless of age.

Partnership Promise

1. What does it mean when the Partnership Promise talks about "taking an active role in my health?"

If you choose the Partnership PPO for 2011, your Partnership Promise will commit you to taking these steps toward healthier living:

1. Complete your health questionnaire
2. Complete your health screening

The questionnaire asks you questions about your age, what you eat, how much you exercise and whether you use tobacco or alcohol. An independent wellness vendor, APS Healthcare, conducts this survey. Next, you'll take part in a health screening. The screening measures your height, weight, blood sugar, blood pressure, triglycerides and cholesterol level. You can do the screening with your doctor as part of your routine physical or at one of the health screening sites that will be set up around the state in 2011. Depending on the results of your questionnaire and screening, you may be eligible for health coach services.

You can expect lower monthly premiums, a lower annual deductible, lower co-pays, lower co-insurance and lower out-of-pocket costs for covered health care services. Members who don't want to commit to the Partnership Promise can choose the Standard PPO, which covers the same types of services, treatments and products but does not offer the reduced costs.

2. What exactly will the health questionnaire involve?

The health questionnaire is only required for those who enroll in the Partnership PPO. It includes a series of questions about your age, what you eat, how much you exercise and whether you use tobacco or alcohol. The questionnaire will be available online, though paper copies will be available for those without Internet access.

3. I understand I will need to complete a health screening as part of my Partnership Promise. Can I do this with my doctor?

Yes. Gathering your health screening information from a worksite screening or during your annual physical is perfectly acceptable.

4. If I choose the Partnership PPO, when do I have to complete my health screening?

Your health screening will include your height, weight, blood sugar, blood pressure and cholesterol levels. This information can be provided based on any tests or screenings (e.g., through your regular annual physical) conducted after July 1, 2010. You will have until June 30, 2011 to fulfill your Partnership Promise.

5. When I take part in the health questionnaire and health screening, who will see my answers and results?

The State is contracting with a health and wellness manager, APS Healthcare, to help members with the health questionnaire and schedule health screening events. APS Healthcare will collect your data—under a current law known as HIPAA, they will not release any identifiable, individual information about you to either the State or your employer without your permission.

6. Do I have to work with a health coach? Will the health coach contact me by phone or e-mail?

In 2010, working with a health coach is optional. Health coaches will contact members via telephone.

7. I want to enroll in the Partnership PPO, but my dependent spouse does not. Can we enroll in separate options?

Generally, if the head of contract selects that Partnership PPO, the dependent spouse must enroll in the same option. However, if two employees of a participating agency are married, each may choose to enroll in single coverage.

8. The Partnership Promise sounds fine for this year. What will I have to do in the future?

We want to help you gradually take control of your health. The requirements each year will depend mostly on you and may change as you take steps to stay well or get better. If you decide not to commit to the Partnership PPO, you can switch to the Standard PPO during the Annual Enrollment Transfer/Open Enrollment Period.

9. If you break the Partnership Promise, will your claims still be paid?

The plans will continue to pay eligible claims for the calendar year, regardless of whether the member meets the Partnership Promise. However, members will not be able to re-enroll in the Partnership PPO for the following year if they do not fulfill their Partnership Promise. The Standard PPO will be available to these individuals.

10. If my spouse does not meet his or her Partnership Promise and I drop him or her from my coverage, can I re-enroll in the Partnership PPO the following year?

While you can terminate spouse coverage (unless there is pending divorce or separation) this will not allow you to re-enroll in the Partnership PPO the following year. Both of you must complete your Partnership Promise by the deadline to re-enroll in 2011.

11. If I enroll in the Partnership PPO for 2011, will I be able to switch to the Standard PPO in 2012?

Yes. You will be able to switch during the enrollment period in the fall.

12. Do I have to take the screening before I can enroll in the Partnership PPO?

No. Anyone can enroll in the Partnership PPO in the fall. Individuals who enroll in the Partnership PPO will have until June 2011 to complete their Partnership Promise.

13. Where can I get the form to take to my doctor? Do I have to wait for it to have my annual physical?

The required form will not be available until January. Have your doctor measure your height, weight, blood pressure, cholesterol levels and blood sugar levels. Then, ask your doctor to complete the form when it becomes available.

14. Will the health screening form from APS be in the Enrollment Kit?

No. This form will be mailed to all plan members who elect the Partnership PPO.

15. What security information will APS ask for to identify members on the phone?

Although the specific questions have not been determined, APS will ask members to identify themselves to ensure privacy and security. However, they will not ask for your Social Security number.

16. I have high blood pressure. Can I enroll in the Partnership PPO?

Yes, absolutely! All eligible members are encouraged to enroll regardless of current health, age or weight.

17. I know I'm overweight. If I enroll in the Partnership PPO, will I be required to lose a certain number of pounds?

No. There will be no "target weights" for members. The requirement is to show that you are making a sincere effort to meet your health goals.

18. Am I going to be charged more for being a tobacco user?

No. There will not be a surcharge for tobacco use. However, the Partnership PPO will offer resources to help you quit through working with your health coach.

19. What happens if my doctor disagrees with my health coach's plan?

The orders of the primary care provider will control. The health coach's role is to provide information and support - not a prescriptive plan that a member must follow. The member can choose the health risk(s) on which they want to focus and they work with both their health coach and primary care provider to develop a plan that is clinically appropriate.

20. Will I get confirmation that I have fulfilled the Partnership Promise and am eligible to stay in the Partnership PPO for the next year?

You have between July 1, 2010 and June 30, 2011 to complete your health screening/annual physical. The health questionnaire will be available beginning in January, and you have until June 30 2011 to complete it. APS will be in touch with Partnerhsip PPO participants, provided they have your current contact information to alert you of your fulfillment progress. Those who have not fulfilled their Promise by the deadline will not be able to enroll for 2012.

21. Will the State offer wellness incentives or discounts to members who use facilities like YMCAs, etc.?

All State employees are already eligible for the fitness center discount program. Participating fitness centers have agreed to offer a discount on their regular member price and/or initiation fees. A list of participating fitness centers and information on accessing the discounts are available at www.tn.gov/finance/ins/sewp_fit.html. We are working to put similar programs in place for all other plan members.

22. I've heard that the State offers discounts for employees to join weight loss groups such as Weight Watchers and Jenny Craig. Where can I find out how to apply for these discounts?

We will continue to offer group discounts on Weight Watchers and other support programs. Currently, the State partners with Weight Watchers to offer Weight Watchers at Work and other weight management programs. Weight Watchers offers all State employees a discounted rate for these programs. To find out more, go to http://www.tn.gov/finance/ins/sewp.html. We are working to put similar programs in place for all other plan members.

23. Does a provider have to be in network to administer the annual health exam? What are the criteria for the annual exam for the Partnership Promise?

Members may see providers either in or out of network. Your out-of-pocket costs will always be lower by using a network provider.

24. If an agency pays 100 percent of the cost, can all members be required to enroll in the Partnership PPO?

No. An agency cannot restrict their employees to enroll in a certain option. The employer agency agrees to offer access to each available option when the agency joins the plans. It is at the agency's discretion as to the amount of employer contribution to monthly premiums.

25. Are Agency Benefits Coordinators required to follow up with employees who enroll in the Partnership Promise to make sure they are keeping their commitment?

No.

26. Are adult children (age 19 and up) required to participate in the Partnership Promise?

No. The Partnership Promise does not apply to dependent children of any age.

27. If a member does not meet the Partnership Promise, is there an appeals process if the member wants to stay in the Partnership PPO?

If an individual does not meet the requirements of the Partnership Promise there is no appeal option.

28. Will my spouse have to pay for a Working Well screening?

The current Working Well screenings, which are only available for state employees, have a charge of $78 for a spouse to participate. Beginning in 2011, APS Healthcare will conduct health screenings for the Partnership Promise which will not have a cost for an employee or spouse.

Pharmacy

1. Will a deductible or out-of-pocket maximum apply for pharmacy benefits?

No. Beginning January 1, 2011, no deductible will apply for pharmacy benefits under the Partnership and Standard PPOs. But your pharmacy co-pays will not count towards your out-of-pocket maximum for medical services.

2. What if I still have not received my prescription cards?

If you have not received your welcome packet, contact Caremark at 1-877-522-TNRX (8679) or visit www.caremark.com.

3. Is there a new drug list for CVS Caremark?

Yes. A list of many of the drugs covered under the program was included in your welcome packet. For a complete list you can contact Caremark at 1-877-522-TNRX (8679) or visit www.caremark.com.

4. What if I take a drug that's not on the CVS Caremark drug list?

You need to contact CVS Caremark about your options if the medication you are taking is not covered under the new approved drug list.

5. Since I'm covered under BlueCross BlueShield, I already have CVS Caremark. Is anything different for me?

Like all members, you may see differences in your covered drug list and pharmacy network as of July 1. Be sure to check that your prescription drugs are on the list. Also, if you are registered on www.caremark.com, you'll need to register again after June 30, 2010.

6. What will happen to prescription drug benefits next year?

CVS Caremark will continue to be the pharmacy benefits manager, but your co-pays will change. The 2011 co-pays can be found on the comparison chart in your enrollment kit or on this website.

7. Are diabetic drugs and supplies still free?

Yes. Diabetic medications are covered at 100% for the rest of 2010 if they are generic or preferred. But, the medications classified as generic or preferred may have changed. For instance, the following diabetes supplies are now preferred:

- Accu-Chek strips and kits
- One Touch strips and kits
- BD insulin syringes and needles

An Accu-Chek or One Touch blood glucose meter will be provided free of charge to members currently using a meter other than Accu-Chek or One Touch. To obtain a free meter call 1-800-588-4456.

Be sure to **check** to see what is and isn't covered now. You can call the Caremark Service Center 24 hours a day, seven days a week to see whether or not your current drugs are covered. You can also check coverage through the Caremark website (www.caremark.com).

8. How are diabetic supplies covered in 2011?

The plans will continue to provide the enhanced access for diabetic medications and supplies through the end of calendar year 2010. The Insurance Committees will decide later this year whether to continue this benefit in 2011.

9. There is a quantity limit on my prescription drug; however, my doctor says I need an amount higher than the limit. What do I do?

Your doctor can contact Caremark to request and preauthorize the higher amount for your drug.

10. I would like to appeal my prescription drug benefits paid with Caremark. What do I do?

All appeals must start with Caremark and the appeals process there must be exhausted before an appeal can be filed through the State. Contact Caremark at 1-877-522-8679 to begin the process, to ask questions about how to appeal and to review the status of your appeal.

11. My prescription drug was classified as a generic (Tier 1) drug under our old plan. Under Caremark, it's classified as preferred (Tier 2), and my co-pay is higher. Can I appeal this issue with Caremark?

No. The co-pays under the new prescription drug program cannot be appealed.

12. My pharmacy said my doctor needs to request prior authorization to refill my prescription. How do I do this?

Contact your doctor and ask him or her to call Caremark directly to obtain prior authorization for your prescription with the pharmacy.

Health & Other Benefits

1. Will there be changes to the Medicare supplement?

No. The plan redesign will not affect the Medicare Supplement Plan.

2. Will retirees under age 65 be able to choose between the Partnership PPO and the Standard PPO?

Yes. All members will have access to the same health options.

3. **I am a retiree under age 65 and have single coverage through the State. My spouse is still an active employee. Can I drop my retiree coverage to become a dependent on my spouse's active plan? Will I be considered a late applicant?**

   Yes, you can drop your retiree coverage to become a dependent on your spouse's coverage. No, it would be considered a transfer and not a late applicant.

4. **Is the State cutting retiree health coverage?**

   No. The State remains committed to providing pre-65 retirees with the same health care options as active employees. (Retirees over age 65 qualify for Medicare and most qualify for our Medicare Supplement Plan.) The changes to the health insurance options will affect all active employees, retirees and their dependents.

5. **Is TCRS changing my retirement pension benefits?**

   The health insurance changes have no impact on your TCRS pension benefits, although the amount deducted from your pension for health insurance premiums may change. If you have questions regarding TCRS, please call 1.877.681.0155 (8:00 am-4:30 pm CST) or visit www.treasury.tn.gov/tcrs/index.html

6. **Why does the State pay 45 percent of health insurance premiums for certified instructional staff and 80 percent for State employees who have served 30 years?**

   The General Assembly sets contribution rates. The contribution rate for the State Plan is found at TCA 8-27-201(b), and the contribution rate for the Local Education Plan is part of the Basic Education Program (BEP). The General Assembly has left the contribution rates unchanged for a number of years.

   Local education agencies have the authority to supplement the employer contribution to the premiums for their employees and retirees over and above the level the State contributes. Many, though not all, elect to do so.

7. **Are mental and behavioral health benefits changing?**

   There will actually be enhanced benefits in 2011 for mental health coverage to conform to the requirements of mental health parity.

8. **Do behavioral health services require prior authorization, or can I refer myself to providers within the network?**

   Members will need to call Magellan Health Services at 1-800-308-4934 for prior authorization of services.

9. **Is life insurance changing?**

   No. However, for basic term, basic Accidental Death & Dismemberment (AD&D) and optional AD&D, the age limit for dependent children will be increased to match the health and dental criteria.

10. **Will vision coverage be offered as part of the new plan design?**

    No. The current vision benefits offered by CIGNA and United will not be available with either BlueCross BlueShield or CIGNA in 2011. However, each carrier will offer discounts and other incentives. Please contact the carrier for more information.

11. Are dental benefits changing, too?

The contracts for dental benefits must be renewed every five years and contracts were just awarded. Assurant will continue to administer the prepaid plan and Delta will continue to administer the PDO.

12. What is considered preventive care? What preventive services are covered?

Preventive care references services such as annual checkups, associated blood work and age appropriate cancer screenings.

13. Are allergy shots covered by a co-pay?

If administered by a doctor, an office visit co-pay will apply. If administered by a nurse or nurse practitioner, it is covered at 100 percent.

14. Do advanced imaging and outpatient surgery require a co-pay or co-insurance?

Advanced imaging and outpatient surgery will be subject to the deductible, co-insurance and the out-of-pocket maximum will apply.

15. Does dialysis require a co-pay or co-insurance?

Co-insurance will apply. Because dialysis is subject to the deductible/co-insurance, the member has the protection of the out-of-pocket maximum; this would not be the case otherwise. Given the frequency of dialysis visits, the deductible/co-insurance/out-of-pocket maximum approach for dialysis is more advantageous for the member.

16. What if I am pregnant and will not deliver until 2011?

You may continue to see your current doctor, even if he or she is not in the insurance carrier's network, at in-network rates. However, you will be subject to the same co-insurance, deductible and out-of-pocket costs as all other members. Since you may be able to estimate your out-of-pocket costs, you are a great candidate for the flexible spending program. Please ask your Agency Benefits Coordinator or see your Decision Guide for more information.

It is important to note that ALL OB/GYN physicians are considered primary care doctors and you will pay the primary care co-pay.

17. What happened to the comparison guide on pregnancy previously provided in the Annual Enrollment Transfer Period materials?

We are using a slightly different format this year.

18. Will members who are pregnant have to choose an in-network provider if their provider is out-of-network?

No. Any pregnant member with an established relationship with an OB-GYN currently in the network will pay in-network co-payments, deductibles, and co-insurance for their maternity care for this pregnancy. Contact your insurance carrier for any prior paperwork or authorization needs.

19. Will members who are undergoing a course of treatment for cancer have to choose an in-network provider if their provider is out-of-network?

No. Any member with cancer who is currently in the middle of a course of treatment with an in-network provider will pay in-network co-payments, deductibles and co-insurance through the end of this course of treatment. Contact your insurance carrier for any prior paperwork or authorization needs.

20. Will transplant candidates have to choose an in-network provider if their provider is out-of-network?

In general, transplant candidates who see a provider currently in the network can remain with that provider and pay in-network cost-sharing. However, the answer in each case may depend on the transplant organ in question and other factors. Transplant candidates should contact the insurance carrier directly for more information. Contact your insurance carrier for any prior paperwork or authorization needs.

BlueCross BlueShield & CIGNA

1. Will all plan members have the same health insurance choices?

Yes. We will offer two health insurance options to all members, the Partnership PPO and the Standard PPO. Everyone will have the same access to the same two options, regardless of their employer. One exception to this is the Limited PPO option available to local government employees.

2. Will everyone have a choice of insurance carriers?

Yes. Every plan member will be able to choose between two insurance carriers. Both carriers will offer the Partnership PPO and Standard PPO options. Each carrier will also offer its own network of providers. BlueCross BlueShield of Tennessee and CIGNA will administer the Partnership PPO and Standard PPO as of January 1, 2011. Members will choose an insurance carrier during the Annual Enrollment Transfer/Open Enrollment Period in the fall.

3. Will I lose benefits with either of the new health insurance options?

The health insurance options will cover the same types of services, treatments and products that they do now. Both options will have deductibles, co-pays and co-insurance. You will have an opportunity to save out-of-pocket costs by choosing the Partnership PPO and taking an active role in your health.

4. Will my current doctor(s) be in both PPO networks?

Each carrier has its own network of preferred doctors, hospitals and other health care providers. Many doctors are in more than one network. You may find yours listed under both carriers.

If you're currently enrolled with BlueCross BlueShield of Tennessee, you may see some changes to the doctors and hospitals that participate in the network because BlueCross BlueShield will offer our employees access to their "Network S" beginning January 1, 2011. This network is smaller than the network currently in place.

You can find out if your providers are in the networks, as follows:

1. Search for your providers online through the carriers' websites:
    1. BlueCross BlueShield of Tennessee (www.bcbst.com/tools/findadoctor)
    2. CIGNA (www.cigna.com and look for OpenAccess Network)
2. Call the ParTNers for Health Call Center beginning August 15. Representatives can research your options

5. **Will I have to select a Primary Care Provider (PCP)?**

   No, you will not have to select a PCP.

6. **Will I need to get a referral to visit network specialists?**

   No.

7. **What happens if I have a high medical bill? Will I have to pay co-insurance for the whole amount?**

   No. The new benefit design has what's known as an "out-of-pocket maximum." Once you pay this amount, the health insurance options will pay 100 percent of your covered expenses. We put this in place in order to protect members who have very high medical bills.

8. **If my doctor orders lab tests, do I have to pay more for these under the new PPOs?**

   Lab work with an associated doctor's office visit will continue to be covered at 100 percent.

9. **I live in Cumberland County (which is in the Middle PPO region) but work in Knoxville (which is the East PPO region). Does the State consider me in the Middle or East PPO region?**

   Since you live in one PPO region and work in another, you may choose which PPO Grand Division makes the most sense for you.

10. **I live out of State. Will the networks cover areas outside Tennessee?**

    Yes. The carriers must have providers in their network in all of the major areas along the Tennessee border. Additionally, members will have access to a national network of providers. Contact the insurance carriers regarding out-of-state network information.

11. **I live and work in Knoxville but go to a specialist in Nashville. Will I have to change doctors?**

    No, not necessarily. You should check the provider directory to determine if your specialist is in-network or out-of-network.

12. **Why are the monthly premiums different among regions?**

    This is due to the negotiated reimbursements for network providers. These payments are higher in some regions than others depending on the carrier.

13. **Can members request provider directories?**

    Yes. Members can order directories directly from the insurance carriers. However, the most up to date information will be available on the carrier's website.

14. **Will both carriers provide an Explanation of Benefits (EOB), and can I use it to keep track of my deductible?**

    Yes.

15. **Do the carriers have network providers out of state? Will I need any special approval to see an out-of-state provider?**

Yes, both carriers have national networks. No you will not need any special approvals for out-of-state providers.

16. Why is HCA not in the BlueCross BlueShield network, and do they have the option to join the network?

It is a business decision on the part of a facility or doctor as to whether they participate in the network or not.

17. What do I do if I have a question regarding my insurance claims?

Members should always carefully review their explanation of benefits and should contact their insurance carrier if they have any questions.