VOLUNTEER STATE COMMUNITY COLLEGE

Main Campus
1480 Nashville Pike
Gallatin, TN 37066-3188
615-452-8600
1-888-335-VSCC (8722)

Vol State at Livingston
113 Windle Community Rd
Livingston, TN 38570

Vol State at Highland Crest
150 Laureate Avenue
Springfield, TN 37172
615-433-7030
1-855-724-8722

Vol State at Cookeville
Cookeville Higher Education Campus
1000 Neal Street
Cookeville, TN 38501
931-520-0551

Dear Employee,

Congratulations on your new position at Volunteer State Community College. We hope this opportunity provides an avenue of growth and development as you pursue your professional and academic goals. The Office of Human Resources has provided a centralized, convenient place to find information you may need in the days ahead. Please review the "Onboarding New Employee's" webpage at https://www.volstate.edu/hr/new-employees

As a higher education employee, you are eligible to participate in insurance plans offered by both the State and Tennessee Board of Regents (Vol State). We have provided a State and Higher Education 2021 Eligibility and Enrollment Guide and a Vol State Employee Benefits Guide to utilize along with the resources on the onboarding webpage https://www.volstate.edu/hr/new-employees.

Volunteer State Community College recognizes benefits as an important part of your total compensation package. Please take the time to review your choices and select the benefits most beneficial for you and your family.

Sincerely,

Sheila Jessup, MBA, PHR, SHRM-CP
Administrator of Human Resources
Office: (615)230-3591
Fax: (615)230-3314
Sheila.Jessup@volstate.edu

PARTNERS FOR HEALTH

Your 2021 Eligibility & Enrollment Guide

State and Higher Education Employees

Tennessee State Group Insurance Program

If you need help…

Contact your agency benefits coordinator. He/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 or 615.741.3590 — M-F, 8-4:30	tn.gov/partnersforhealth
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	Optum Bank	866.600.4984 — 24/7	optumbank.com/Tennessee
Pharmacy Benefits	CVS Caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Use and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	ActiveHealth Management	888.741.3390 — M-F, 8-8	http://go.activehealth.com/wellnesstn
Disability Insurance	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Vision Insurance	Davis Vision	800.208.6404 — M-F, 7-10, Sat, 8-3 Sun, 11-3 Basic Client Code: 8155 Expanded Client Code: 8156	davisvision.com/stateofTN
Life Insurance	Securian Financial (Minnesota Life)	866.881.0631 — M-F, 7-6	lifebenefits.com/stateoftn
OTHER PROGRAMS			
Edison	Tennessee 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	www.edison.tn.gov
Flexible Benefits medical & dependent care transportation & parking (state employees only)	 Optum Bank Benefits Administration	 866.600.4984 — 24/7 800.253.9981 — M-F, 8-4:30	 optumbank.com/Tennessee tn.gov/partnersforhealth

Online resources…

Visit the ParTNers for Health website at https://www.tn.gov/PartnersForHealth. It has information about all the benefits described in this guide. Enrollment forms and handbooks referenced in this guide are located on our website or you can get copies from your agency benefits coordinator.

The ParTNers for Health website also includes a green "Help" button, or live-chat feature, that is operational during normal business hours.

In Zendesk at https://benefitssupport.tn.gov/hc/en-us, you can search the help center, find articles or submit questions. To access Zendesk, you can also click the blue "Questions?" button on the website.

Follow us on social media…

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TN Department of Finance and Administration,
Authorization No. 317374, October 2020.
This public document was promulgated at a cost of $0.01 per copy.

INTRODUCTION

Benefits Administration, within the Department of Finance and Administration (F&A), manages the State Group Insurance Program. ParTNers For Health is the official logo and website name for Benefits Administration.

The State Group Insurance Program's State Plan includes employees of state government and higher education. This guide explains insurance options and coverage rules for state and higher education employees participating in the State Plan. There is a separate guide for continuing insurance at retirement.

If you are eligible for the State Plan, you may enroll in health, dental, vision, life and disability insurance. Flexible spending accounts (FSA) are also available.

Authority

The State Insurance Committee is authorized to determine the premiums, benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the State Plan. You will be given written notice of changes.

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 Committees

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

Employees

Eligible

- 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

NOT Eligible

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 (PPACA).

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

Dependents

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.

Eligible

- 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

Not Eligible

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

All eligible dependents must be listed by name on the enrollment change application in part 7. You are also required to provide a valid Social Security number for a dependent (if they have one). Other required information includes date of birth, relationship, gender and acquire date. See below.

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ 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 (see page 2).

❑ A separate sheet with more dependents is attached

Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart below and also at tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf for the types of proof you must provide.

A dependent can only be covered once within the State 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.

DEPENDENT ELIGIBILITY

Definitions and Required Documents

PARTNERS FOR HEALTH

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** one document from the additional documents list below:
		Proof of Marital Relationship • Government issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • 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" or "married filing separately" with the name of the spouse provided thereon, submit page 1 of the return with the income figures blacked out
		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	Final court order granting adoption; **or**
		International adoption papers from country of adoption; **or**
		Court order placing child in custody of member for purpose of adoption
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Court order making member a guardian of another and stating the length of the 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 documents determined by BA to be the legal equivalent
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.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. The insurance carrier will review the form, make a determination, and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.

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.

Revised 07/20

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. 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.

An employee may not be enrolled as both head of contract and dependent within the State Plan. 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/she requests to change during the annual enrollment period or later qualifies under the special enrollment provisions. The spouse who is also an employee, however, may only apply as an employee for the voluntary term life insurance program.

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, except for voluntary term life insurance. Voluntary term life insurance will become effective after you have completed three full calendar months of employment.

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

You must be in a positive pay status (i.e., any type of approved leave with pay) 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 during the year. Refer to the special enrollment provisions on pages 7-8 of this guide for more information.

Positive Pay Status — Being paid even if you are not actually performing your normal work duties. 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. The application to add a newly acquired dependent (tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf) 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.

Insurance cards 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. You may choose the same or different levels for health, dental and vision.

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

Family Coverage — Is any coverage level other than "Employee Only."

If you enroll as a family, which is any coverage level other than Employee Only, 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 basic term life insurance coverage as the head of contract. Refer to the available benefits section of this guide beginning on page 13 for more information.

Edison Employee Self Service (ESS) Instructions

You will need to log in to Edison at https://hub.edison.tn.gov/psp/paprd/EMPLOYEE/EMPL/h/?tab=PAPP_GUEST to enroll. Instructions for enrolling are available at tn.gov/partnersforhealth. Click on the For New Employees tile and then look under Resources for State Employee Self Service (ESS) Instructions.

If you have trouble logging in to Edison, go to the Edison home page and instead of clicking on the red Portal Login button, click on the First Time Login/New Hire blue button. It will take you to a page where you can verify your identity and receive your access ID. Active State of Tennessee employees can call the Edison Help Desk for password assistance at 866.376.0104.

Premium Payment

For state and higher education employees, the state pays about 80% 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 worker's compensation and receiving pay for lost time, 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, disability and vision, get no state support, and you must pay the total premium.

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.

The plan permits a 30-day deferral of premium for premiums being billed directly instead of through payroll deduction. If the premium is not paid at the end of that deferral period, coverage will be cancelled back to the date you last paid a premium. There is a provision for restoring your coverage through a one-time opportunity for coverage reinstatement.

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

Adding New Dependents

Enrollment must be completed within 60 days of the date a dependent is acquired (tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf). 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 day of the following month, depending on the coverage start date.

Add Dependents — Within 60 days of the acquire date/Within 40 days for qualified medical support order

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 Employee Only coverage, you must request the correct family coverage level 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 each 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 Employee Only 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, starting on page 9.

Updating Personal Information

State employees can update personal information in Edison, or by contacting their agency benefits coordinator or human resources offices. Higher education employees can update information in Edison, contact their agency benefits coordinators or call the Benefits Administration service center (800.253.9981 or 615.741.3590) to request an address or email address change.

All employees who contact Benefits Administration will be required to provide their Social Security number or Edison ID, date of birth, previous address and confirm authorization of the change before Benefits Administration (BA) can update the information.

It is your responsibility to keep your address, phone number and email address current with your employer.

Annual Enrollment Period

During the fall of each year, benefit information is mailed to you and provided in detail on our Partners for Health website at tn.gov/partnersforhealth. Review this information carefully to make the best decisions for you and your family members. The annual enrollment period gives you a chance to enroll in health, dental, vision, voluntary accidental death coverage, voluntary term life and disability insurance coverage. You can also make changes to your existing coverage, like increasing or decreasing voluntary term life insurance, transferring between health, dental, disability and vision options and cancelling insurance.

During the annual enrollment period, state employees (does not include higher education employees) MUST choose health savings account (HSA) amounts and all employees MUST choose flexible spending account (FSA) election amounts if you want to put money in them for the next year.

Most changes you request start the following January 1. However, voluntary term life and disability insurance may start January 1, February 1 or March 1. This is because the insurance carriers may need to review your medical history to determine if you qualify for coverage.

Benefit enrollments remain in effect for a full year (January 1 through December 31). However, you may cancel disability and voluntary term life coverage at any time. You may not cancel other coverage outside of the enrollment period unless eligibility is lost or there is a qualifying event. For more information, see the section on cancelling coverage below.

Cancelling Coverage

Outside of the annual enrollment period, you can only cancel coverage (other than disability and voluntary term life insurance) for yourself and/or your covered dependents, IF:

60-day Deadline — Read details at left

- 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 cancelled 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.

Divorce — If you request to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 34-4-106 and the requirement that you provide notice of termination of health insurance to your covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. As the employee, it is your responsibility to make sure that any request to terminate your dependent spouse is consistent with those legal requirements.

Cancelling coverage in the middle of the plan year —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/your dependents 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 (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1047_2020.pdf). The required proof is shown on the application. Events that might result in becoming newly eligible for coverage elsewhere are:

- Marriage, divorce, legal separation, annulment
- Birth, adoption/placement for adoption
- Death of spouse, dependent
- New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependents)
- Entitlement to Medicare, Medicaid or TRICARE
- Court decree or order
- Annual enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment (Marketplace enrollments are those offered under the Patient Protection and Affordable Care Act (PPACA)

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

You may request to cancel the Prepaid Dental Plan if there is no participating general dentist within a 25-mile radius of your home address.

If you request to cancel disability coverage, 30 days advance written notice is required.

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 or loss of eligibility under another plan. The State Group Insurance Program will consider special enrollment requests for health, dental, disability, voluntary term life and vision insurance 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. Submission of medical history will be required by the disability and voluntary term life insurance carriers to determine your qualification for coverage.

- A new dependent spouse is acquired through marriage
- A new dependent 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 (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf). 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

60-day Deadline — Read details at left

The above events are subject to special enrollment ONLY 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's 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
- Loss of coverage due to exhausting lifetime benefit maximum
- 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 you are 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

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 and 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. Cancelation 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 cancelled, 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 coverage. 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 cancelled 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 day of the next month after you return to work. There are additional requirements for the disability insurance that may be found in the sample certificate of coverage.

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 agency 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% 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. Approved by the Department of Treasury, Division of Claims Administration.

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. Disability insurance will end after your last day worked.
- Higher education employees: Coverage will end on the last day of the month following the month you terminate employment. Disability insurance will end after your last day worked.

A COBRA notice to continue health, dental and/or vision coverage (depending upon your enrollment as an active employee) will be mailed to you. Disability and life insurance conversion notices will also be mailed, if applicable.

If 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 insurance 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 and/or vision insurance if:

- Coverage is lost due to a qualifying event (refer to the COBRA brochure at tn.gov/content/dam/tn/finance/fa-benefits/documents/cobra.pdf on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

BA will send you a COBRA packet to the address on file within 7-10 days after receiving notification of your coverage ending. 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

Please note that under TCA 8-27-205, your initial employment with the state or participating local education agency must have commenced prior to July 1, 2015 in addition to other eligibility criteria. There are separate eligibility guides for retirement insurance. The Guide to Continuing Insurance at Retirement for State and Higher Education is available on the Partners for Health website under "Publications" at tn.gov/partnersforhealth.

Coverage for Dependents in the Event of Your Death

If you die while actively employed, your covered dependents will be offered continuation of whatever State health, dental and vision insurance they have on the date of your death. Your dependents may also be able to convert life insurance.

Health — Your covered dependents get six months of health coverage at no cost. After that, your dependents may continue health coverage under COBRA for a maximum of 36 months, as long as they remain eligible. Instead of COBRA, your eligible dependents may continue coverage through retiree group health if you meet the eligibility criteria for continuation of coverage as a retiree at the time of your death.

If you are a member of the Tennessee Consolidated Retirement System (TCRS), election of a monthly pension benefit is one of the required criteria to continue insurance for your covered dependents on the retiree plan if you die. Your covered dependents do not have to be the pension beneficiaries, but if either you or your designated pension beneficiary elected to take a lump sum pension payout, this will result in your surviving dependents losing the right to continue retiree health insurance coverage even if the other eligibility criteria are met.

If eligible, premiums for continued coverage of your eligible surviving dependents will be deducted from your monthly TCRS pension check if a covered dependent is your designated pension beneficiary. Covered surviving dependents must submit insurance premiums directly to Benefits Administration if your TCRS pension check is insufficient to cover the premiums or if your designated pension beneficiary is someone other than a dependent covered on your insurance at the time of your death.

Dental and Vision — Your dependents may be eligible for continuation of dental and vision coverage through COBRA or the retirement program as outlined below.

Your surviving dependents covered under your dental and/or vision plan on the date of your death may continue their enrollment in the plan with one of the two options listed below. (**Note:** Your dependents must continue enrollment in the retiree health plan to be able to continue retiree vision insurance.)

- If you are eligible for continuation of coverage as a retiree at the time of your death, your dependents may elect COBRA or retiree continuation of dental and/or vision elections in effect for them on the date of your death
- If you are not eligible for continuation of coverage as a retiree at the time of your death, your dependents may elect COBRA continuation for dental and/or vision elections in effect for them on the date of your death.

All eligibility questions to continue coverage for surviving dependents on the state plans should be directed to Benefits Administration.

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 only continue health coverage 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 have up to a total of 36 months of COBRA, provided they continue to meet the eligibility requirements.

AVAILABLE BENEFITS

Health Insurance

You have a choice of three health insurance options:

- Premier Preferred Provider Organization (PPO)
- Standard PPO
- Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA)

You also have a choice of three insurance carrier networks. There are two narrow networks, BlueCross BlueShield Network S and Cigna LocalPlus, which exclude some providers to keep premiums and rate increases low. There is also one broad network, Cigna Open Access Plus (OAP), for maximum choice.

- BlueCross BlueShield (BCBST) Network S
- Cigna LocalPlus Network
- Cigna Open Access Plus Network – is a broad network with the most providers in Tennessee. OAP gives you access to more providers than the other networks but this broad choice costs more. You pay a monthly surcharge: $40 for employee only and employee+child(ren)/$80 for employee+spouse and employee+spouse+child(ren)

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

Network providers and facilities can and do change. Benefits Administration cannot guarantee that all providers and hospitals that are in a network when you enroll will stay in that network. A provider or hospital leaving a network is not a qualifying event and does not allow you to make changes.

Each health insurance option:

- Provides the **same comprehensive health insurance coverage** (although medical policies for specific services may vary between carriers)
- Includes in-person and Telehealth medical services through PhysicanNow or MDLive programs sponsored by BCBST and Cigna
- 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/HSA

- You pay a lower monthly premium but have a higher deductible
- You pay the full discounted network cost for **ALL** healthcare expenses, except for in-network preventive care and certain maintenance drugs, until you meet your deductible
- You have a tax-free HSA which can be used to cover your qualified medical expenses, including your deductible

CDHP/HSA

If you enroll in this option, the state will deposit $250 for employee only coverage or $500 for family coverage into your HSA. If your coverage effective date is September 2 through the end of the year, you will not receive the state contribution towards your HSA.

Health Savings Account

If you enroll in the CDHP, a 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, or save it. For example, you could take the money you save in premiums for this plan versus a PPO and put it in your HSA. The HSA is managed by Optum Bank, 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 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 $3,600 for individuals and $7,200 for families in 2021.
- At age 55 and older, you can make an additional $1,000/year contribution.

These limits include the $250 individual and $500 family state contributions.

Your full HSA contribution is not available upfront at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period. You may only spend the money that is available in your HSA at the time of service or care.

Enrolling in Social Security at age 65 automatically triggers Medicare Part A enrollment. If enrolled in a CDHP, this may have tax consequences and affect your HSA contribution.

Consult with your tax advisor for advice.

CDHP/HSA Restrictions

You cannot enroll if you are enrolled in another plan, including a PPO, your spouse's plan or any government plan (e.g., Medicare A and/or B, Medicaid, TRICARE, Social Security benefits), or if you have received care from any Veterans Affairs (VA) facility or the Indian Health Services (IHS) within the past three months. Generally, members receiving free care at any VA facility cannot enroll in the CDHP because a HSA is automatically opened for them. Individuals are not eligible to make HSA contributions for any month if they receive medical benefits from the VA at any time during the previous three months. However, members may be eligible if they did not receive any care from a VA facility for three months, or member only receives care from a VA facility for a service-connected disability (it must be a disability). Go to https://www.irs.gov/irb/2004-33_IRB/ar08.html for HSA eligibility information.

HSA and FSA Restrictions

You cannot enroll in the CDHP/HSA if either you or your spouse have a medical flexible spending account (FSA) or health reimbursement account (HRA) at either employer. But if your employer offers one, you can have a limited purpose FSA (L-FSA) for vision or dental expenses along with your HSA.

Pharmacy

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. Specialty drugs must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price for these certain medications, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication. The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), diabetes (oral medications, insulins, needles, test strips and lancets) and some osteoporosis medications.

Eligible members will be able to receive certain low-dose statins in-network at zero cost share. These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

Any and all compound medications (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound medications require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Members won't have to pay for some specific medications used to treat opioid dependency.

Basic Features of the Health Options

In-network	PPOs (Premier & Standard)	CDHP/HSA
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 CDHP	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 CDHP	Higher than the PPOs
Physician Office Visits — includes specialists and behavioral health and substance use 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 CDHP	Lower than the PPOs
Health Savings Account	None	The state will contribute $250 for single coverage and $500 for family coverage to help offset the deductible — your contributions are pre-tax

2021 Benefit Comparison

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications. In the table, $ = your copayment amount; % = your coinsurance; and 100% covered or No charge = you pay $0 in-network. See footnote on page 19.

Note: This grid is available in a one-page, easy-to-use format at this link on the Benefits Administration website: https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/benefit_grid_2021_st_he_final.pdf

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS				
Well-baby, well-child visits as recommended Adult annual physical exam Annual well-woman exam Immunizations as recommended Annual hearing and non-refractive vision screening Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45	No charge	$50
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA				
Primary Care Office Visit 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	$45	$30	$50
Specialist Office Visit Including surgery in office setting Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45	$70	$50	$75
Behavioral Health and Substance Use [2] Including virtual visits	$25	$45	$30	$50
Telehealth (approved carrier programs only)	$15	N/A	$15	N/A
Allergy Injection Without an Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic and Acupuncture Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75
Convenience Clinic	$25	$45	$30	$50
Urgent Care Facility	$45	$70	$50	$75
Emergency Room Visit	$150		$175	
PHARMACY				
30-Day Supply	$7 generic; $40 preferred brand; $90 non-preferred	copay plus amount exceeding MAC	$14 generic; $50 preferred brand; $100 non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 generic; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 generic; $40 preferred brand; $160 non-preferred	N/A - no network	$14 generic; $50 preferred brand; $180 non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10%; min $50; max $150	N/A - no network	10%; min $50; max $150	N/A - no network

CDHP/HSA Member Costs	
IN-NETWORK [1]	OUT-OF-NETWORK [1]
No charge	40%
20%	40%
20%	40%
20%	40%
20%	N/A
20%	40%
20%	40%
20%	40%
20%	40%
20%	
20%	40% plus amount exceeding MAC
20%	N/A - no network
10% without first having to meet deductible	N/A - no network
20%	N/A - no network

2021 Monthly Premiums for Health

ALL REGIONS				
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS	EMPLOYER SHARE
PREMIER PPO				
Employee Only	$140	$140	$180	$558
Employee + Child(ren)	$210	$210	$250	$837
Employee + Spouse	$292	$292	$372	$1,172
Employee + Spouse + Child(ren)	$362	$362	$442	$1,451
STANDARD PPO				
Employee Only	$95	$95	$135	$558
Employee + Child(ren)	$143	$143	$183	$837
Employee + Spouse	$200	$200	$280	$1,172
Employee + Spouse + Child(ren)	$248	$248	$328	$1,451
CDHP/HSA				
Employee Only	$62	$62	$102	$558
Employee + Child(ren)	$91	$91	$131	$837
Employee + Spouse	$129	$129	$209	$1,172
Employee + Spouse + Child(ren)	$158	$158	$238	$1,451

2021 Benefit Comparison, continued

PPO services in this table ARE subject to a deductible unless noted with a [5]. CDHP/HSA services in this table ARE subject to a deductible with the exception of in-network preventive care. In the table, % = your coinsurance. See footnote on page 19.

Note: This grid is available in a one-page, easy-to-use format at this link on the Benefits Administration website: https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/benefit_grid_2021_st_he_final.pdf

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES				
Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge [5]	40%	No charge [5]	40%
OTHER SERVICES				
Hospital/Facility Services [4] Inpatient care; outpatient surgery Inpatient behavioral health and substance use [2] [6]	10%	40%	20%	40%
Maternity Global billing for labor and delivery and routine services beyond the initial office visit	10%	40%	20%	40%
Home Care [4] Home health; home infusion therapy	10%	40%	20%	40%
Rehabilitation and Therapy Services Inpatient and skilled nursing facility [4]; outpatient Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10%	40%	20%	40%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	10%		20%	
Advanced X-Ray, Scans and Imaging Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10%	40%	20%	40%
All Reading, Interpretation and Results [5]	10%		20%	
Ambulance (Air and ground)	10%		20%	
Equipment and Supplies [4] Durable medical equipment and external prosthetics Other supplies (i.e., ostomy, bandages, dressings)	10%	40%	20%	40%
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered subject to applicable deductible and 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 – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT TOWARD THE OUT-OF-POCKET MAXIMUM				
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
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION				
For individuals who enroll in the CDHP/HSA	N/A		N/A	

CDHP/HSA Member Costs	
IN-NETWORK [1]	OUT-OF-NETWORK [1]
No charge	40%
20%	40%
20%	40%
20%	40%
20%	40%
20%	40%
20%	40%
20%	
20%	
20%	40%
See separate sections in the Member Handbook for details.	
$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: $250 for employee only; $500 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

Using Edison ESS

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system. When using Employee Self Service (ESS) in Edison on your computer to add/make changes to benefits, Internet Explorer 11 is the preferred browser. You may also enroll on your smart phone or mobile device.

Passwords

If you have trouble logging in to Edison, go to the Edison home page and click on the Retrieve Access ID button if you have logged in before and don't remember your Access ID, or click the First Time Login / New Hire link if you have never logged in before. If you know your Access ID but need to reset your password, click the red Employee Portal Login button, enter your Access ID, and click Continue. Then click the link that says Forgot your Password? You can also view helpful troubleshooting videos on the Partners for Health website at https://www.tn.gov/partnersforhealth/videos.html.

- Active State of Tennessee employees can call the Edison Help Desk for password assistance at 866.376.0104.
- Higher Education employees can call the Benefits Administration Service Center at 800.253.9981 or 615.741.3590.

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 (MAC) 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 Plan**, the deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied. See the "Out of Pocket Maximums" section in the Member Handbook for more details. For CDHP Plan, coinsurance is after deductible is met unless otherwise noted.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. 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/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[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), depression and osteoporosis medications.

[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.

[5] For PPO Plans, the deductible DOES NOT apply.

[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - PPO members won't have to pay a deductible or coinsurance for facility-based substance use treatment; CDHP members must meet their deductible first, then coinsurance is waived. Copays for PPO and deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

Disability Insurance

The state offers voluntary disability benefits to full-time state and higher education employees.

- Full-time **state employees** may enroll in short term disability (STD) insurance and/or long term disability (LTD) insurance.
- Full-time **higher education employees** may enroll in short term disability insurance. Higher education employees should contact their agency benefits coordinators for more information on long term disability insurance available to them.
- Those who enroll will pay 100% of the premium with after-tax dollars. By paying with after-tax dollars, any benefits paid to you will result in a tax free benefit.
- **State employees only:** If you intend to enroll in both short term and long term disability insurance, you should consider enrolling in one of the long term disability options with a 180-day elimination period. The 26-week short term disability insurance will best cover the 180-day elimination period for your long term disability, at a lower monthly cost.
- Enroll in either or both of the state group insurance disability programs within the first 31 days of your eligibility date and you will not be required to answer any medical history questions. If you wait to apply for coverage during the next annual enrollment period or due to a special qualifying event, you will be required to answer questions about your full medical history. MetLife will review your completed medical questionnaire and determine whether to approve or deny your coverage.
- **You must use all of your accumulated leave (sick, annual and compensatory or comp time) before your disability payments begin.**
- Benefits payable during the payable benefit period may be reduced by other sources of income, e.g., worker's compensation, unemployment insurance, and sick leave bank. See the certificate of coverage for a comprehensive list of other sources of income which may reduce the STD and/or LTD benefit.

Why is having disability insurance important?

Disability Insurance is insurance for your paycheck. If you are unable to work due to sickness, pregnancy or as a direct result of accidental injury, disability insurance can help pay your most important expenses. These include:

- Mortgage or rent
- Car payments
- Food
- Child care/tuition
- Utilities

Short term disability insurance (available to state and higher education employees)

Short term disability insurance replaces a percentage of your income during a disability, which could last up to 26 weeks. It may be good for those who:

- Have little annual or sick leave
- Take part in high-risk activities
- Don't have six-month emergency funds

To calculate your monthly premium, go to metlife.com/StateOfTN, click on state employees or higher education employees and then click on **Rates** at the top.

Long term disability insurance (available to state employees only)

Long term disability insurance replaces a percentage of your income during a disability that is expected to last for an extended period of time. This period of time is typically longer than 90 or 180 days. It may be good for those who:

- Need their income to pay for housing, food and other bills
- Would have trouble supporting themselves if out of work more than 90 days

For more information and to calculate your rates, go to metlife.com/StateOfTN.

The State Group Insurance Program long term disability and short term disability insurance plans are both managed by MetLife. Please call the MetLife State of Tennessee Dedicated Customer Service Line with questions: 855.700.8001, Mon.-Fri., 7 a.m.-10 p.m., Central time.

Note: A complete description of the benefits, provisions, conditions, limitations and exclusions for both the MetLife STD and LTD plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. These documents may be reviewed at https://www.tn.gov/partnersforhealth/publications/publications.html.

Short Term Disability Options

	Option A	Option B
Eligibility	All employees working not less than 30 hours/week or seasonal employees hired prior to July 1, 2015, with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June), or deemed eligible by applicable federal law, state law or action of the State Insurance Committee.	
% of Gross Annual Base Salary[1] Paid Weekly	60% of salary paid weekly	
Maximum Weekly Benefit	Up to $2,500	
Minimum Weekly Benefit[2]	$25	
Elimination (Waiting) Period	14 calendar days	30 calendar days
Duration of Benefit	26 weeks	
Evidence of Insurability (EOI)[3]	Guaranteed Issue (no health questions asked) for New Hires who enroll within 31 days of eligibility date. A full Statement of Health is required for all new applicants and for current participants electing a higher plan of benefit during the 2021 Annual Enrollment period.	
Pre-existing Condition[4]	None	

1 Annual salary will be based on your date-of-hire salary for new hires; thereafter, the gross base annual salary you make on September 1 of each calendar year determines the benefit you are eligible for beginning October 1 of each calendar year.

2 The Minimum Monthly Benefit will not apply if you are receiving 100% of Your Predisability Salary under your employer's paid leave policy, which includes annual, sick and comp time.

3 MetLife will review your information and evaluate your request for coverage based upon your answers to the health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage.

4 Pre-existing Condition means a Sickness or accidental injury for which you: 1) received medical treatment, consultation, care or services; or took prescribed medication or had medications prescribed; in the 3 months before Your insurance under the certificate takes effect.

2021 Monthly Premiums for Short Term Disability (STD)

STD COST: PER $100 OF MEMBER'S COVERED MONTHLY SALARY	
Option A: 60%, 14-day elimination period	$1.34
Option B: 60%, 30-day elimination period	$1.08

Long Term Disability Options

	Option 1	Option 2	Option 3	Option 4
Eligibility	All employees working not less than 30 hours/week; seasonal employees hired prior to July 1, 2015 with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June); or deemed eligible by applicable federal law, state law, or action of the State Insurance Committee			
% of Gross Annual Base Salary[1] Paid Monthly	60% of salary paid monthly		63% of salary paid monthly	
Maximum Monthly Benefit	Up to $7,500 per month (covers annual salary of $150,000)		Up to $10,000 per month (covers annual salary of $190,476.24)	
Minimum Monthly Benefit[2]	Greater of 10% of benefit or $100 per month			
Elimination (Waiting) Period	90 calendar days	180 calendar days	90 calendar days	180 calendar days
Own Occupation	24 months	24 months	36 months	36 months
Maximum Benefit Period	Disabled prior to age 65, then to Social Security Normal Retirement Age (SSNRA); Age 65, 24 months; Age 66, 21 months; Age 67, 18 months, Age 68, 15 months; age 69+, 12 months			
Evidence of Insurability (EOI)[3]	Guaranteed Issue (no health questions asked) for New Hires who enroll within 31 days of eligibility date. A full Statement of Health is required for all new applicants and for current participants electing a higher plan of benefit during the Annual Enrollment period.			
Pre-existing Condition[4]	3 months prior to effective date and 12 months from effective date			

1 Annual salary will be based on your date-of-hire salary for new hires: thereafter, the gross base annual salary you make on September 1 of each calendar year determines the benefit you are eligible for beginning October 1 of each calendar year.

2 The Minimum Monthly Benefit will not apply if you are receiving 100% of Your Predisability Salary under your employer's paid leave policy, which includes annual, sick and comp time.

3 MetLife will review your information and evaluate your request for coverage based upon your answers to the health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage.

2 Pre-existing Condition means Sickness or accidental injury for which you: 1) received medical treatment, consultation, care or services; or took prescribed medication or had medications prescribed; in the 3 months before Your insurance under the certificate takes effect.

2021 Monthly Premiums for Long Term Disability (LTD)

LTD: EMPLOYEE'S AGE (PER $100 OF COVERED MONTHLY SALARY)										
Benefit %/ Elimination Period	**Under 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
Option 1 60%/90 days	$.20	$.20	$.40	$.59	$.75	$.92	$1.10	$1.46	$.97	$.97
Option 2 60%/180 days	$.16	$.16	$.31	$.46	$.59	$.72	$.86	$1.14	$.76	$.76
Option 3 63%/90 days	$.24	$.24	$.49	$.72	$.91	$1.12	$1.34	$1.78	$1.18	$1.18
Option 4 63%/180 days	$.19	$.19	$.39	$.57	$.72	$.89	$1.06	$1.41	$.94	$.94

Dental Insurance

Two different dental plans are offered. You pay the full monthly premium. 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.

2021 Monthly Premiums for Dental

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	$13.84	$23.64
Employee + Child(ren)	$28.75	$54.36
Employee + Spouse	$24.54	$44.72
Employee + Spouse + Child(ren)	$33.74	$87.50

Prepaid Plan (Cigna)

- Must select and use a network general dentist (NGD) from the prepaid dental plan list for each covered family member — the network is a select number of dentists in Cigna Dental HMO (DHMO). You may select a network pediatric dentist as the NGD for your dependent child under age 13. At age 13, you must switch the child to a NGD or pay the full charge from the pediatric dentist. The list of providers for the state may be found by visiting the website, https://www.cigna.com/sites/stateoftn/.
- Copays for dental treatments, including adult and child orthodontia for up to 24 months
- An office visit fee copay applies per patient, per office visit, and is in addition to any other applicable patient charges
- No claim forms
- Preexisting conditions are covered if they are listed in the patient charge schedule, unless treatment starts before coverage begins
- Certain limitations and exclusions apply. Please refer to the patient charge schedule and the Cigna dental certificate (https://www.tn.gov/partnersforhealth/publications/publications.html) for additional details
- Referrals to specialists are required
- 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 applies
- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna. The completion of crowns, bridges, dentures or root canal treatment already in progress on the member's effective date of coverage is also not covered.

DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. The list of network providers in the MetLife DPPO network for the state may be found by visiting the website, https://www.metlife.com/stateoftn/.
- $1,500 calendar year benefit maximum per person
- Deductible applies for basic and major dental care. Coinsurance for basic, major, orthodontic and out-of-network covered services
- You or your dentist will file claims for covered services
- Referrals to specialists are not required
- Pre-treatment estimates are recommended for more expensive services
- Benefits for covered services are paid at the lesser of dentist charge, maximum allowable charge or alternate benefit amount
- Some services require waiting periods of six months and up to one year, and certain limitations and exclusions apply
- Lifetime benefit maximum of $1,250 for orthodontia

NOTE: A complete description of the benefits, provisions, conditions, limitations and exclusions for both the MetLife and Cigna dental plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. These documents may be reviewed at https://www.tn.gov/partnersforhealth/publications/publications.html.

Dental Insurance Benefits at a Glance

The benefits listed below are a sample of the most frequently utilized dental treatments. For a complete list of copays for the Cigna Prepaid option, please refer to the patient charge schedule. Review the Cigna certificate of coverage for complete details on benefits, limitations and exclusions. Both documents are at cigna.com/stateoftn.

MAC or maximum allowable charge is the highest dollar amount of reimbursement for specific dental procedures provided by DPPO network providers. The in-network dentists have agreed to not charge members or the plan more than the MAC. When a member receives dental services from an out-of-network provider, the out-of-network dentist will be paid by the plan for covered procedures according to the in-network MAC and respective plan coinsurance. The member then is responsible for all other charges by the out-of-network dentist. Review additional information on the ParTNers for Health website tn.gov/partnersforhealth.html under Other Benefits and Dental.

	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
COVERED SERVICES	**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 Two Surfaces Permanent teeth	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$125 copay[7]	$600 copay [7]	20% of MAC	40 % of MAC
Major Restorations — Crowns	$190 copay, plus lab fees [3] [7]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Implant (endosteal)	$1,025 copay [7]	$1,025 copay [7]	50% of MAC [4][8]	
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][7]		50% of MAC [4] [8]	
Orthodontics	$140 monthly copay for treatment equal or less than 24 months. Then, full charge.[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	$3,360 copay ($140 x 24 months) for treatment fee only. Then, member pays full charge after initial 24 months. [6]		$1,250 [5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

[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. (See #8 for additional information for dentures and implants.)

[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. Cigna will not cover orthodontic procedures after a member's effective date with Cigna Prepaid if orthodontic treatment began prior to the member's effective date. Orthodontic treatment started under the prior Cigna Prepaid contract with the state will continue to be covered under the new Cigna Prepaid contract effective January 1, 2021.

[7] Completion of crowns, bridges, dentures, implants, or root canal already in progress on member's effective date of coverage with Cigna Prepaid will not be covered.

[8] A 12-month waiting period applies to dentures and implants to replace one or more natural teeth missing before member's effective date of coverage.

Vision Insurance

Voluntary vision coverage is available to state and higher education employees and dependents. You must pay 100% of the premium for coverage. Two options are available: a basic and an expanded plan. Both offer:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglasses or contact lenses once every calendar year
- Discount on LASIK/Refractive surgery
- Discount on hearing aids (includes Free Hearing Exam) through Your Hearing Network (YHN)

What you pay for services depends on the plan you choose. The Basic Plan pays for your eye exam and various "allowances" (dollar amounts) for materials such as eyeglass frames, lenses, contact lenses, etc. The Expanded Plan includes greater "allowances" (dollar amounts) and additional materials versus the Basic Plan. See the benefit chart on the following page to compare benefits in both plans.

The basic and expanded plans are both administered by Davis Vision. You will receive the maximum benefit when visiting a provider in their 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/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.

Davis Vision offers some value-added services which include:

- Zero copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location
- Free pair of "Fashion Selection" eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Basic Plan. "Designer" and "Premier" Selections have $15 and $40 copays respectively
- Free pair of eyeglass frames from any Davis Vision's "The Exclusive Collection", which includes "Fashion, Designer and Premier" Selections under the in-network Expanded Plan
- Free pair of frames at Visionworks retail locations
- 40% discount off retail under the in-network Expanded plan and 30% discount off retail under the in-network Basic plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations
- 20% discount off retail cost of additional pair of conventional or disposable contact lenses under in-network Expanded plan
- One year warranty for breakage of most eyeglasses

Covered Vision Services

Here is a comparison of discounts, copays and allowed amounts for 2021 under the vision options. Copays represent what the member pays. Allowances and percentage discounts represent the cost the carrier will cover. Actual costs and benefits may vary based upon the plan design selected. Exclusions and limitations may apply. Out-of-network member costs can be found in the Davis Vision Handbook at https://www.tn.gov/partnersforhealth/publications/publications.html.

SERVICE	BASIC PLAN IN-NETWORK COSTS [1]	EXPANDED PLAN IN-NETWORK COSTS [1]
Eye Exam With Dilation as Necessary	$0 copay	$10 copay
Retinal Imaging	$39 copay	$39 copay
Contact Lens fit and Follow up (standard/specialty)	80% of charge	$50/$60 copay
Eyeglass Benefit—Frame		
Retail Frame	80% of balance over $55[2]	80% of balance over $150[2]
Visionworks Frame	Covered in full	Covered in full
The Exclusive Collection[3] (Fashion/Designer/Premier)	In lieu of retail frame $0/$15/$40 copay	In lieu of retail and Visionworks frame $0/$0/$0 copay
Eyeglass Benefit—Spectacle Lenses		
Single Vision, Bifocal, Trifocal & Lenticular Lenses	$0 copay	$0 copay
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	80% of balance over $55; not to exceed $65/$105/$140/$175 out of pocket	$50/$90/$140/$175 copay
High-index (1.67/1.74)	80% of charge not to exceed $60/$120	$60 copay/$120 copay
UV Treatment	80% of charge up to $15	$10 copay
Tint (solid and gradient)	80% of charge up to $15	$15 copay
Standard Polycarbonate (adults/children[4])	80% of charge up to $35/$0 copay	$30 copay/$0 copay
Anti-reflective Coating (Standard/Premium/Ultra/Ultimate)	80% of charge up to $40/$55/$69/$85	$40/$55/$69/$85 copay
Polarized	80% of charge up to $75	80% of charge up to $75
Plastic Photochromic Lenses	80% of charge up to $70	80% of charge up to $70
Scratch coating (standard plastic/premium scratch-resistant)	$0 copay/80% of charge up to $30	$0 copay/$30 copay
Scratch Protection Plan (single vision/multifocal lenses)	$20 copay/$40 copay	$20 copay/$40 copay
Trivex Lenses	80% of charge up to $50	$50 copay
Digital Single Vision (intermediate) lenses	80% of charge up to $30	$30 copay
Blue Light Filtering	80% of charge up to $15	$15 copay
Other Add-ons and Services	80% of charge	80% of charge
Contact Lenses		
Conventional and Disposable	80% of balance over $55	80% of balance over $140
Visually Required[5]	80% of balance over $155	$0 copay
Frequency of Vision Benefits		
Eye Exam	Once every calendar year	Once every calendar year
Eyeglass Lenses	Once every calendar year	Once every calendar year
Frames	Once every two calendar years	Once every two calendar years
Contact Lenses	Once every calendar year in lieu of eyeglasses	Once every calendar year in lieu of eyeglasses
Contact Lens Evaluation, Fitting and Follow-up	Once every calendar year in lieu of eyeglasses	Once every calendar year in lieu of eyeglasses

[1] Member pay will not be greater than the copay, but could be less based upon the actual charge.
[2] $0 copay for eyeglass frames at Visionworks.
[3] Collection is available at most participating eye care professional offices. Collection is subject to change.
[4] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
[5] If visually required as first contact lenses following cataract surgery, or multiple pairs of rigid contact lenses for treatment of keratoconus.

Additional Benefits

- High Index Lenses — 1.74
- Progressive Lenses — Ultimate Tier
- Anti-reflective Coating — Ultimate Tier
- Premium Scratch-resistant Coating
- Digital Single Vision Lenses
- Trivex Lenses
- Blue Light Filtering (Coatings & Lens Options)
- Scratch Protection Plan

NOTE: A complete description of the benefits, provisions, conditions, limitations and exclusions for the Davis Vision Basic and Expanded plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. The documents are available at https://www.tn.gov/partnersforhealth/publications/publications.html.

2021 Monthly Premiums for Vision

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.07	$5.56
Employee + Child(ren)	$6.13	$11.12
Employee + Spouse	$5.82	$10.57
Employee + Spouse + Child(ren)	$9.01	$16.35

Employee Assistance Program

Your Employee Assistance Program (EAP) is administered by Optum. EAP services are available to all benefits-eligible state/higher education employees and their eligible dependents, even if they are not enrolled in a health plan.

Master's level specialists are available 24/7 to assist with stress, legal, financial, mediation and work/life services.

- Get five EAP counseling visits, per problem, per year, per individual at no cost to you. Available in person or by virtual visit . Get the care you need in the privacy and comfort of your own home.
- Use Sanvello, an on-demand mobile app to help with stress, anxiety and depression. Available anytime at no extra cost at HERE4TN.com.
- Participate in a telephonic coaching program called Take Charge at Work. It helps people (EAP-eligible and working) dealing with stress or depression improve performance at work. Available at no additional cost if you qualify. Participants can earn a wellness program cash incentive, if eligible.

Here4TN Behavioral Health and Substance Use Services

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. All enrolled members will get an ID card from Optum to use for your behavioral health services.

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Optum can help you find a provider (in person or virtual visits), explain benefits, identify best treatment options, schedule appointments and answer your questions.

Costs are waived for members who use certain preferred substance use treatment facilities. PPO members who use these facilities won't pay a deductible or coinsurance for facility-based substance use treatment. CDHP/HSA members' coinsurance is waived after meeting their deductible. However, copays for PPO members and the deductible/coinsurance for CDHP/HSA members will still apply for standard outpatient treatment services.

To receive maximum benefit coverage, participants must use an in-network provider. For assistance finding a network provider, call 855.Here4TN (855.437.3486).

For virtual visits, you can meet with a provider through private, secure video conferencing. Virtual visits allow you to get the care you need sooner and in the privacy of your home. Virtual visit costs are the same as an office visit.

Talkspace online therapy is also available for all members with behavioral health benefits. Download the application (app) through Here4TN.com. You can communicate safely and securely 24/7 with a therapist from your smartphone or desktop. Talkspace sessions are subject to the same cost share or coinsurance rate (after deductible) as an outpatient office visit.

ParTNers for Health Wellness Program

State and higher education members and enrolled spouses have access to a wellness program administered through our vendor ActiveHealth Management. They can help you achieve your health goals through special programs and resources, and you can also get rewarded for taking action by earning cash incentives that will be deposited through payroll*.

Here's how it works:

You and your enrolled spouse can each earn up to $250 a year by completing certain wellness activities (if eligible). Each participant will be able to earn the maximum $250 per person ($500 annual maximum per family). You must first complete ActiveHealth's health assessment before you can earn the cash incentives. **Note:** New hires/new plan members, your earnings may be limited depending on your hire date.

There are a variety of programs to choose from. They include:

- Biometric screenings
- Weight management program**
- Tobacco cessation program
- Wellness counseling (diet, stress, exercise, etc.)
- Digital coaching
- Disease management program
- Group coaching for lifestyle and disease management programs
- Online resources (challenges, health education library with videos and articles)

A printable Incentive Table and information about programs and activities are at www.tn.gov/partnersforhealth, under Other Benefits and Wellness.

*Members must be in a positive pay status to receive an incentive. The cash incentive for both the employee and eligible spouse will be deposited directly into the member's paycheck and will be taxed.

** To be eligible to enroll, your BMI must be equal or greater than 30.

Diabetes Prevention Program

Health plan members also have access to a free Diabetes Prevention Program if you meet eligibility criteria. The program can help you prevent or delay type 2 diabetes. It's offered as part of your health insurance at no cost if you use an in-network provider. There are two online programs offered; one for Cigna members through Omada, and another for BlueCross BlueShield members through Livongo. We also have an in-person program available through the ParTNers Health and Wellness Center.

For details, go to tn.gov/partnersforhealth under Other Benefits and Wellness and scroll down to the Diabetes Prevention Program (DPP) webpage.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program available to all state and higher education employees and spouses enrolled in health coverage. Local education, local government and retirees enrolled in health coverage have access to certain programs like disease management and the web portal. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You are not required to complete the assessment or other medical examinations.

Although you are not required to complete the health questionnaire, only active state and higher education employees and spouses who do so are eligible to receive cash incentives.

If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the ParTNers for Health Wellness Program at 888.741.3390.

The information from your health questionnaire and the results from your biometric screening (active state and higher education employees and spouses only) will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer you services through the wellness program such as weight management, Diabetes Prevention Program and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information (PHI). Although the wellness program and the State of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the ParTNers for Health Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness vendor (nutritionists, nurses, nurse practitioners, registered dietitians, health coaches and other healthcare professionals) and their vendor partners (case managers with the medical and behavioral health vendors, weight management vendor and the biometric screening vendor) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified promptly.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ParTNers for Health at partners.wellness@tn.gov.

Life Insurance

Securian Financial has an online tool, Benefit Scout, to help you estimate the amount of life insurance you need at lifebenefits.com/stateoftn.

Basic Group Term Life and Accidental Death & Dismemberment Insurance

The state provides, at no cost to you, $20,000 of basic term life insurance and $40,000 of basic accidental death & dismemberment (AD&D) coverage. If you enroll in health insurance as the head of contract, 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 basic term life and $100,000 for accidental death & 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 on age or salary take effect the first day of October based on your age and salary as of September 1.

Eligible dependents (spouse and children) enrolled in health insurance are covered for $3,000 of basic dependent term life coverage and for basic AD&D. The amount of AD&D coverage is based on salary and family composition. If you do not enroll in health coverage, your dependents are not eligible for basic term life or basic AD&D coverage.

Voluntary Accidental Death & Dismemberment

You and your dependents (spouse and children) may enroll in this coverage at low group rates, no questions asked. It is in addition to the basic AD&D coverage and you must pay a premium. Benefits are paid for dismemberment if the loss occurs within 180 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 your salary. The maximum benefit for you is $60,000.

Voluntary Term Life Insurance

You and your dependents 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, without answering health questions. 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 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 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 certificate or your spouse's certificate, but not both. These amounts will cover all eligible 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 each January 1st if you move into a higher age bracket. It also offers an advance benefit rider, which allows payment of the life insurance proceeds if an insured encounters a terminal illness with a life expectancy of no more than 12 months.

Enroll

Computer enrollment for Voluntary Term Life — It's easy to enroll (and to designate your beneficiary) online.

1. Log on to lifebenefits.com/stateoftn with the ID and password provided 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 Financial at 1.866.881.0631 or from your agency benefits coordinator.

2. 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.

3. Clean up. Clear your personal information before leaving the computer.

To enroll for Voluntary AD&D — Please log into Edison and complete your enrollment and designate your beneficiary or utilize a paper form. Consult with your agency benefits coordinator in your human resources office on the appropriate method to use for enrollment.

Your enrollment in Basic Term Life and Basic AD&D — Will be automatically processed based upon your enrollment choice for medical insurance in Edison. You should sign-on to Edison to enter your beneficiary information.

For more details, refer to the member handbook, available on the Publications page at https://www.tn.gov/partnersforhealth/publications/publications.html. Your agency benefits coordinator can provide premium information. For Securian Financial (Minnesota Life) go to lifebenefits.com/stateoftn or call 866.881.0631.

Note: A complete description of the benefits, provisions, conditions, limitations and exclusions for the Securian Financial Basic Life/AD&D, Voluntary AD&D, and Voluntary Life plans will be included in their respective Certificates of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. The documents are available at https://www.tn.gov/partnersforhealth/publications/publications.html.

Flexible Spending Accounts

Flexible spending accounts (FSAs) help you decrease your taxable income and increase your take-home pay. They allow you to pay certain expenses (such as healthcare and dependent care) from your pre-tax income rather than after-tax income. The maximum amount you can contribute to a FSA is set by the Internal Revenue Service (IRS). The limits are subject to change yearly. Unless you have an approved family status change, you cannot enroll in or cancel a medical, limited purpose or dependent care FSA in the middle of a calendar year.

Full-time, Insurance-eligible employees (excludes offline agencies) can enroll in the following FSAs:

- **Medical FSA:** For medical, dental and vision expenses (Annual limit: $2,750/Carryover limit: $500). If you enroll in the CDHP/HSA, you do not qualify for a medical FSA.
- **Limited Purpose FSA:** For dental and vision expenses only (Annual limit: $2,750/Carryover limit $500). If you have the CDHP/HSA, the Limited Purpose FSA is a great way to save on vision and dental expenses.
- **Dependent Care FSA:** For certain dependent-care costs, such as after school care and baby-sitting fees (Annual limit $5,000, up to $2,500 per spouse for married couples filing jointly/No carryover amount).
- **Transportation and Parking FSA:** Available to state employees only for certain work-related commuting and/or parking expenses (Monthly limit is $270). A debit card is not provided. Claims are filed with Benefits Administration.

Optum Bank administers all of the FSAs except Transportation and Parking.

Important:

- You cannot enroll in both a medical FSA and a Limited Purpose FSA in the same year.
- For Medical and Limited Purpose FSAs, all contributions are available up front.

Note: Medical FSA and Limited Purpose FSA members get debit cards to use their funds at the pharmacy or provider's office. Per IRS rules, Optum Bank may need you to verify some debit card purchases by providing your explanation of benefits or claims document. Make sure to respond or your debit card may be suspended.

There is an FSA/HSA chart showing contribution amounts, tax benefits and how to use your funds at tn.gov/partnersforhealth under Publications.

Enrollment

- State employees enroll in Edison for Medical, Limited and Dependent Care FSAs. For Transportation and Parking, state employees submit a paper form (https://www.tn.gov/partnersforhealth/publications/forms.html).
- Higher education employees enroll on the Optum Bank website at optumbank.com/Tennessee.

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together to determine which plan will pay first, how much each plan will pay, and how much you will pay. When this plan pays secondary you will pay your member cost share as noted in this guide on the Benefit Comparison. At no time should payments exceed 100% 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/her employer, that coverage would be primary for your spouse and secondary for you. Generally, Medicare will pay secondary unless the covered individual is enrolled in Medicare due to End Stage Renal Disease or disability, as other coordination of benefits rules may apply.

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 agency benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he/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 agency 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/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 have a problem with coverage or payment of medical, behavioral health and substance use or pharmacy services, there are internal and external procedures to help you. 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 member service numbers provided at the front of this guide. You can also find those numbers on your insurance cards. Benefits Administration is not involved in the appeal process. The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

Benefit Appeals

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

Different insurance carriers manage approvals and payments related to your medical, behavioral health, substance use and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you submit your request on time and direct it to the correct insurance carrier. For example, you or your authorized representative will have 180 days to start an internal appeal with the medical insurance carrier following notice of an adverse determination with regard to your medical benefits.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), you or your authorized representative should call the toll-free member service number on your insurance card. You or your authorized representative may file an appeal/member grievance by completing the correct 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.

LEGAL NOTICES

Anti-Discrimination and Civil Rights Compliance

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 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697 OR U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 OR Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

If you speak a language other than English, help in your language is available for free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-576-0029 (رقم 1-800-848-0298: هاتف الصم والبكم: 1)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው

ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با تماس بگیرید.

The Notice of Privacy Practice

Your health record contains personal information about you and your health. This information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). The Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), including Privacy and Security Rules. The notice also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practice is located on the Benefits Administration website at https://www.tn.gov/partnersforhealth.html. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. By law, we are required to inform plan members of this coverage yearly. You can find a copy of the required notice regarding your options on the Benefits Administration website, https://www.tn.gov/partnersforhealth.html.

If you are actively employed or a pre-65 retiree enrolled in health coverage, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age. Once your retiree group health coverage terminates due to becoming Medicare eligible you may want to enroll in Medicare prescription drug coverage if you need pharmacy benefits.

Summary of Benefits and Coverage

As required by law, the State of Tennessee Group Health Plan has created a Summary of Benefits and Coverage (SBC) for the state-sponsored health plans. The summary describes your 2021 health coverage options. You can view it online at https://www.tn.gov/partnersforhealth/summary-of-benefits-and-coverage.html or request that we send you a paper copy free of charge. To ask for a paper copy, call Benefits Administration at 855.809.0071.

Plan Document

The information contained in this guide provides a detailed overview of the benefits available to you through the State of Tennessee. More information is contained within the formal plan documents. If there is any discrepancy between the information in this guide and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at https://www.tn.gov/partnersforhealth/publications.html.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at https://www.tn.gov/partnersforhealth/publications.html, including, but not limited to, a sample basic term life/basic AD&D certificate, sample voluntary AD&D certificate, brochures and handbooks for medical, pharmacy, dental, vision, life insurance and the plan document, brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).

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

Employee Benefits Guide

2021

Volunteer State Community College is an Affirmative Action/Equal Opportunity Employer
1480 Nashville Pike, Ramer Administration Bldg. STE 127, Gallatin, TN
37066, Phone: (615) 230-3592 Fax: (615) 230-3314

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Affordable Care Act (ACA) Health Insurance Market Place Notice

January 1, 2021

Volunteer State Community College is required to provide the attached notice to all employees (full and part- time) as part of The Affordable Care Act (ACA).

The attached federally mandated notice is to provide you with information you need to know regarding this law and how you can participate in the new Health Insurance Marketplace.

- At this time, you are eligible to enroll in the State of Tennessee group health insurance program during the Annual Enrollment Transfer period (October 1 through November 1) for a January 1st effective date***. If you are currently enrolled in coverage through VSCC and do not wish to make changes to your coverage, no action is necessary.***

- For information regarding the health insurance plans available to you as a regular benefited employee, please visit our web page at https://www.tn.gov/partnersforhealth/health-options.html

- For questions regarding State of Tennessee group health insurance coverage and your eligibility, please contact the Office of Human Resources at 615-230-3592.

If you decide to shop for coverage in the Marketplace, please visit www.HealthCare.gov. The attached notice provides you with information about your health insurance eligibility and will assist you in making decisions about the Health Insurance Marketplace.

Revised 1/1/20 - Required Notice - Eligible

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.

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 **Office of Human Resources - (615)230-3592**

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.

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 **Volunteer State Community College**	**4. Employer Identification Number (EIN)** 62-0818836
5. Employer address 1480 Nashville Pike	**6. Employer phone number** 615-230-3592
7. City Gallatin	**8. State** **9. Zip Code** TN 37066
10. Who can we contact about employee health coverage at this job? Office of Human Resources	
11. Phone number (if different from above) 615-230-3592	**12.** Email address

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 program.

a. How much would the employee have to pay in premiums for this plan? $60.00
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 would the employee have to pay in premiums for this plan? $62.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☑ Monthly ☐ Quarterly ☐ Yearly Date of change (mm/dd/yyy): 01/01/2021 .

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 (Sections 35B©(2)(C)(ii) of the Internal Revenue Code of 1986)

Long Term Disability Insurance

Employees may enroll in a long-term disability insurance plan offered by Lincoln Financial Group. Long Term Disability Insurance replaces a portion of your income during a disability that is expected to last for an extended period of time. The cost is dependent upon your salary and the level of coverage you wish to carry. The plan offers three levels of coverage:

	Level 1	Level 2	Level 3
Maximum Monthly Benefit	$2,000	$4,000	$7,000
Income Replacement Percentage	Protects 50% of monthly wage base*	Protects 60% of monthly wage base*	Protects 60% of monthly wage base*
Elimination Period	180 days	120 days	90 days
Maximum Coverage Period	Up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later		
Premium Rate	.00146	.00237	.00280

Sample Premium Calculation:

Salary: 30,000/year	**Option 1**	**Option 2**	**Option 3**
Monthly Cost (Monthly salary multiplied by Rate) * If monthly salary exceeds $4,000, multiply $4,000 by 0.00146	$30,000/12 x .00146 = $3.65	$30,000/12 x .00237 = $5.93	$30,000/12 x .00280 = $7.00

To calculate your cost:

Enter your monthly salary*. $_____

Enter your rate from the table above: $_____

This is your monthly cost. $_____

*Maximum $4,000 for Option 1; $6,667 for Option 2, $11,667 for Option 3

When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage with no health examination.

State of TN Retirement Programs

Hired before July 1, 2014

Employees who became members of TCRS after July 1, 1981 and before July 1, 2014 are non-contributory. The State's non-contributory plan is referred to as the Legacy Plan.

Rehired employees are eligible for enrollment in the Legacy Plan as follows:

- Vested in Legacy Plan with a break in service – may return to Legacy Plan upon reemployment with State agency.
- Not vested in Legacy Plan and return to service in less than 7 years – may return to Legacy Plan.
- Not vested in Legacy Plan and return to service after 7 years – must enroll in new Hybrid Plan.
- If eligible for the Legacy Plan, the rehired employee must be enrolled in the same retirement plan he/she was previously a member (i.e. TCRS to TCRS Legacy and ORP to ORP Legacy).

All regular, full-time employees are required to participate in the retirement plan as a condition of employment. In addition to the State's retirement system, rehired employees will also be automatically enrolled to contribute 2% into a defined contribution plan (401k). While the auto-enroll is an automated process, employees do have an opportunity to 'opt-out' of the 2% contribution.

Auto-enroll:

Auto-enroll allows an employer to automatically deduct elective deferrals from an employee's wages unless the employee makes an election not to contribute or to contribute a different amount. Employees will receive a letter from the Defined Contribution Record-Keeper, which is currently Empower Retirement. Employees will have thirty (30) days from the date of the letter to opt-out or change the contribution amount.

Eligible rehired employees determined to be "Exempt" from the Fair Labor Standards Act (FLSA) have two (2) retirement plans available, the TCRS or ORP. Eligible rehired employees determined to be "Nonexempt" from the Fair Labor Standards Act (FLSA) have one retirement plan available, which is the TCRS. Rehired employees will be electronically enrolled in the same retirement plan he/she was previously a member (i.e. TCRS to TCRS Legacy and ORP to ORP Legacy).

Employees will be required to enter beneficiary information online once the account is set- up with the chosen vendor.

Additional information: ORP
https://treasury.tn.gov/Retirement/Retire-Ready-Tennessee/for-Higher-Education-Employees

TCRS—(800) 922-7772
https://treasury.tn.gov/Retirement/Information-and-Resources/TCRS-Overview-and-Self-Service

ORP and TCRS Comparison Chart

Hired before July 1, 2014

FEATURE	TCRS	ORP
Contributions	The member makes no contributions to the plan. The employer pays both the employee and employer costs for funding the benefits. A 2% employee auto-enroll contribution will also be made on behalf of all participants to the 401(k) plan for which a participant may opt- out or change his/her contribution amount at any time.	The member makes no contributions to the plan. The employer contributes 10% of gross salary covered by Social Security and 11% of salary in excess of the Social Security Wage Base. A 2% employee auto-enroll contribution will also be made on behalf of all participants to the 401(k) plan for which a participant may opt-out or change his/her contribution amount at any time.
Vesting	Higher education employees participating in TCRS are **vested after five (5) years** of service.	All contributions made to the plan are **100% vested from the date of contribution.**
Creditable Service	Vested members may also establish credit in TCRS for up to 4 years of eligible military service. At retirement, unused sick leave may be converted to retirement service credit at the rate of one month of service credit for each 20 days of leave.	Benefits are based on the member's account balance rather than on service. Contributions are credited to the member's account during service to a Tennessee higher education institution while a member of the ORP.
Retirement Benefits	TCRS retirement benefits are computed under a formula which uses the average of the member's highest five consecutive years of salary (while a member of TCRS) and the years of service credited in TCRS. Members are eligible for unreduced benefits upon attaining age 60 or 30 years of service. Reduced benefits are available upon attaining age 55 or 25 years of service.	**ORP benefits are based on the member's account balance and the member's age at the time benefits begin.** Members are eligible to begin drawing benefits at any age if separation from service has occurred.
Disability Benefits	Accidental disability retirement benefits are available immediately if a member is injured on the job. Ordinary disability retirement benefits are available to members with five (5) years of creditable service, regardless of where the member is employed at the time the disability occurs.	Upon disability retirement or upon termination of employment for any reason, the member may request an annuity settlement of lifetime distribution payout. Members receiving social security disability benefits may also elect a partial lump sum payment from their account, subject to the provisions of the product(s) the member selected.
Cost of Living Adjustment	TCRS retirement benefits are payable in the form of a fixed annuity. Compounded adjustments in the benefits to reflect increases in the Consumer Price Index (CPI) of up to 3% are made annually. Adjustments appear in the July 31 payment.	There are no automatic cost-of-living adjustments in most ORP payment options; however, the benefit payable under a variable annuity may fluctuate up or down depending on market conditions.
Payouts Methods	**Vested members are eligible to select a single life annuity or one of several joint and survivor annuities at retirement**. No refunds of contributions are provided for members who joined after July 1, 1981.	A member's account balance can be distributed in lump sum payments, partial lump sum payments, periodic payments, and required minimum distribution payments, among others. Payouts are subject to any restrictions on individual funds.
Death Benefits Before Retirement	The beneficiary of a TCRS member who dies before retirement may be eligible for one of the following benefits: (1) if the member is eligible to retire, TCRS will provide a survivor annuity to a surviving beneficiary upon the member's death before retirement; or (2) if the member has at least 10 years creditable service, the surviving spouse is eligible for a 100% joint and survivor annuity if the spouse is named as beneficiary; or (3) if the member has made contributions to TCRS, the beneficiary or estate may receive a lump-sum payment equal to twice the value of the member's accumulation.	The value of the total accumulation is payable to the named beneficiary or the estate. If the value of the accumulation is sufficiently large, the beneficiary may be eligible to elect an annuity payout.
Transfers Between TCRS and ORP	Employees who are eligible to participate in the ORP, but who elected to participate in TCRS, **may make a one-time election to transfer membership from TCRS to the ORP.** Members are advised to obtain a TCRS benefit estimate before making a decision to transfer.	Employees who participate in the ORP generally may not transfer membership to TCRS; however, beginning in 2005, **ORP members who reach five (5) years of service have a one-time transfer option.** This election must be made and filed no later than the end of the calendar year following the year that five (5) years of service is achieved.
Transfers Outside Tennessee's Plans	Employees who joined TCRS after July 1, 1981 may not transfer their TCRS account to another employer's plan or to an Individual Retirement Account (IRA).	Some employees who participate in the ORP may be eligible to transfer a portion of their Tennessee ORP account balance to another employer's plan or to an Individual Retirement Account (IRA) if they qualify for partial or total lump sum distribution.

State of TN Retirement Programs

Hired after July 1, 2014

All regular full-time employees of Volunteer State Community College are required to participate in a State of TN retirement program. Participation entails a mandatory 5% contribution by the employee. Employees will also be automatically enrolled to contribute an additional 2% into a defined contribution plan. While the mandatory 5% is a condition of employment, employees do have an opportunity to 'opt-out' of the additional 2% contribution to a 401(k). In addition to the employee contribution, Volunteer State Community College will contribute 4% (TN Consolidated Retirement System (TCRS) plus 5% to 401(k) or 9% (Optional Retirement Program (ORP) of salary annually.

Eligible employees determined to be "Nonexempt" from the Fair Labor Standards Act (FLSA) have one retirement plan available, which is TCRS.

Eligible employees determined to be "Exempt" from the Fair Labor Standards Act (FLSA) have two (2) retirement plans available to choose from, either TCRS or ORP.

NOTE:
The Treasury Department is requiring all newly hired employees to make a retirement election on his/her **FIRST DAY OF EMPLOYMENT**. Employees who do not make a binding retirement decision on the first day of employment will be automatically defaulted into TCRS.

Eligibility

- All regular full-time employees are required to participate.
- Regular part-time employees are eligible, but not required to participate.
- Employees who have current membership (because of previous State of TN employment) in either TCRS or the ORP may be eligible for the legacy TCRS/ORP programs.
- Non-Exempt employees will be enrolled in the TCRS.
- Exempt employees shall have the option of becoming a member of either TCRS or ORP.

State Retirement Program (Hybrid Plan)

The State retirement program is a combination of a defined benefit plan and a defined contribution plan. The defined benefit portion is managed by TCRS and benefits are defined according to length of service, age and salary. The defined contribution portion is managed by Empower Retirement Services and assets will be deposited into the State's 401(k) plan. Contributions are both employee and employer paid.

Employees participating in TCRS are **vested after five (5) years** of service. A member becomes eligible for service retirement at age 65 with the completion of five (5) years of creditable service or the Rule of 90. The Rule of 90 means the completion of a combination of age and years of creditable service as to equal 90. A member becomes eligible for reduced early retirement benefits at age 60 with the completion of five (5) years of creditable service or the Rule of 80. The Rule of 80 means the completion of a combination of age and years of creditable service as to equal 80. TCRS provides retirement benefits as well as death and disability benefits to plan members and their beneficiaries. Also, a member may establish up to four (4) years of credit for active military duty service. At retirement, unused sick leave may be converted to retirement service credit at the rate of one (1) month of service credit for each 20 days of leave.

State Retirement Program Highlights

- Defined benefit contributions: (TCRS)
  - Employee contributes 5% of gross salary
  - Employer contributes 4% of gross salary
- Defined contribution (the State's 401(k) plan):
  - Employee contributes 2% of gross salary (with opt-out feature)
  - Employer contributes 5% of gross salary
  - Employer match up to $50 per month
- Five (5) year vesting for defined benefit portion
- Defined benefit retirement benefit is based on years of service, age and average salary
- Disability benefit available if vested
- May apply additional service credit for sick leave accruals and military leave

TCRS Contributions and Match:

	Defined Benefit	Defined Contribution	Total
Employer Contributions	4%	5%	9%
Employee Contributions: Required	5%	0%	5%
Employee Contributions: Auto-enroll [1]	NA	2%	2%
Employee Contributions: Voluntary [2]	NA	IRS Limit	IRS Limit
Employer Contributions: 401k [3]	NA	$50 match	$50 match
Total (excluding $50 match)	9%	7%	16%

[1] Employees may opt out of the auto-enroll contributions.
[2] Employees may make additional voluntary contributions to the 401(k), 457, and 403(b) plan up to Federal IRS limit.
[3] Employer match up to $50 per month for employees contributing to 401k.

Employees electing to participate in TCRS will receive an Active Member Welcome Packet. This packet is mailed to the home address and will contain instructions on accessing Member Self-Service (MSS) and electing a beneficiary.

Additional information: TCRS—(800) 922-7772
https://treasury.tn.gov/Retirement/Information-and-Resources/TCRS-Overview-and-Self-Service

Optional Retirement Program (ORP)

ORP is a defined contribution 401(a) plan. Employees who participate in the ORP may direct contributions to one or more of the three vendors designated under the State's ORP. These companies are TIAA, AIG (VALIC), and VOYA. Auto-enrollment into the State's 401(k) is included with this plan. Contributions are both employee and employer paid.

Employees participating in ORP are **100% vested from the date of contribution**. Once funds are on deposit, the participant may move funds among the investment accounts offered under the company's annuity contract, subject to restrictions of the contract. An employee may request assistance from one or more ORP representative(s) listed below.

Optional Retirement Program Highlights

- Employee contributes 5% of gross salary
- Employee contributes 2% of gross salary (with opt-out feature)
- Employer contributes 9% of gross salary
- Vested from the date of contribution
- Participant directed investment program
- Benefits are determined by the employees account balance

ORP Contributions and Match:

	ORP	Defined Contribution	Total
Employer Contributions	9%	0%	9%
Employee Contributions: Required	5%	0%	5%
Employee Contributions: Auto-enroll [1]	NA	2%	2%
Employee Contributions: Voluntary [2]	NA	IRS Limit	IRS Limit
Employer Contributions: 401k [3]	NA	$50 match	$50 match
Total (excluding $50 match)	14%	2%	16%

[1] Employees may opt out of the auto-enroll contributions.
[2] Employees may make additional voluntary contributions to the 401(k), 457, and 403(b) plan up to Federal IRS limit.
[3] Employer match up to $50 per month for employees contributing to 401k.

Employees electing to participate in ORP will be required to enter beneficiary information online once the account is set-up with the chosen vendor.

Additional information: ORP
https://treasury.tn.gov/Retirement/Retire-Ready-Tennessee/for-Higher-Education-Employees
Representatives:

TIAA	Austin Jefferson	(615) 783-2956 or (800) 842-2252
AIG (VALIC)	Lowell Warren	(615) 221-2541 or (800) 448-2542
VOYA (ING)	Julie Chambers	(615) 556-6135 or (800) 584-6001

TCRS and ORP Comparison Chart

Hired after July 1, 2014

FEATURE	TCRS	ORP
Contributions to TCRS or ORP	Employer: amount equal to 4% of your compensation You: 5% of your compensation5% of your compensation	Employer: amount equal to 9% of your compensation You: 5% of your compensation
Contributions to 401(k)	Employer: amount equal to 5% of your compensation You: auto-enrolled at 2% of your compensation* * The State will match the first $50.00 of your monthly employee deferral	Employer: no employer contributions You: auto-enrolled at 2% of your compensation* * The State will match the first $50.00 of your monthly employee deferral.
Vesting	Fully vested after 5 years of service in the defined benefit plan; immediately vested in all contributions to the 401(k) plan	Immediately vested from date of contributions
How the benefit is determined	Retirement benefit from the defined benefit plan is based on years of service, salary, and the payment option chosen, including credit for any unused sick leave (if applicable). The 401(k) benefit is your account balance upon retirement	Retirement benefit is based on your account balances upon retirement
Creditable service	Benefits based on years of service with Tennessee (1.0% annual service accrual multiplier), and other possible retirement credits; (e.g. up to 4 years of military service; unused sick time)	Not applicable to the ORP
Benefit eligibility	Defined benefit plan: 65 plus five years creditable service, or the Rule of 90 where age plus years of service equal 90. Defined contribution plan: eligible to begin receiving distributions from account balance at any age if separation from service has occurred, subject to IRS requirements.	Amount of benefit based on account balances. Members are eligible to begin receiving distributions at any age after separation from service, subject to IRS requirements.
Disability	Defined benefit plan members approved for disability may receive 90% of service retirement benefit that would have been payable.	Not applicable to the ORP
Payout methods	Defined benefit plan: vested members are eligible to select a single life annuity or joint and survivor annuities at retirement. Defined contribution plan: based on the member's account balance and can be distributed in lump sum payments, periodic payments, and required minimum distribution payments, among others.	A member's account balance can be distributed in lump sum payments, partial lump sum payments, periodic payments, and required minimum distribution payments, among others. Payouts are subject to any restrictions on individual funds.
Cost of living adjustment	Defined benefit plan: A member who has been retired for at least 12 full months on July 1 of each year is eligible to receive an increase in his or her retirement allowance if there is an increase in the Consumer Price Index of at least .5% for the preceding calendar year. Defined contribution plan: Not applicable.	Not applicable.
Death Benefits Before Retirement	Defined benefit plan: Beneficiaries of members who die before they retire may be eligible for benefits. Defined contribution plan: The value of the total accumulation is payable to the listed beneficiary or the estate.	The value of the total accumulation is payable to the listed beneficiary or the estate. The beneficiary may be eligible to elect an annuity payout. Restrictions may apply.
Transfers Between TCRS and ORP	Employees who are eligible to participate in the ORP, but who elected to participate in TCRS, may make a one-time election to transfer membership from TCRS to the ORP. Members are advised to obtain a TCRS benefit estimate before making a decision to transfer.	If you join the ORP and decide later you would like to join the State retirement program, you have a one-time transfer option upon reaching 5 years of service. You must make, file the election, and remit funds to TCRS no later than the end of the calendar year following the year you reach 5 years of service. TCRS will notify eligible members of this opportunity.
Transfers Outside Tennessee's Plans	Upon separation from service, a member's account balance is eligible to be rolled over to another employer's qualified plan or to an Individual Retirement Account (IRA), subject to any applicable individual fund restrictions.	Upon separation from service, a member's account balance is eligible to be rolled over to another employer's qualified plan or to an Individual Retirement Account (IRA), subject to any applicable individual fund restrictions.

Deferred Compensation Plans

The Volunteer State Community College offers four long-term savings plans designed to supplement income after retirement on a tax-deferred basis. **You may enroll at any time** in the following programs:

- 401(k) – deferred compensation plan, before-tax
- ROTH 401(k) – deferred compensation plan, after-tax
- 457 – before-tax plan only
- 403(b) – designed for educational and nonprofit institutions

Contributions

Employees may contribute a specified dollar amount or a percentage of salary to the plans through salary reduction. Amounts contributed do not affect retirement or social security. Contributions and earnings on the plans are not subject to federal income tax until funds are withdrawn (with exception of the ROTH 401(k) plan). Generally, withdrawals are not permitted before age 59 1/2 or retirement. Early withdrawals are subject to taxes and IRS regulations and penalties. The minimum monthly contribution is $20. The table below shows the annual maximum amounts that can be taxed under these programs.

	401(k) and 403(b) combination	457
Age/Calendar year	2021	2021
Less than age 50	$19,500	$19,500
Age 50 or older	$26,000	$26,000

401(k) and 403(b) = combined annual maximum contribution 457 = separate annual maximum contribution

401(k), 401(k) ROTH, and 457

The Traditional 401(k), 401(k) ROTH, and 457 are administered by Empower Retirement Services (formerly Great-West). Each program offers the same investment options. The State of TN will also contribute a match with a minimum contribution of at least $20 up to a maximum contribution of $50 per month. There is not a match in the 457.

403(b)

There are currently 3 companies that are available for investment in the 403(b). Those companies are TIAA, AIG (VALIC), and VOYA. There is not a match in the 403(b). Please contact HR for enrollment materials for 403 (b).

Additional information: Empower Retirement Services—1-800-922-7772

- State of TN Deferred Compensation (401(k) and 457 plans): https://retirereadytn.empower-retirement.com/participant/#/login?accu=TennesseeWR
- Plan Comparison: *https://docs.empower-retirement.com/EE/TennesseeWR/DOCS/Plan-Comparison-flier.pdf*

Annual Leave and Sick Leave

Volunteer State Community College offers a generous leave program to all regular full-time and regular part-time (hours prorated) employees. Employees hired on a temporary appointment (adjunct faculty, temporary hourly, work study) are not eligible for the programs.

Executive, administrative, professional, and twelve-month academic personnel, who are regular full-time employees, shall accrue annual leave at the rate of 15 hours (2 days) per month.

Regular full-time clerical and support personnel shall accrue annual leave in accordance with the following schedule:

Years of Service	*Accrued Rate for Month	*Maximum Annual Accumulation	*Maximum Total Accumulation Within Fiscal Year	*Maximum Accumulation Carried Forward to Next Fiscal Year
0 – 5	7.5	90.0	315.0	225.0
5 – 10	11.3	135.6	405.6	270.0
10 – 20	13.2	158.4	450.9	292.5
20 or more	15.0	180.0	495.0	315.0

*Number of hours

Nine, ten, and eleven-month faculty, regular full-time or regular part-time, whether or not compensated over a twelve-month period, are **not** eligible to accrue annual leave.

All personnel entitled to accrue annual leave may request use of annual leave at any time preferred by application to their proper approving authority. Such requests are subject to the discretion of the approving authority, which is responsible for planning the work under his or her control and should be approved only at such times as the employee can best be spared.

Sick Leave

Regular full-time and regular part-time employees employed on a twelve-month or nine-month basis accrue sick leave at the rate of 7.5 hours per month. Sick leave is generally applicable to absences due to illness or injury to an employee, including illness or incapacity to work due to pregnancy, medical examinations and dental appointments. In addition, sick leave may be used for parental leave (Refer to TBR Policies 5:01:01:08).

Where an employee must be absent because of serious illness in the immediate family, sick leave may be granted by the appropriate approving authority. For purpose of this section, "immediate family" shall be deemed to include: (1) spouse; (2) children, step- children: (3) parents, step-parents, foster parents and parents-in-law; (4) sibling; and (5) other members of the family who reside within the home of the employee.

For the actual language and full coverage of leave regulations enforced by the college, please visit https://www.volstate.edu/policies

Sick Leave Banks

Vol State employees wishing to join the Sick Leave Bank may sign-up during the annual enrollment period in the fall. Please refer to policy V:01:30 Formation and Operation of Faculty Sick Leave Banks (TBR P-060 and policy V:01:25 Formation & Operation of Staff Sick Leave Bank (TBR P-061) for further details and eligibility.

Regular Non-Faculty and Faculty Sick Leave Banks provide emergency sick leave to members of the program who have experienced disability or quarantine resulting from personal catastrophic illness and/or unexpected medical emergencies and who have exhausted their sick leave, annual leave, and compensatory time, if applicable. All eligible employees who elect to participate in the bank shall be assessed fifteen (15) sick leave hours by the trustees as the initial enrollment assessment. An employee must have been a member of the bank for thirty (30) calendar days prior to applying for withdrawal of sick leave bank hours. Faculty must have 67.5 accumulated sick leave hours accrued before they can enroll. Professional/Administrative staff must have 90 hours accumulated sick leave hours before they can enroll.

The Sick Leave Bank Trustees must review your request to be approved for sick bank leave. Contact the Office of Human Resources (615) 230-3592 for more information.

Workers' Compensation

The State of Tennessee Workers' Compensation program is administered through CorVel Corporation.

For life threatening emergencies call Campus Police at 3595 or 911 immediately. For non-life threatening job-related injury or illness, call Campus Police to report injury and instruct the employee to report injury/illness to supervisor and call (866)245-8588 and select option 1 to speak with a Corvel triage nurse. See link to instructions.
https://www.volstate.edu/sites/default/files/documents/plantops/safety/WC%20Injury%20Reporting%20Procedures.pdf

Additional Information: Contact Michelle Boyd, Manager of EH&S at (615) 230-3617

Family Medical Leave Act

Policy V:02:15 Family Medical Leave Act
https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-02-15-Family-Medical-Leave-Policy.pdf

In compliance with the Family Medical Leave Act of 1993, as amended, ("FMLA" OR "THE ACT"), it is the policy of the Tennessee Board of Regents and Volunteer State Community College to provide eligible employees up to 12 workweeks (450 hours) of job-protected leave during a 12-month period for family or medical leave, or for a qualifying exigency; or , up to 26 workweeks of leave for military caregiver leave during a 12-month period for reasons specified in the policy V:02:15 Family, Medical, and Service Member Leave Act, to provide continued health insurance coverage during the leave period and to insure employee reinstatement to the same or an equivalent position following the leave period.

For eligibility purposes, an employee must have worked for at least twelve months for the State of Tennessee and must have worked 1250 hours for the Volunteer State Community College during the year preceding the beginning of the leave. The Office of Human Resources is responsible for determining these criteria at the beginning of the leave. The FMLA policy includes both regular and temporary employees of Vol State.

In all circumstances, the employee and/or supervisor are responsible for notifying Vol State Office of Human Resources of any employee who has been off or plans to be off more than three (3) consecutive work days due to family and medical reasons. This guideline applies whether or not the employee actually has sick leave or annual leave or is on leave without pay. Vol State Policy V:02:15 stipulates that any employee who has accumulated sick and annual leave must use this leave during a period of FMLA before going on leave without pay; FMLA shall run concurrently with the paid leave.

The Office of Human Resources will provide the employee with the necessary paperwork, and all forms must be completed and returned to the Office of Human Resources within 15 calendar days. FMLA forms are also located on Human Resources webpage https://www.volstate.edu/hr/forms.

FMLA qualifying events include:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Parental Leave

It is the policy of the Tennessee Board of Regents/Vol State to provide a period of up to four (4) months of leave to eligible employees for adoption, pregnancy, childbirth and nursing the infant, where applicable, in accordance with T.C.A. § 4-21-408. With regard to adoption, the four (4) month period shall begin at the time the employee receives custody of the child.

For the actual language and full coverage of leave regulations enforced by the college, please visit Policy V:02:12 Parental Leave (TBR policy 5:01:01:08)
https://policies.tbr.edu/policies/parental-leave

Bereavement Leave

It is the policy of Volunteer State Community College to provide all regular, full-time and regular part-time employees time off without loss of pay due to the death of an immediate family member as defined below, consistent with T.C.A. § 8-50-113.

Immediate family-shall be deemed to include 1) spouse; 2) child, step-child; 3) parent, step-parent, foster parent, parent-in-law; 4) sibling(s); 5) grandparents and grandchildren and: 6) other members of the family who reside within the home.

For the actual language and full coverage of leave regulations enforced by the college, please visit Policy V:02:11 Bereavement Leave
https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-02-11-Bereavement-Leave.pdf

Civil Leave

Any employee, except for a temporary employee with a contract of less than six (6) months, shall be granted civil leave when, in obedience to a subpoena or direction by proper authority, the employee appears as witness for the Federal government, the State of Tennessee, or a political subdivision of the State, or when it is necessary to attend any court in connection with official duties or serve on a jury in any State or Federal Court.

For the actual language and full coverage of leave regulations enforced by the college, please visit Policy V:02:05 Civil Leave
https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-02-05-Civil-Leave.pdf

Leave of Absence

Volunteer State Community College provides approved, unpaid time off to regular employees due to reasons of illness or injury, or disability of an employee who has insufficient accumulated annual and/or sick leave, leave for educational purposes and leave for justifiable personal reasons.

For the actual language and full coverage of leave regulations enforced by the college, please visit Policy V:02:03 Leave of Absence
https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-02-03-Leave-of-Absence.pdf

Workplace Policies and Rules

For the actual language and full coverage of all policies enforced by the Vol State, please visit https://www.volstate.edu/policies and Tennessee Board of Regents policies and guidelines at https://policies.tbr.edu/

Stop Sexual Misconduct/Violence
Sexual misconduct is a form of sex discrimination prohibited by Title IX. Volunteer State Community College prohibits sex discrimination, sexual harassment and sexual misconduct on all of its campuses and is committed to taking action to prevent all acts of sexual misconduct and to investigating and adjudicating all reports of sexual misconduct. Sexual misconduct includes dating violence, domestic violence, sexual assault and stalking. For more information, visit Vol State webpage at https://www.volstate.edu/hr/title-ix

Equal Opportunity Employer
Volunteer State Community College, an AA/EEO employer, does not discriminate on the basis of race, color, religion, creed, ethnic or national origin, sex, sexual orientation, gender identity/expression, disability, age (as applicable), status as a covered veteran, genetic information, and any other category protected by federal or state civil rights law.
College employees, or applicants for employment at Volunteer State Community College, who believe they have been discriminated against or harassed based on any of the protected classes identified above should contact the College's Manager of Employee Relations and Equity at 615-230-3592 or at eeo@volstate.edu. For more information, please refer to the College's general non-discrimination policy.
https://www.volstate.edu/equal-opportunity-employer

Required Employee Training
For more information, visit Vol State webpage for instructions for required training https://www.volstate.edu/hr/training. Once you have access to "MyVOLSTATE" portal, you can view other college trainings.

Drug-Free Campus
Volunteer State Community College seeks to encourage and sustain an academic environment that respects individual freedoms and promotes the health, safety, and welfare of its students, faculty, and staff. In keeping with TBR policy 3:05:01:01, the use and/or possession of alcoholic beverages on university, community college, and college of applied technology owned or controlled property shall be prohibited except as provided by TBR policy 1:07:00:00. VSCC has

also adopted a drug free school and campus policy in compliance with the Drug-Free Schools and Communities Act Amendments of 1989 (20 U.S.C.3171, et. seq.) and strictly prohibits the use and/or possession of alcoholic beverages or of any drug or controlled substance or sale or distribution of any such controlled substance on its campuses. In making a good faith effort to maintain a drug-free campus, Volunteer State Community College networks with the Sumner County Anti-Drug Coalition (SCADC) in conjunction with the Coalition for Healthy and Safe Campus Communities (CHASCo) and the Governors Highway Safety Office (GHSO) *Booze It or Lose It* program.

The VSCC Campus Police Department is the primary contact for questions concerning drug and alcohol abuse and prevention and can be contacted by calling (615) 230-3595 or stopping by the main office located in the Wood Campus Center, Room 105. Please assist in maintaining the drug-free environment by reading the Drug-Free Campus Statement and by being aware of those around you and any changes in behaviors, routines or habits. For more information, visit Vol State webpage at https://www.volstate.edu/campuspolice/alcohol-drugs-weapons

Fraud, Waste, and Abuse
State law requires all public institutions of higher education to provide a means by which students, employees, or others may report suspected or known improper of dishonest acts. In addition, Volunteer State Community College is committed to the responsible stewardship of our resources. Whether you are part of departmental management, a faculty or staff member, a student, or an interested citizen, we encourage you to report known or suspected dishonest acts by employees, outside contractors, or vendors.
For more information, visit Vol State webpage at
https://www.volstate.edu/sites/default/files/documents/human-resources/new-hires/Reporting_Fraud_Information.pdf

Outside Employment
Upon initial employment, an employee must disclose any existing outside employment that they intend to continue and seek approval in accordance with Policy V:01:20 Outside Employment and Extra Compensation (TBR policy 5.01.05.00). https://policies.tbr.edu/policies/outside-employment-and-extra-compensation

Once employed, prior to engaging in outside employment, an employee must notify appropriate supervisors and the president, or his or her designee, of the nature of the employment and the expected commitment of time and obtain approval. See link to form
https://nextgensso.com/sp/startSSO.ping?PartnerIdpId=http://sts.volstate.edu/adfs/services/trust&TargetResource=https://dynamicforms.ngwebsolutions.com/Submit/Form/Start/12993741-2a9c-4d13-ae35-e9b90f6f32e1

Financial Disclosures/Conflict of Interest
All employees of the TBR/and its constituent Institutions serve the interests of the State of Tennessee and its citizens, and have a duty to avoid activities and situations that, either actually or potentially, put personal interests before the professional obligations that they owe to the State and its citizens. The conflict of interest policy is intended to establish standards of integrity and objectivity that should guide the actions of all employees of the Tennessee Board of Regents System. For the actual language and full coverage of the policy enforced by the college, please visit TBR Policy 1:02:03:10 https://policies.tbr.edu/policies/conflict-interest and complete exhibit 3 staff form and instructions if you may have a conflict of interest or if the Office of Human Resources requests you to complete the form based on your position with the college.

Payroll / Time and Attendance

All employees of the College must have a current W-4 form on file in the Payroll Office. If a new employee has not provided a completed W-4 form prior to the processing of their first payroll check, per IRS Circular E, taxes will be withheld at a single with no allowances rate.

Direct deposit of paychecks is required for all full-time and part-time employees, per TBR Policy 5:01:00:00 https://policies.tbr.edu/policies/general-personnel-policy

All approved timesheets, attendance records and extra compensation forms must be submitted to the Payroll Office by the day designated by that office each month, normally around the 17th of the month. Only information received by the required date will be reflected in the payroll check for that month.

For the actual language and full coverage of the policy enforced by the college, please visit V:06:02 https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-06-02-Payrolls.pdf

Other related policies:
V:01:03 Employment Classification
V:01:15 Hours of Work, Classified Employees
V:02:14 Days of Administrative Closing

Longevity Pay

The State of Tennessee offers longevity pay for employees who work eighty-two percent (82%) of full time or more as a bonus for years of service. You will begin receiving longevity pay after you have completed three (3) years of employment with the State of Tennessee. Longevity is rewarded at a rate of $100 per year up to a maximum provided by law, and is paid in your regular pay for that month. For the actual language and full coverage of the policy /guideline enforced by the college, please visit TBR P-120 Longevity Pay https://policies.tbr.edu/guidelines/longevity-pay

Performance Evaluations

Volunteer State Community College recognizes that employees have a need and expectation to be continuously advised of their performance as perceived by their supervisors. The purpose of the evaluation is to provide employee feedback and to enhance the ability of the employee to advance the mission of the College. Although Volunteer State Community College's performance evaluation process is designed to provide feedback and measure an employee's overall job performance during the performance year, the evaluation should focus on goal planning and goal attainment.

For the actual language and full coverage of the policy enforced by the college, please visit V:0-1:22 Performance Evaluation For Executive/Administrative/Professional and Clerical/Support Employees. https://www.volstate.edu/sites/default/files/documents/policies/human-resources/V-01-22-Perf-Eval-for-Exec-Admin-Prof-Cler-Sup-Emp.pdf

Educational Assistance Programs

Educational Assistance Programs provide benefits to employees at TBR institutions (Vol State), Tennessee Colleges of Applied Technology, and employees of the System Office to further their formal education. The following programs are subject to eligibility based on service requirements and funding:

Educational Assistance for TBR/Vol State Employees

- Faculty or Administrative/Professional Staff Tuition or Maintenance Fee Reimbursement Program
- Clerical and Support Staff Tuition or Maintenance Fee Reimbursement Program
- Fee Waiver for TBR System Employees Program (PC- 191)

Educational Assistance for Spouse and Dependents of TBR/Vol State Employees

- Fee Discount for Spouse and/or Dependent Children Program

In order to ensure fee waiver and tuition reimbursement forms for employees are processed in a timely manner, all forms must be submitted no later than 2 weeks prior to the beginning of the semester/term at the institution where the employee will be taking classes. Proof of grades earned for any previous classes for which an employee has received a fee waiver must be submitted to the Office of Human Resources (Ramer room 127) before forms for upcoming classes can be processed. In the case of tuition/fee reimbursement, checks cannot be released until both proof of grades earned and proof of payment has been received. Receiving anything other than a passing grade (including withdrawal and incomplete status) in a course may disqualify an employee from future participation in these Educational Assistance Programs. Full details are available in the following policies:

- Educational Assistance for TBR System Employees: P-130
- Educational Assistance for Spouse & Dependents of TBR Employees: P-131

To obtain application forms, employees must access the Vol State Human Resources page at https://www.volstate.edu/hr/forms and go to **Tuition and Fee Forms**. Complete form and route for approvals and processing. For additional information, please contact the Office of Human Resources at (615) 230-3592.

Volunteer State Community College
Office of Human Resources: (615) 230-3592
Application Process: https://www.volstate.edu/hr/forms

Employee Discounts

The State of Tennessee Employee Discount Program exists to offer state employees discounts on products and services from various vendors in order to express appreciation for the valued service state employees provide Tennessee citizens.

Tennessee State Parks

Between April 1 and October 31, employees may receive a discount on inn rooms and cabins. Between November 1 and March 31, the discount is 50%. The discount does not apply to business travel and is valid only if reservations are made no more than 30 days in advance for inn rooms and 7 days in advance for cabins. Current state ID or verification of retirement will be required at check-in. Check availability and make payments using the online reservation system. Please visit https://www.tbr.edu/hr/discounts for more information.

Other Main Campus Resources

Vol State Main Campus has a cafeteria (Wood Campus Center), bookstore (Wood Campus Center), library (Thigpen Library), and small gym (Pickel Field House) available to all staff and students.

Disclaimer

The discounts may vary and are subject to change or cancellation without notice. For a list of vendors, please visit the websites listed below.

https://www.volstate.edu/discounts

Holiday Schedule

The following dates will be observed as holidays:

2021 Calendar Year

Holiday	Date Observed
New Year's Day	Friday, January 1, 2021
Martin Luther King Jr. Day	Monday, January 18, 2021
***Good Friday* Administrative Day**	*Friday, April 2, 2021
Memorial Day	Monday, May 31, 2021
Independence Day	Monday, July 5, 2021
Labor Day	Monday, September 6, 2021
Thanksgiving Day	Thursday, November 25, 2021
***Day After Thanksgiving* Administrative Day**	*Friday, November 26, 2021
Christmas Day	Friday, December 24, 2021
Administrative Day	*Monday, December 27, 2021
Administrative Day	*Tuesday, December 28, 2021
Administrative Day	*Wednesday, December 29, 2021
Administrative Day	*Thursday, December 30, 2021

* New Year's Day for 2022 will be observed Monday, January 3, 2022.

***** VSCC Designated Administrative Holidays

Please note that Friday, December 31, 2021 is designated as a day of work.

In order to minimize the use of utilities and provide additional time with family, a decision has been made to encourage all faculty and staff to utilize a day of annual leave on Friday, December 31, 2021. This will enable the College to shut down facilities from the conclusion of work on Thursday, December 23, 2021 until Tuesday, January 4, 2022. Individuals who do not want to use a day of annual leave will need to make arrangements to work in the Ramer Administrative Building since all other buildings will remain closed and locked.

Please complete customary paperwork for a day of annual leave. If you plan to work on Friday, December 31, 2021, please notify your supervisor so that we can compile a list of employees who will be on campus that day.

Quick References

Division of Insurance Administration
Benefits Administration
Phone: 1-800-253-9981
Fax: 1-615-741-8196
Email: benefits.administration@tn.gov
Website: www.tn.gov/partnersforhealth.html

ParTNers for Health
Email: partners.wellness@tn.gov
Website: www.tn.gov/partnersforhealth.html

Health Insurance
BlueCross BlueShield of Tennessee
Phone: 1-800-558-6213
Website: www.bcbst.com/members/tn_state

Cigna HealthCare
Phone: 1-800-997-1617
Website: www.cigna.com/stateoftn

Dental Insurance
Cigna Dental DHMO
Prepaid Dental Plan
Phone: 1-800-997-1617
Website: www.cigna.com/stateoftn

MetLife Dental
Dental Preferred Provider Organization (DPPO)
Phone: 1-855-700-8001
Website: www.mybenefits.metlife.com/stateoftn

Vision Insurance
Davis Vision
Phone: 1-800-208-6404
Website: http://www.davisvision.com/stateofTN
Basic Client Code: 8155
Expanded Client Code: 8156

Pharmacy
Caremark Prescription
Phone: 1-877-522-8679
Website: https://info.caremark.com/stateoftn

Flexible Benefits
Optum Bank
Phone: 866-600-4984
Website:
https://www.optumbank.com/tennessee.html

Employee Assistance Program
Optum
Phone: 1-855-437-3486
Website: www.HERE4TN.com

Life Insurance
Securian (Minnesota Life – Term & Accidental)
Phone: 1-866-881-0631
Website: www.lifebenefits.com/statetn

Short Term Disability
MetLife
Phone: 1-855-700-8001
Website: https://www.metlife.com/stateoftn/

Long Term Disability
Lincoln Financial Group
Phone: 1-800-423-2795
Email: www.lincolnfinancial.com

Retirement Plans
TCRS
Tennessee Consolidated Retirement System
Phone: 1-800-922-7772
Email: tcrs.counseling@state.tn.edu/
Website: www.treasury.tn.gov/tcrs/

ORP-Optional Retirement Services
Website: https://treasury.tn.gov/Retirement/Retire-Ready-Tennessee/for-Higher-Education-Employees

TIAA
Representative: Austin Jefferson
Email: ajefferson@tiaa.org
One American Center
Phone: 615-783-2956 ext. 25-2956
Website: www.tiaa-cref.org/tnorp

AIG (Valic)
Representative: Lowell Warren
Phone: 615-221-2541
Email: lowell.warren@aig.com
Website: https://tennesseebor.valic.com/home

VOYA Financial (formerly ING)
Representative: Julie Chambers
Phone: 615-556-6135
Email: julie.chambers@voyafa.com
Website: https://tennorp.beready2retire.com/

401k Plan – Empower Retirement
Representative: Ben Straley
Phone: 1-615-564-7005 or 1-615-244-1030
Email: ben.straley@empower-retirement.com
Website: https://retirereadytn.empower-retirement.com/participant/#/login