

# Questions and Answers

(updated October 21, 2016)



## Enrollment & Eligibility

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If you are looking for enrollment and eligibility information, [visit our publications page](#) to find the eligibility and enrollment guide and plan documents.

**1. Can children under age 26 be covered as dependents on their parents' plan if they are eligible for their own coverage (e.g., at another job)?**

Yes, access to other coverage is not a factor.

**2. Can incapacitated children be covered beyond age 26?**

If they are already enrolled in the state group health insurance plan and incapacitation was prior to age 26, they will be covered as long as they continue to meet eligibility requirements.

**3. If two employees in the same plan (state, local education or local government) are married, are you required to choose the employee + spouse premium level, or can each sign up for employee only coverage? What if there are children?**

Married members can each enroll in employee only coverage. If you have a child(ren), one of you can choose employee only and the other can choose employee + child(ren).

**4. Can a dependent be dropped from coverage in the middle of the plan year?**

Coverage can only be canceled during the fall enrollment period or if a member has a qualifying family status change. A list of qualifying events is on the cancel request form located on the Benefits Administration website on the forms page.

**5. Are preexisting conditions covered?**

Yes. There is no preexisting condition exclusion for anyone of any age and no proof of creditable coverage is required.

## Partnership Promise

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If you are looking for information about the Partnership Promise requirements and deadlines, visit our [Partnership Promise](#), [Well-Being Assessment](#), [Biometric Screening](#) and [Coaching](#) pages.

**1. If my spouse and children are covered by my insurance, do they have to fulfill the Partnership Promise too?**

Both you and your covered spouse have to meet the Partnership Promise in order to qualify for the lower premium Partnership plan. Or, if you are a state or higher education employee and enroll in the Promise HealthSavings CDHP, to qualify for the state to put money in your HSA. Children enrolled in your plan, regardless of age, do not have to fulfill the Partnership Promise.

**2. Do I have to sign the Partnership Promise if I am enrolling for the first time?**

Yes. When you sign the enrollment form or click “OK” in Edison employee self-service (ESS) to enroll in the Partnership Promise PPO or Promise HealthSavings CDHP, you are committing that you and your covered spouse will complete the Partnership Promise.

**3. I failed to fulfill the Partnership Promise in the past and was transferred to the Standard PPO or HealthSavings CDHP. When am I eligible to re-enroll in the Partnership PPO or the HealthSavings CDHP?**

It will be different in 2017. Due to federal rule changes, all members can enroll in any health option. In 2017, the Partnership Promise PPO has lower monthly premiums if the member agrees to the Partnership Promise. For members who want switch or enroll in a different plan option, they can make this change during the fall annual enrollment period.

**4. If I don’t complete the Partnership Promise in 2017, what happens?**

You will be able to stay in your current plan the following year, but you won’t qualify for the lower premium Partnership PPO or if a state or higher education employee, you won’t qualify for state HSA funds.

**5. If my covered spouse does not meet the Partnership Promise and I drop him or her from my coverage, can I re-enroll in the Partnership Promise PPO or Promise HealthSavings CDHP (state and higher education employees) for the following year?**

Yes. If the head of contract fulfills the Partnership Promise but the covered spouse does not, the head of contract may re-enroll in the Partnership Promise PPO or Promise HealthSavings CDHP during annual enrollment ONLY if the non-compliant spouse is dropped from coverage.

You must first drop the non-compliant spouse from coverage before you can re-enroll in the Partnership Promise PPO or Promise HealthSavings CDHP. You must submit a paper form before the end of the annual enrollment period to notify Benefits Administration that you would like to be moved back to the Partnership Promise PPO or Promise HealthSavings CDHP. This change will be made after the enrollment period ends and Benefits Administration confirms with Healthways that you completed the Promise.

## Well-Being Assessment (WBA)

**6. Do I have to complete a questionnaire?**

Yes. All members and covered spouses must complete the Healthways Well-Being Assessment (WBA) between January 1 and March 15, 2017. Other health questionnaires (e.g., Cigna, BlueCross BlueShield, Optum Health assessments) will not count toward fulfilling the Partnership Promise. We recommend that you complete the Well-Being Assessment online. The online WBA offers a better member experience with instant results and access to a personalized Well-Being Plan. Please note: After you finish your Well-Being Assessment, although not required to fulfill the Partnership Promise, you will need to create a Well-Being Plan to have access to the other resources in Well-Being Connect. There are alternatives to completing the questionnaire online. Please call Healthways at 888.741.3390 for other options.

**7. Do I have to create an online Well-Being Account?**

Yes. If you have not previously set up an online Well-Being Account, you will need to register and create an account before you can complete the Well-Being Assessment, create a Well-Being Plan, and access the tools, trackers and resources. Once you create an account, you will use the same username and password to access Well-Being Connect going forward. In order to create an online Well-Being Account, you are required to provide your legal first and last name, date of birth, mailing ZIP code and your email address. If you do not have an email address, you can create a free email account at websites such as [gmail.com](http://gmail.com) or [yahoo.com](http://yahoo.com).

**8. How does the spouse create an online account to complete the Well-Being Assessment?**

A covered spouse will have access to set up his or her own [Well-Being Account](#) by going to the [ParTNers for Health website](#) and clicking on “[My Wellness Login](#).” All employees and spouses enrolled in the Partnership Promise PPO or Promise HealthSavings CDHP can check their status in the Partnership Promise by calling 888.741.3390 and selecting option 1 to use the automated verification system.

**9. What is a Well-Being Plan?**

The plan is a personalized tool that helps you reach your healthy best. After you complete your online Well-Being Assessment (WBA), you can view your results as well as recommended focus areas, like healthy eating, stress management and tobacco cessation. You can use these recommendations to create your online Well-Being Plan with suggested action items. The Well-Being Plan is not required.

## **Biometric Screening**

**10. How do I complete my Biometric Screening?**

All Partnership Promise PPO and Promise HealthSavings CDHP members must complete a Biometric Screening by July 15, 2017, as part of your Partnership Promise requirements. This year, you will have two ways to get a biometric screening:

- At a worksite screening: Select screening sites will be available across the State. In the spring of 2017, a complete list of worksite screening locations can be found on the [ParTNers for Health website](#) in the Resources box.
- Completing a Physician Screening Form with your physician.

**11. How do I sign up for an onsite screening?**

Go to the [OHD website](#) to sign up for a screening near you. Select a screening location, time and date that works best for you. Remember, you must fast for nine hours prior to your screening appointment. Arrive 15 minutes early.

All onsite screening results will be sent directly to Healthways. You will not be required to send in any forms.

**12. Can my covered spouse participate in an onsite screening event?**

Each onsite screening location is different, but there are some onsite screening locations that will allow your covered spouse to attend.

**13. Can I order a Physician Screening Form over the phone?**

Yes. You can call Healthways at 888.741.3390 and select option 1 and a customer service representative will be happy to assist you.

**14. If I am unable to complete all of the tests of the biometric screening (e.g., blood tests due to needles) will I still meet the requirement?**

Yes, but you will need to complete the other tests required as a part of the biometric screening and your doctor will need to make a note on your Physician Screening Form about the tests not completed.

**15. Will I have to pay a copay for my biometric screening?**

Your annual wellness visit (i.e., physical exam) is a preventive service and offered to members at no cost. However, if you have your biometric screening completed at the same time you receive other medical services or treatments, you may have to pay a copay.

**16. If my doctor charges a fee to submit the Physician Screening Form, am I responsible for paying that fee?**

Yes. The state cannot control what a doctor's office charges to complete a form, and some doctor's offices may charge an administrative fee to complete the Physician Screening Form.

**17. Can I submit the Physician Screening Form or should it come from my doctor?**

You can submit the form as long as it is completed and signed or stamped by your doctor AND signed by you.

**18. Can I or my physician submit a copy of the Physician Screening Form that was provided in 2011?**

No. The form provided by our previous vendor, APS Healthcare, cannot be used. The fax number on that form is now used by a private company. Any forms received at that fax number are destroyed immediately as required by HIPPA regulations.

## Case Management

**19. What is case management?**

For 2017, case management is administered by BlueCross BlueShield, Cigna and Optum. You must participate in case management if you are contacted by one of these carriers. Case management helps coordinate care across all of your providers for chronic conditions and/or catastrophic illness or injuries. If you are identified based on your insurance claims, you will be contacted by BlueCross BlueShield, Cigna or Optum and asked to participate in case management.

If you are participating in case management and Healthways disease management coaching, you can place the Healthways coaching on hold until the case management calls have ended. Healthways will reach out to you after case management has ended to set up on-going coaching calls for the wellness program.

**20. What does behavioral health case management involve?**

Situations where someone would be contacted for behavioral health case management include inpatient behavioral health or substance abuse treatment and/or the diagnosis of a serious and persistent mental illness. Members in the behavioral health case management program will have access to a licensed behavioral health professional who can help advocate for their care and assist them in navigating the system.

Behavioral health case management is separate from the five free sessions offered by the Employee Assistance Program, which are not tied to the Partnership Promise.

## Coaching

**21. Who do the coaches work for and what are their credentials?**

All coaches are employees of Healthways, the company that the state has contracted with to manage the wellness program. The ParTNers for Health Wellness Program coaches have wide expertise and are degreed professionals. They include licensed registered nurses and licensed dieticians, certified health educators and

those with degrees in exercise physiology, exercise science, health promotion and psychology. This vast experience allows you access to speak with coaches based on your needs and personal health goals.

**22. How does Healthways decide who is contacted for coaching?**

Healthways decides who is contacted for disease management coaching based on your medical/pharmacy claims.

**23. How often, when and how do I communicate with my coach?**

Frequency of the disease management calls will be based on the level of severity of the chronic condition. Chronic conditions are diabetes, heart failure, chronic pulmonary disease (COPD), coronary artery disease and asthma. A coach may contact you at any time during the plan year (January 1 – December 31). You may talk via phone. There is no set number of phone calls. You and your coach will talk as needed and will develop a schedule that works best for you. If you miss a call, your coach will try to call you back or you can contact Healthways at 888.741.3390. The coaches are available Monday – Friday from 8 a.m. – 8 p.m. and Saturday from 8 a.m. – 6:30 p.m. (Central time). When you participate in coaching, your frequency of calls will be tailored to your individual plan of care.

**24. What if I miss a call? What happens if my coach is unable to reach me?**

If a coach cannot reach you after two attempts, Healthways will send a letter to your primary address on record. Then, it is up to you to contact your coach. If you do not follow up within the time frame specified in the letter (14 days), you will be mailed a letter and given the opportunity to file an appeal. Don't put your Partnership Promise at risk. Disease management coaching is part of your requirements and Healthways wants to partner with you to make sure your requirements are met. You must complete all Partnership Promise requirements to remain eligible for the lower Partnership plan premium/state HSA funds offered with the Partnership Promise PPO or Promise HealthSavings CDHP.

**25. If I am able to meet my goals for better health, will I still be required to work with a coach to fulfill the Partnership Promise?**

If contacted for disease management coaching or case management, you will need to take part in the ParTNers for Health Wellness Program. At the end of 12 months, your data and information will be reviewed. Those with chronic conditions such as diabetes, heart disease or COPD, will benefit from remaining in the program with calls being less frequent based on improvement and good maintenance of the chronic condition. You may choose to opt out of a program, but you will be ineligible for the lower Partnership plan premium/state HSA funds offered with the Partnership Promise PPO or Promise HealthSavings CDHP the following program year.

**26. What happens if I don't meet the goals I initially set with my coach?**

As long as you are making an effort to work towards your goals and tell your coach about your challenges and successes, you will remain eligible for the lower Partnership plan premium/state HSA funds offered with the Partnership Promise PPO or Promise HealthSavings CDHP. Your coach will work with you to create reasonable and achievable goals that can be changed at any time when appropriate.

**27. If I talk to my doctor instead, does that satisfy the coaching requirement?**

No. Talking to your doctor does not fulfill the coaching requirement. Coaches provide one-on-one support to help you adopt and maintain healthy behaviors to prevent and control chronic diseases.

**28. Will the coaches work with my doctor and my doctor's orders?**

Your doctor's advice always takes priority over guidance from the ParTNers for Health Wellness Program. Please share your doctor's advice with your coach so that he/she can work as part of your healthcare team. With your permission, your coach can talk with your doctor to share your health goals and plan of care.

Your coach's role is to provide information and support—not a prescriptive plan that a member must follow. You can work with both your coach and doctor to develop a plan that is clinically appropriate.

**29. If my spouse gives me permission to speak to a coach on his/her behalf, can I do that?**

Yes, but your spouse will have to speak to the coach first to give permission.

**30. If I was required to coach in 2016, will I automatically continue coaching in 2017?**

Those enrolled in disease management coaching will continue to work with your Healthways coach to meet the 2017 Partnership Promise requirements.

If you participated in lifestyle management in 2016, you will need to continue to take your coaching calls until the end of the 2016 program year (December 31, 2016). Lifestyle management coaching will be voluntary for the 2017 program year, therefore you will not be required to continue to work with your coach in 2017. You do have the option to remain enrolled in the coaching program if you wish to continue working with your coach. If you wish to continue your calls, you will need to let your coach know on your last scheduled call in 2016.

**31. How will my spouse be contacted if required to participate in disease management coaching?**

A coach will contact him/her using the phone number for the spouse on file with Healthways. If there is not a number on file for the spouse, he or she will receive a "wrong phone number" letter and will have 14 days to respond. If the spouse does not respond in time, the head of contract (the primary health plan member) and covered spouse will be able to stay in the current plan next year, but will pay a higher premium in the Partnership Promise PPO or will not receive HSA funds if in the Promise HealthSavings CDHP. A spouse can create and log into the online Well-Being Account to enter a current phone number. If a spouse does not have access to the internet, he/she can also call Healthways at 888.741.3390 to update contact information. This will ensure that Healthways can reach the spouse if he/she needs to participate in coaching.

**32. Can I work with a coach even if I am not contacted by Healthways to coach?**

Absolutely. All members, including those enrolled in plans that do not include the Partnership Promise, can voluntarily participate in lifestyle management and disease management coaching. We currently have members who opt in to coaching.

**33. What security information will coaches ask for to identify members on the phone?**

To ensure privacy and security, Healthways will ask you to verify your name, mailing address and date of birth. Healthways will not ask for your social security number. However, if you are unable to verify your personal information, Healthways will not be able to release any information to you at that time or complete a coaching call. In such a case, you need to call Healthways back when you can verify all personal information. Healthways strives to protect the personal health information of all members while providing the best customer service.

**34. How can I verify the identity of my coach when he or she calls?**

If you are concerned about the identity of your coach, simply express your concerns to the coach. He or she will give you the number for the ParTNers for Health Wellness Program and ask you to call back to verify.

**35. How can I contact Healthways if I have questions about the Partnership Promise or coaching?**

You can call Healthways directly at 888.741.3390, Monday – Friday from 8 am – 8 pm (Central time).

## Healthways Tobacco Cessation Program

**36. Will I be charged more for being a tobacco user?**

No. There is no surcharge for tobacco use and you will not be required to quit. If you would like help or support in quitting the use of tobacco, Healthways' tobacco cessation program is offered within lifestyle management coaching.

**37. Do I have to complete a Healthways tobacco cessation program?**

No. However, if you are ready to try to quit, you do have some options for a tobacco cessation program.

Healthways offers two different levels of engagement depending on your readiness to quit.

- If you are a tobacco user who is not ready to quit, you can work with a coach in the lifestyle management 12-month program. The coach will meet you where you are, help you work towards becoming tobacco free and support you in your other well-being improvement goals.
- If you are ready to quit, Healthways offers a more intensive program, QuitNet. This program involves setting a quit date, more frequent calls and online support.

While the goal is always to quit using tobacco products, you are not required to quit.

**38. Am I considered a tobacco user if I only use tobacco occasionally?**

Yes. A tobacco user is someone who uses any tobacco product, including cigarettes, e-cigarettes, cigars or smokeless tobacco. However, there is one exception. Someone who smokes an occasional cigar (up to one a month) is not considered a tobacco user (based on similar guidelines from life insurance companies that allow for occasional cigar use).

**39. What if I am not ready to quit using tobacco?**

The Healthways lifestyle management coaching is voluntary, and designed to create a positive experience for the member. The coaches recognize that not everyone is ready to quit and they are trained to work with you in different stages of readiness to quit. A coach will work with you to design a plan that is best for you.

You are not required to stop using tobacco by the end of the year.

## Updating Contact Information

**40. How do I update my contact information?**

- **State employees:** You can change your contact information in Edison or by contacting your agency's human resources office.
- **Higher education, local education and local government employees:** You can change your contact information in Edison, by contacting your agency's human resources office or by calling the Benefits Administration service center at 800.253.9981 and selecting option 6.
- **Retirees:** You can change your contact information by contacting the Benefits Administration service center at 800.253.9981 and selecting option 2.

- **Spouses:** Spouses can create and login to their online Well-Being Account to enter their contact phone number OR call Healthways at 888.741.3390, Monday to Friday from 8 am to 8 pm Central time to update their information.

**41. If I update my contact information in Employee Self Service (ESS) in Edison, will my coach receive my new information?**

Yes. Benefits Administration sends a weekly file to Healthways so they will have your current information. Please know that the number you have listed as your home number is the phone number that is provided to Healthways. If no home number is listed, then the preferred number is sent.

**42. What if I don't have an email address?**

An email address is not required, but you MUST keep your phone number and mailing address up to date. If you do not have an email address, you can create a free email account at websites such as [www.gmail.com](http://www.gmail.com) or [www.yahoo.com](http://www.yahoo.com). You do need an email address to complete the Well-Being Assessment (WBA) online. If you do not have an email address, contact Healthways at 888.741.3390 to receive a paper WBA or complete a telephonic WBA.

## ParTNers for Health Wellness Program

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For general information about the Wellness Program including wellness and fitness discounts and Weight Watchers at Work, [visit the Wellness Program page](#).

**1. What is a wellness challenge?**

Wellness challenges are offered online and focus on topics such as fitness, nutrition and weight management. They offer fun ways to help members develop healthier lifestyles while providing group support. Challenges in 2017 include Mission Nutrition (healthy eating), 10K-A-Day (physical activity), Head-to-Tone (physical activity), and Add On (well-being).

**2. Can Standard PPO, Limited PPO, No Promise HealthSavings CDHP and Local CDHP members use the ParTNers for Health Wellness Program services with no additional cost?**

Yes. All members may use resources such as coaching, wellness challenges, educational mailings, the 24-hour nurse call advice line or other health and wellness services. Coaching and other services will be provided with no additional charge for members in each PPO option as well as the CDHPs.

## HealthSavings CDHP Plan

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The HSA administrator is PayFlex: [stateoftn.payflexdirect.com](http://stateoftn.payflexdirect.com)

**1. What is the HealthSavings CDHP insurance plan?**

The HealthSavings CDHP is a consumer driven health plan (CDHP) with a Health Savings Account (HSA). It uses the same provider networks and discounted rates as the PPOs.

You control and manage more of your healthcare dollars. It has a higher deductible and lower monthly premiums. Instead of copays, you pay the full, discounted medical or prescription drug cost for any claims that you incur until you reach your deductible. You pay coinsurance after you meet your deductible until you reach your maximum out of pocket. Then you are covered 100 percent.

To go with your CDHP, you also have a **Health Savings Account (HSA)**, a tax-free savings account that you can use to pay for your deductible and coinsurance expenses.

For state and higher education employees, if you participate in the Partnership Promise, the state will put money into your HSA in 2017: \$500/individual and \$1,000/family. If your coverage effective date is after September 1, 2016, the state contribution for 2016 is not available.

Local government and local education employees should check with your agency benefits coordinator to see if your agency will provide funding for your HSA.

## **2. Who or what is ALEX and how does it work?**

ALEX is an online benefits counselor. He will ask you questions about your estimated healthcare costs. Then he will provide a comparison of the plan options that may help you decide which is best for you and your family. Keep in mind, ALEX may not know everything about you, so ultimately, it is up to you to research your insurance options.

## **3. Does the HealthSavings CDHP cover preventive care?**

Yes. It covers in-network preventive care services at 100 percent. It uses the same network of providers as the PPO plans.

## **4. Why might I choose the HealthSavings CDHP option?**

You need to look at your choices very carefully. ALEX your online benefits advisor may help choose which plan may be best for you. Here are some things to think about:

- This plan has a lower premium but it has a higher deductible.
- There are no copays. You pay the full discounted network rate for services until you meet your deductible.
- After you meet your deductible, you will pay a portion of your costs (coinsurance) until you meet your annual out-of-pocket maximum (20 or 30 percent of discounted network rates depending on your options).
- You will have a Health Savings Account (HSA) and if you wish, can start adding the money you save in premiums along with any other contributions you or your employer makes to your account.
- The HealthSavings CDHP and the PPOs use the same networks and offer the same discounted network rates.

## **5. Who is eligible for the HealthSavings CDHP?**

Employees who meet eligibility requirements for health insurance benefits as defined in the State Group Health Insurance Plan documents may choose the HealthSavings CDHP option.

However, to qualify for a health savings account (HSA) you must:

- Be covered under the HealthSavings CDHP
- Have no other health coverage
- Not be covered by an FSA or an HRA. This means that if your spouse works elsewhere and enrolls/contributes to a FSA then you may not enroll in the CDHP option and contribute to an HSA. This is called double-dipping and the IRS has strict rules against this.
- Not be enrolled in Medicare or other government insurance program

- Not received benefits from the Veteran’s Administration in the past three months
- Not be claimed as a dependent on someone else’s tax return

**6. Can I have “gap” insurance or other health coverage and the CDHP?**

According to the IRS, [irs.gov/publications/p969/ar02.html](https://irs.gov/publications/p969/ar02.html), you (and your spouse, if you have family coverage) generally cannot have any other health coverage that is not a CDHP. However, you can still be an eligible individual even if your spouse has non-CDHP coverage provided you are not covered by that plan. You can have additional insurance that provides benefits only for the following items.

- Liabilities incurred under workers' compensation laws, tort liabilities or liabilities related to ownership or use of property
- A specific disease or illness
- A fixed amount per day (or other period) of hospitalization

You can also have coverage (whether provided through insurance or otherwise) for the following items.

- Accidents
- Disability
- Dental care
- Vision care
- Long-term care

PLEASE NOTE: Coverage not specifically listed above cannot include payment for or reimbursement for your copays or deductible.

**7. How is the HealthSavings CDHP similar to the Partnership, Standard and Limited PPOs?**

They are all insurance plans. The HealthSavings CDHP and the PPO plan options cover the same services and use the same networks and carriers. Just as with your other health plan choices, preventive services are covered 100 percent for in-network providers.

All the plans provide comprehensive medical, behavioral health and prescription drug coverage.

**8. How is the HealthSavings CDHP different from Partnership, Standard and Limited PPOs?**

It has a Health Savings Account and the cost sharing is different. The HealthSavings CDHP has lower premiums and higher deductibles.

- Instead of paying copays, you will pay the full cost of the discounted network rates for services until the deductible is met. Then you pay a portion of the discounted network cost (a 20 or 30 percent coinsurance) until the annual out-of-pocket maximum is reached for in-network providers. The HealthSavings CDHP covers 100 percent of in-network costs after that.
- Instead of paying pharmacy copays, you pay the full negotiated cost of the prescription drugs up to the plan’s combined medical/pharmacy annual deductible, and then pay the coinsurance until the annual out-of-pocket maximum is reached. The plan covers 100 percent of in-network costs after that. There is not a separate pharmacy deductible or out-of-pocket maximum.

For certain 90-day chronic maintenance drugs (e.g., hypertension, high cholesterol), when you choose to fill these kinds of medications in a 90 day supply through Mail Order or a participating Retail-90 network pharmacy, you pay a lower (10 or 20 percent) coinsurance and do not have to meet your deductible first.

There is no individual deductible with family coverage. All deductibles are combined in the family deductible. When it is met, even if it is reached by just one family member, coinsurance rates will be charged until your out-of-pocket maximum is reached. Keep in mind, though, that the entire family deductible amount must be met before any insurance coverage kicks in and you will begin paying coinsurance.

Local government and local education employees: The Limited PPO has a \$100 pharmacy deductible. The HealthSavings CDHP does not have a separate pharmacy deductible or out-of-pocket maximum.

**9. Can I be covered under two CDHP plans?**

Yes, you can be covered under two qualified consumer driven or high deductible health plans, however, you are still limited to the total amount you can contribute to an HSA per year.

**10. Does the coinsurance amount for a maintenance drug count towards the deductible?**

No, but it does go towards the out-of-pocket maximum.

**11. How will I know the cost of healthcare or prescription drugs?**

Your first resource is to check your explanation of benefits statements from the prior year to see what your provider's discounted rates are. You can view online tools on your carriers' websites to view those statements and to search for the consumer cost of healthcare services prior to receiving care (you must register on these sites to access the costs). You can also call the respective carrier and ask them what the provider cost is for the services you seek.

Medical costs:

- BlueCross BlueShield of Tennessee: [bcbst.com/members/tn\\_state](http://bcbst.com/members/tn_state)
- Cigna: [cigna.com/stateoftn](http://cigna.com/stateoftn)

Prescription drugs costs:

- CVS/caremark: [info.caremark.com/stateoftn](http://info.caremark.com/stateoftn)

Contact your healthcare provider or pharmacy directly to verify the cost.

**12. Some 90-day maintenance drugs are at the coinsurance rate before I meet my deductible. How do I know which ones those are?**

There is not an all-inclusive list of drugs for all of the categories because there are a large number of generics and many preferred brands and the number changes regularly.

Drug categories generally covered as a 90-day maintenance drug are:

- Anti-hypertensives (for high blood pressure)
- Statins (for high cholesterol)
- Diabetes drugs, insulins, One Touch test strips, One Touch lancets, and BD needles
- Coronary Artery Disease (CAD) medications
- Congestive Heart Failure (CHF) medications
- Depression medications
- Asthma/COPD meds

If you are unsure whether a medication is a qualified 90-day maintenance drug, call Caremark at 877.522.8679.

Note: The list of Retail 90 day pharmacies is available at:  
[caremark.com/portal/asset/Mail\\_Retail\\_Network\\_Listing.pdf](http://caremark.com/portal/asset/Mail_Retail_Network_Listing.pdf)

**13. If I enroll in the Promise HealthSavings CDHP insurance plan, do I have to complete the Partnership Promise?**

Yes, state and higher education members (and spouses covered by their insurance) who enroll in the Promise HealthSavings CDHP option must complete the Partnership Promise, in exchange for the state's contribution to your HSA

**14. What if I join the Promise HealthSavings CDHP option and do not complete the Partnership Promise. Do I have to give the state's contribution to my HSA back?**

No, you do not have to return the contribution. Once the funds are in your account, they belong to you. If you do not meet the 2016 Partnership Promise requirements, you will not be eligible for the Promise HealthSavings CDHP or Partnership Promise PPO in 2017. Can I change from the HealthSavings CDHP to one of the PPO options next year and then rejoin the HealthSavings CDHP the following year?

Yes, you have the option of changing plans during annual enrollment in the fall, as long as you are eligible for the other plan options.

If you move from a HealthSavings CDHP to a PPO, you will have to pay administrative fees (\$5/month) on your HSA account. The state covers the fees for HealthSavings CDHP actively-enrolled members only.

**15. What if I want to choose the HealthSavings CDHP but my spouse is covered under a non-high-deductible plan?**

This is okay if you are not covered by your spouse's health plan (you cannot have family coverage). You cannot enroll in the CDHP and contribute to the HSA if you have any other coverage unless the other coverage is a CDHP.

If either spouse has family CDHP coverage, both spouses are treated as having family CDHP coverage. If the spouse's employer offers a high-deductible plan, both the employee and spouse can enroll and contribute to their individual HSAs. However, the maximum contribution limit for the two of you is combined.

**16. What if my spouse and I both work for the same employer, what are our HealthSavings CDHP enrollment options?**

If you want to enroll in the HealthSavings CDHP as a family, one of you will choose family coverage under the HealthSavings Plan, and the other will waive medical coverage and will be enrolled as a dependent.

Your spouse may also choose to enroll in one of the PPO options or enroll in the HealthSavings CDHP Plan. If your spouse takes a PPO option, and you take the CDHP option, you may use your HSA funds for your spouse's out of pocket qualified expenses, but your spouse may not cover you under his or her PPO plan if you are enrolled in the CDHP, because IRS rules stipulate that you cannot enroll in the CDHP and contribute to the HSA if you have any other coverage unless the other plan is a qualified high deductible health plan

**17. How do I pay claims with a HealthSavings CDHP?**

There are three ways to pay:

- Use the PayFlex card (your HSA debit card) which you will receive after your enroll, to pay for an eligible expense.

- Pay for eligible expenses with cash, check or a personal credit card. Then request reimbursement online or through the PayFlex Mobile app using “Make a Withdrawal.”
- Use online bill payment (“Make a Payment”) to pay your provider directly from your HSA.

It is up to the provider’s office if you pay during the visit or if the office bills you. In general, providers will submit the claim to the insurance company and bill you the amount owed.

Note: You do not have to pay the medical expenses from the HSA account if you don’t want to do so.

## Health Savings Account (HSA)

### 18. What is a Health Savings Account?

A Health Savings Account (HSA) is a tax-exempt account that individuals can use to pay or save money for qualified medical expenses on a tax-free basis. Our HSA is administered by PayFlex. The money in the account earns interest and when it reaches \$1,000 you can invest any amount over the \$1,000.

### 19. How does the HSA benefit me?

- The money you save in the HSA (both yours and applicable state or local agency contributions) rolls over each year and collects interest. You don’t lose it at the end of the year.
- You can use money in the account to pay your deductible and qualified medical, vision and dental expenses.
- The money is yours! You take the HSA with you if you leave or retire.
- You will receive a PayFlex debit card for yourself and may order additional cards for your spouse and/or dependent(s) to use for medical expenses. There is no charge for the initial cards.

### 20. What are the HSA tax benefits?

The HSA offers a triple tax advantage on money in your account:

- Both employer and employee contributions are tax-free
- Withdrawals for qualified medical expenses are tax-free
- 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 plan (like vision and dental expenses, hearing aids, wheelchairs, contact lenses, acupuncture and more) with a great tax advantage.

Money in the account can be used tax-free for health expenses when you retire. And, when you turn 65, it can be used for non-medical expenses. However, non-medical expenses will be taxed.

### 21. How does an HSA work?

You can use your HSA to pay for qualified medical expenses with tax-free dollars. That includes your deductible costs and your coinsurance amount. You can also use it for other qualified expenses as defined in IRS Publication 502 ([irs.gov/publications/p502/ar02.html](https://www.irs.gov/publications/p502/ar02.html)). Any money left at the end of the year is yours to keep in your HSA for future health expenses.

Visit **ALEX** at [partnersforhealthtn.gov](https://partnersforhealthtn.gov) for more information about how the HealthSavings CDHP HSA works.

For more information about HSAs in general, visit the U.S. Treasury website: [treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx](https://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx)

## 22. How do I contribute and is there an annual limit?

After you enroll in the HealthSavings CDHP, your account with PayFlex will be set up. You can make contributions by payroll deductions, online by linking your bank account to your HSA account on the [PayFlex](#) portal or by mailing a check to PayFlex. You can change your payroll deduction amount at least once per month throughout the year. Any deposits made directly from your bank account or sources other than payroll deduction will need to be claimed on your tax return in order to get the tax benefit.

The IRS determines the maximum amount that can be contributed to your HSA. In 2017, you can contribute up to \$3,400 (single) or \$6,750 (family) annually on a pre-tax basis. If your employer contributes to your account, that is included in the annual maximum amount.

Individuals age 55 and older can make an additional annual catch-up contribution of \$1,000.

**State and higher education employees:** You will enter the amount you want to contribute to your HSA on a per-pay-period basis in ESS. **The state will contribute \$500 (single) or \$1,000 (family) into your HSA account if you are enrolled in the Partnership Promise HealthSavings CDHP and you can make additional contributions. Employees in the No Promise HealthSavings CDHP can make their own contributions by payroll deduction.**

If the coverage effective date for a plan member is anytime from September 2, 2017, through the end of 2017, then the employee will not receive any seed funding from the state (state and higher education employees).

**Local education and local government employees:** Check with your agency benefits coordinator regarding setting up payroll deduction. Your employer may also contribute money to your HSA. Please check with your agency benefits coordinator to find out if there is an employer contribution.

## 23. How and when is money contributed to my HSA?

Once your PayFlex account is activated, your payroll contributions and your employer's contributions (if applicable) will be deposited in your PayFlex account and are typically available within 48 hours.

**State and higher education employees:** If eligible, the state's contribution will be deposited in your HSA account each year in January. For new hires, the funds will be deposited into the HSA after your coverage begin date and once your HSA is set up.

**Local education and local government employees:** Check with your agency benefits coordinator to find out if and when any employer contribution might be deposited in your HSA account.

## 24. If I need to pay for a medical expense and my account does not have enough money to cover it, what happens?

You can pay for it with other funds and then reimburse yourself when the money is available in the HSA account. If an unexpected qualified medical expense comes up, you can deposit additional money in the HSA to cover it, as long as it does not exceed the IRS maximum. You do not have to use the money in your HSA account if you don't want to.

## 25. What are qualified medical expenses?

An HSA-qualified medical expense is any healthcare cost paid on behalf of an individual or his or her spouse or dependents as defined in the Internal Revenue Code. The most common are listed on the PayFlex site: <https://www.payflex.com/individuals/common-eligible-expenses/health-care> You can also find them on the IRS site: [irs.gov/publications/p502/ar02.html](https://www.irs.gov/publications/p502/ar02.html) (see page 5)

Some examples include:

- Acupuncture
- Substance abuse treatment
- Artificial limbs
- Chiropractor
- Crutches
- Disabled Dependent Care
- Fertility treatment
- Home care
- Therapy
- Nursing home
- Long-term care
- Wheelchair

**26. Can my HSA be used to pay premiums?**

No. Generally, you may not pay for your health insurance premiums from your HSA. However, HSA funds can be used to pay for premium payments for the following:

- Long-term care insurance; however, the amount is based on age and adjusted for inflation each year. See IRS Revenue Code 213(d)(10). Currently, the limits for the following attained ages before the close of the tax year are:
  - 40 or less \$390
  - More than 40 but less than 50 \$730
  - More than 50 but less than 60 \$1,460
  - More than 60 but less than 70 \$3,900
  - More than 70 \$4,870
- Healthcare continuation coverage (such as coverage under COBRA)
- Healthcare coverage while receiving unemployment compensation under federal or state law
- Medicare and other healthcare coverage if you are 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap)

**27. Can I use the HSA funds to pay for alternative medicine?**

You should check IRS Publications 502 for eligible items. Acupuncture, chiropractor services and more are among the non-traditional services you can pay for with your HSA. [irs.gov/publications/p502/ar02.html](https://www.irs.gov/publications/p502/ar02.html) (see page 5)

**28. Can I use the HSA funds for non-healthcare expenses?**

Yes. However, if you do and are under age 65, you will need to reimburse your account the funds withdrawn. If you don't reimburse the funds, you will be taxed on the amount you use and assessed a 20 percent penalty. Once you are age 65 or older, you will be taxed for monies used for non-medical expenses, but will not pay a penalty.

**29. Can I use the HSA to cover my children?**

If you claim a child age 24 or under as a tax dependent and he or she is on your family health plan, the HSA can be used for his or her medical expenses. If you have a child age 25-26, your HSA may not be used to cover his or her expenses even if he or she is on your HealthSavings CDHP plan. This dependent can have his or her own HSA account and contribute up to the family maximum in this account as long as he or she is not claimed on another tax return.

**30. Can medical expenses for children not claimed on taxes be paid from the HSA account?**

You cannot cover medical expenses for children not claimed as dependents on your tax return. However, if you and a former spouse were legally divorced or separated at the end of the calendar year or lived apart during the last six months of the calendar year, your child is then treated as a dependent of both you and

your former spouse, even if your child's tax exemption is claimed by your former spouse. In this situation, you could use your HSA to pay for your child's eligible healthcare expenses.

It is important to note that if you use your HSA to pay for your child's eligible healthcare expenses; your former spouse can't use his or her HSA to pay for the same expenses. For more information, please refer to [IRS publication 969](#).

### **31. Is the HSA opened for me automatically?**

If you choose the HealthSavings CDHP option, you will automatically receive a welcome letter or email from Payflex. In order to open your HSA, Payflex has to confirm your full name, address, birth date and social security number. This is required under Section 326 of the USA PATRIOT ACT. You may have heard of it as the Customer identification Process (CIP). Be sure to use the most accurate and current information when you enroll in your benefits. For example, use your legal name, not a nickname. Once your identity is confirmed, you will receive a debit card from Payflex and can set up your account online or on your mobile app. If your information does not pass the CIP, Payflex will send you a letter requesting documentation needed to confirm your identity or address.

**State and higher education employees: If you select the Promise HealthSavings CDHP, the state's contribution of \$500 (single coverage) or \$1,000 (family coverage) will be deposited into your HSA once it is set up.** If your coverage effective date is after September 1, 2017, the state contribution for 2017 is not available. However, if you stay enrolled in the Promise HealthSavings CDHP into 2018 then you will receive the state contribution to your HSA in early January 2018.

**Higher education employees:** Even if you already have a PayFlex FSA debit card, you will be issued a new card for the HSA. Keep in mind, if you have funds in your FSA account, you will not be able to fund your HSA until the balance is zero and after the grace period has ended.

### **32. Can the funds in a HSA be invested?**

Yes, you can invest the funds in your HSA once the balance in your account reaches \$1,000. Any amount over the \$1,000 can be invested. The same types of investments permitted for IRAs are allowed for HSAs, including stocks, bonds, mutual funds and certificates of deposit. Visit the PayFlex website or call them for more information about investment opportunities.

Even if you do not invest the funds, the money will earn interest at the current rate. The interest rate as of 8/31/16 is 0.25%

### **33. What if the investment account loses money?**

As with any investment, there are no guarantees. You are not obligated to invest the funds. In addition, any non-invested funds in your account earn interest based on the current interest rates.

### **34. What are the differences between a Flexible Spending Account (FSA) and a HSA?**

A healthcare flexible spending account (FSA) allows employees to be reimbursed for medical expenses. An FSA is usually funded through voluntary salary contributions. No employment or federal income taxes are deducted from your contribution.

The most important difference between the FSA and the HSA is that any remaining balance in the HSA rolls over at the end of the year. You can only carry over a maximum of \$500 in your FSA account at the end of the year. Any unused funds beyond the carry over amount of \$500 will be forfeited.

To access money in your HSA or FSA, simply use the debit card provided by PayFlex. If you elect to add your own funds to your HSA through monthly payroll you can use only the amount that is actually in the account, not the amount that you "pledge" for the year as with the FSA.

**35. Can I have both a HSA account and a FSA account?**

If you have a HSA you cannot have a medical FSA account, but you can open a “limited purpose medical FSA” to use for dental and vision expenses. Dependent care, parking and transportation flexible spending accounts are still allowed. Consider a limited purpose FSA if you contribute the annual maximum to your HSA. You should consider contributing the maximum allowed to your HSA before contributing to your limited purpose FSA because HSA dollars are not “use it or lose it” like an FSA.

And, you cannot open an HSA if there are funds remaining in your 2016 FSA in 2016 as follows:

- If your FSA plan runs on a calendar year and has a grace period:
  - Your FSA balance must be zero on December 31, 2016, in order to be eligible for the HSA on January 1, 2017.
  - If your FSA has a balance on December 31, 2016, you will not be eligible to set up your HSA until April 1, 2017.
- If you have an FSA plan that runs on a non-calendar year (the State and Higher Education’s FSA plan runs on a calendar year, but Local Education and Local Government agencies who administer their own FSA plans may utilize a different timetable), you cannot fund your HSA until the end of your FSA year and if there is a grace period, use this example. DR Comment Please see date changes in this section.
  - Using this year as an example: a FSA that runs from 2/1/16 – 1/31/17 with a grace period allowing an employee to incur claims until 4/15/17 and if:
    - Your FSA balance must be zero on 1/31/16 to be eligible to open an HSA on 2/1/17 if covered by the CDHP.
    - Your FSA balance is not at zero on 1/31/16, you are not eligible to open an HSA until the end of the FSA calendar year (1/31/17) or, if your plan offers a grace period, until first of the month following the grace period, or 5/1/17 in this example, to fund or use the HSA.

NOTE: Any funds posted in the HSA cannot be used for claims incurred prior to or the date the HSA opened. For FSA plans where grace period is less than examples shown, employees are not eligible to open an HSA until the first of the month following that grace period.

**36. If I enroll in the HealthSavings CDHP and my spouse has a medical FSA, can I still contribute to a HSA?**

No, you are not eligible for a HSA if you have access to medical FSA funds, unless it is a limited purpose medical FSA for dental and vision expenses only. Dependent care, parking and transportation flexible spending accounts are still allowed. The same rules apply to HRAs.

**37. Who can contribute to my HSA?**

You, your employer and family members who are eligible to use the HSA account. Contribution gifts from friends or relatives are also allowed but are not eligible for tax benefits. Only the employee account holder and employer contributions are tax free.

**38. Can I take the money out of my HSA any time I want?**

For qualified medical expenses, you can take money out anytime, tax-free and without penalty. If funds are withdrawn for other purposes, you will pay income taxes on the withdrawal plus a 20 percent penalty. You need to keep all of your receipts for possible IRS audit.

When you reach 65, you can use the money for non-medical expenses but will be required to pay taxes on those expenditures; however there will not be a penalty.

- 39. Does the money I have in my HSA rollover from year to year or do I lose the money at the end of the year?**  
Your HSA balance will roll over from year to year. You do not lose the money left in your HSA, or the interest it has earned at the end of the year like some other health accounts. It is your money.
- 40. What happens to the money in my HSA if I change health plans, leave my job or retire?**  
You own the HSA. The money is yours to keep. If you retire, are insured by Medicare, on COBRA, change to a non HSA-qualified plan or go to another employer that does not offer a qualified plan, you can still use the money in your HSA to pay for out-of-pocket qualified medical expenses. However, you will not be able to continue to add money to your HSA. Also, PayFlex will start deducting the account fees that the state was covering (\$5/month) from the account.
- 41. If I leave the state and go to an employer that offers a traditional plan (without a HSA) can I still use my HSA money?**  
Yes. As long as you use the money for qualified medical expenses, you can use the HSA funds until they are gone. You can also save them to cover medical costs when you retire. However, if you use them for non-qualified expenses you will pay the taxes. There is also a 20 percent penalty for non-qualified payments (prior to age 65).
- 42. If I quit my job in the middle of the year, do I have to give part of my employer's contribution back?**  
No, that money is yours to take with you when you leave and use for qualified medical expenses. However, your annual maximum amount allowed by the IRS will be prorated based on the amount of time you were employed at the state in that year. If your contributions exceed that prorated amount, you will be responsible for paying income tax on the additional amount.  
  
For example, if you leave your job on June 30, the individual amount you will be allowed to contribute for that year will be prorated to 6 months, or divided in half. Instead of \$3,400 it will be \$1,700. Any contributions (both yours and your employers) above that amount that year will be subject to tax.
- 43. Can I contribute the maximum annual amount to my account no matter when I am hired?**  
You can contribute the maximum amount if you follow the IRS testing period and remain in a CDHP all 12 months of the next calendar year. Otherwise, your allowable contribution for the year will be prorated based on the number of months you are enrolled in the HealthSavings CDHP. DR Comment – I'm not sure if you want to add this in, but there is something called the last month rule and the testing period. This is taken directly from IRS Publication 969.
- 44. Can I roll the HSA account into a 401K?**  
No. Your HSA cannot be rolled into another account. You are, however, able to make a one-time transfer from an IRA into your HSA account. DR Comment – this IRS transfer does apply to your contribution limit for the year.
- 45. Will I receive any regular reporting on my account?**  
Statements are available monthly online. You can request a paper statement from PayFlex.
- 46. What happens if I exceed the contribution amount?**  
You will be responsible for reporting the excess funds on your income taxes. Any excess funds will be taxed based on the 1099 form and rates. It is best to consult a tax professional for additional information.

**47. Are there fees associated with a HSA?**

Yes. The state group health insurance plan will pay the monthly maintenance fee as long as you are enrolled in either HealthSavings CDHP. You are responsible for investments fees. You are also responsible for standard banking fees such as non-sufficient funds and stop payments.

- Non-Sufficient Funds (NSF) Fee (Overdraft) - \$25.00
- Deposit Item Returned – \$25.00
- Stop Payment (per check) - \$25.00
- Wire Transfer (per instance) - \$15.00
- Monthly Investment Account Fee (if member chooses to invest any HSA balance over \$1,000) - \$1.30

**48. Who pays the HSA fees if I leave the state group health insurance plan?**

You will be responsible for any fees associated with the HSA including the ones previously covered by the state group health insurance plan.

**49. What happens to my HSA when I die?**

You will choose a beneficiary when you set up your HSA.

- If your spouse is the designated beneficiary of your HSA, it will be treated as your spouse’s HSA after your death.
- If your spouse is not the designated beneficiary of your HSA:
  - The account stops being an HSA, and
  - The fair market value of the HSA becomes taxable to the beneficiary in the year in which you die.
- If your estate is the beneficiary, the value is included on your final income tax return.

**50. Can I make post-tax contributions? And if so, will I get the tax benefit?**

Yes, and then it can be claimed as a deduction on your annual tax return.

**51. If my spouse has insurance, can I use my HSA account for his/her expenses?**

Yes. Qualified medical expenses are those incurred by the following persons.

- You and your spouse
- All dependents you claim on your tax return
- Any person you could have claimed as a dependent on your return except that:
  - The person filed a joint return,
  - The person had gross income of \$4,000 or more, or
  - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

**52. Can my employer see my HSA account balance?**

No. That is your personal account, like a bank account. It is ultimately your responsibility to ensure that you stay within the maximum contributions allowed by the IRS annually.

**53. Are the PayFlex HSA funds FDIC insured?**

Yes, the funds in the HSA account are FDIC insured. However, once the funds reach \$1,000 and if the account holder chooses to invest the funds, the investments are not insured. Additionally, the PayFlex debit card is a MasterCard so PayFlex cardholders have access to identity theft resolution services at no cost.

**54. Do I have to use PayFlex for my HSA?**

Plan members are not required to use the state-sponsored insurance program's vendor, PayFlex, for their HSA. However, when you enroll in a CDHP, an HSA will automatically be set up for you with PayFlex, and it will be your responsibility to close it if you choose to do so. Also, be aware that actively enrolled plan members' monthly account maintenance fees for the HSA are being paid for by the State Insurance Program. If you open another HSA elsewhere, you will be responsible for any monthly account fees. Further, your employer (whether it be the State, a Higher Education institution, a local education school system, or a local government entity) will not be able to take funds from your paycheck on a pretax basis and transmit them to your HSA institution. If your employer plans to transmit their contributed funds (not your paycheck contributions) on a monthly or bi-monthly basis to PayFlex, you would likely lose out on those funds as they are already set up to transmit to PayFlex. If you want to open an HSA with your own institution, you would need to contribute after-tax funds (up to your maximum contribution) via check or electronic deposit and then take an above-the-line tax deduction on your taxes next year.

**55. If I am eligible to receive free health care at any VA, can I enroll in the CDHP plan?**

The short answer is no. At the IRS website we have included below, there are a series of questions and answers that have been posed by employers and payers alike regarding Health Savings Accounts and CDHPs (also known as HDHPs – high deductible health plans). Q&A 5 addresses the question posed here, and we have cut and pasted it below for clarity:

Q-5. If an otherwise eligible individual under section 223(c)(1) is eligible for medical benefits through the Department of Veterans Affairs (VA), may he or she contribute to an HSA?

A-5. An otherwise eligible individual who is eligible to receive VA medical benefits, but who has not actually received such benefits during the preceding three months, is an eligible individual under section 223(c)(1). An individual is not eligible to make HSA contributions for any month, however, if the individual has received medical benefits from the VA at any time during the previous three months.

Because a plan member must enroll in a CDHP in order to open an HSA and because the HSA is automatically opened for the member once they enroll in a CDHP option, this would preclude a member from enrolling in the CDHP since the member is receiving free healthcare at a VA facility. The only provision that would allow the member – in this instance – to enroll in the CDHP and open an HSA is if he or she either-

- a. Does not receive any care from a VA facility for 3 months -OR-
- b. Only receives care from a VA facility for a service-connected disability (and it must be a disability)

[https://www.irs.gov/irb/2004-33\\_IRB/ar08.html](https://www.irs.gov/irb/2004-33_IRB/ar08.html)

## CDHP/HSA and Medicare

### Medicare, Medicaid, TennCare with CDHP

When looking at the HealthSavings CDHP and the HSA, it is best to consult a tax professional regarding your personal finances and the impact on your federal income taxes.

Two publications for reference:

- IRS Publication 969 [irs.gov/pub/irs-pdf/p969.pdf](https://irs.gov/pub/irs-pdf/p969.pdf)
- IRS Publication 502 - [irs.gov/pub/irs-pdf/p502.pdf](https://irs.gov/pub/irs-pdf/p502.pdf)

#### 56. Can I enroll in the HealthSavings CDHP if I have Medicare?

No, you are not eligible to enroll in the state's HealthSavings CDHP if you receive Medicare or any other government program coverage (Medicaid, TennCare, TRICARE).

#### 57. What if I enroll in the HealthSavings CDHP and then enroll in Medicare Part A later in the plan year?

You will be able to remain in the HealthSavings for the plan year, but will no longer be allowed to make contributions or receive employer contributions in your HSA. You may continue to use the existing funds in your account to pay for qualified medical expenses. You will not be eligible to continue in the HealthSavings CDHP plan for the following year.

#### 58. Can I use the money in my HSA when I am receiving Medicare (Part A, B or D) benefits?

Yes. If you are receiving Medicare benefits, you can withdraw from your remaining HSA balance to pay for healthcare expenses and pay for your Medicare premiums (does not apply to Medigap or Medicare Advantage premiums).

However, you will not be able to continue contributions to your account once you are enrolled in Medicare. This includes pre-65 disability Medicare.

When you are no longer enrolled in the CDHP, you will become responsible for paying any administrative bank fees previously covered by the state.

#### 59. If my spouse is on Medicare, can I choose the HealthSavings CDHP?

Yes. As long as you are otherwise eligible to have a HSA (you are not on Medicare, not enrolled in another plan that is not a qualified HDHP, not claimed as a dependent on another individual's tax return) you can choose the HealthSavings CDHP.

#### 60. If my dependent child is on Medicaid or TennCare, can he or she be covered by the HealthSavings CDHP?

Yes. Your dependent child can also be covered by the HealthSavings CDHP and you will qualify for the family maximum in your HSA. The HSA funds can be used to cover dependent medical expenses not covered by the other insurance plan.

**61. Can you postpone Medicare enrollment if you are still working in order to sign up for the CDHP plan and contribute to a HSA account?**

Yes (see Medicare, page 10 [ssa.gov/pubs/EN-05-10043.pdf](https://ssa.gov/pubs/EN-05-10043.pdf)). However, even if you want to postpone Medicare enrollment until after you quit working but intend to enroll in Social Security, you will be automatically enrolled in Part A when you do enroll in Social Security as the law does not allow one to enroll in Social Security and opt out of Medicare Part A. So if you want to postpone Part A you must also postpone Social Security benefits to be eligible for HSA contributions.

## **Flexible Spending Account (FSA)**

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**1. What is a flexible spending account (FSA)?**

A FSA lets you set aside pre-tax money from your paycheck to use for eligible out-of-pocket expenses. You do not need to be enrolled in the state health plan to enroll in a FSA.

**2. Can you have both a medical FSA and a HSA?**

No, but you can have a limited purpose FSA and a HSA.

**3. What is the benefit of a FSA?**

A medical FSA makes it easy to save funds to use for eligible healthcare expenses that are not covered by insurance.

- Your entire contribution is available at the beginning of the plan year.
- Your healthcare FSA funds can be used by you and:
  - Your spouse
  - Your child (up to age 26); and/or
  - Your tax dependent who is permanently and totally disabled

**4. What are some common medical FSA eligible expenses?**

- Medical and dental deductibles, copays and coinsurance
- Prescriptions
- Over-the-counter (OTC) items (OTC drugs and medicines require a prescription)
- Hospital expenses
- LASIK surgery and eye glasses
- Contact lenses and saline solution
- Hearing aids and batteries
- Orthopedic devices

**5. What is the benefit of a dependent care FSA?**

A dependent care FSA is a great way to save funds for eligible childcare and adult-care expenses. Eligible expenses can be used for:

- Childcare for your eligible dependent under age 13 and

- Care for a spouse or dependent unable to take care of him/herself.

To use your funds, you must be working. If you are married, your spouse must either be working, looking for work, a full-time student or incapable of self-care. Funds become available as they are deducted from your paycheck and deposited into your account. In other words, you do not have your entire yearly pledge available to use on January 1 as you do with a healthcare FSA.

**6. What are some common eligible expenses?**

- Child and adult day care
- In-home provider (this cannot be your child under age 19 or someone you claim as a tax dependent)
- Summer camps (not overnight)
- Tuition through preschool
- Before and after school care

**7. Will dependent care FSA funds be available on the PayFlex debit card?**

No. Those funds will not be loaded onto the debit card. You will have to file a claim with PayFlex for a dependent care expense.

**8. What else do I need to know about my contributions?**

To help plan your contribution, think about the eligible expenses you had last year and/or this year. Then, what you expect next year.

**9. How do you use the PayFlex Card®?**

Simply swipe the card and select either debit or credit. If you choose debit, you may need a PIN to complete the transaction. You must contact PayFlex after you receive your debit card to set up a PIN. After you swipe the card, the system automatically confirms whether you have enough funds to pay for the expense.

**10. What can you buy with the card?**

You can use the card to pay for eligible healthcare FSA expenses.

**11. Where can you use the card?**

- Physician and dentist offices, vision care providers and hospitals
- Grocery stores, discount stores, web-based merchants
- Drug stores and retail pharmacies

**12. What can you use a limited purpose FSA for?**

You can use a limited purpose FSA only to pay for eligible out-of-pocket dental and vision expenses. Eligible expenses include:

- Dental and orthodontia care, including fillings, x-rays and braces
- Vision care, including eyeglasses, contact lenses and LASIK surgery

**13. What are some benefits of a limited purpose FSA?**

- A limited purpose FSA helps you save money on taxes for certain eligible expenses
- Your entire contribution is available at the beginning of the plan year
- Works great with a HSA, helping save your HSA funds for future medical expenses or for healthcare expenses in retirement

**14. Can you have both a HSA account and a FSA account?**

- If you have a HSA, you cannot have a medical FSA account, but you can open a limited purpose FSA to use for dental and vision expenses.
- Consider a limited purpose FSA if you contribute the annual maximum to your HSA. You should consider contributing the maximum allowed to your HSA before contributing to your limited purpose FSA because HSA dollars are not “use it or lose it” like an FSA.
- Dependent care, parking and transportation FSAs are still allowed.

NOTE: You cannot open a HSA for 2017 if there are funds remaining in your 2016 FSA as follows:

- If your FSA plan runs on a calendar year, which the state’s does, and has a grace period:
  - Your FSA balance must be zero on December 31, 2016, in order to be eligible for the HSA on January 1, 2017.
  - If your FSA has a balance on December 31, 2016, you will not be eligible to set up your HSA until April 1, 2017.
  - If your FSA has a balance on December 31, 2016, and you are not eligible to set up your HSA with PayFlex until April 1, 2017, then you will not be able to claim any expense for January, February and March against your FSA pledge.

**15. How can you use your medical or limited purpose FSA funds?**

Use the PayFlex Card®, your account debit card (medical or limited purpose FSA only)

- Use the card to pay for eligible healthcare FSA expenses.
- Funds automatically come out of your account, if the funds are available.

**16. Does a FSA hurt my other benefits?**

Your Social Security will be slightly impacted if below the Social Security wage base.

**17. What about termination or change in employment?**

- You may want to accelerate your expenses to use up your account balance before termination. Once terminated, no expenses incurred after your last paid date can be reimbursed.
- Flexible benefits participation continues for job transfers within state government.
- Breaks and leaves of absence can cause you to be treated as a terminated employee.
- Check with your personnel officer for details.

**18. What is the significance of the plan year?**

Your enrollment cannot be changed during the plan year unless you have a change in family status and you report the change to the plan within 60 days of the event.

You must re-enroll in medical and dependent care accounts each year to continue participation.

Only expenses for services incurred during the plan year and your period of coverage may be reimbursed.

The plan year is a calendar year: January 1 through December 31. If you are hired after the plan year has already begun, the plan begins with the first contribution and ends December 31.

## Pharmacy

For general information about pharmacy including finding a network pharmacy, flu and pneumococcal vaccine and tobacco quit aids, visit the [Pharmacy](#) page.

**1. What happens if I ask for a brand name medication when my doctor writes a prescription indicating that a generic drug can be substituted?**

When a generic is available and your doctor indicates “may substitute” but you request the brand name drug from the pharmacy, you will pay the difference between the brand name drug and the generic drug plus the brand copay (PPO) or coinsurance (CHDP).

**2. Is the shingles vaccine covered by the state’s health insurance plans, and can the state lower the age limit for receiving the vaccine?**

The Zoster vaccination for Shingles is covered. Immunization schedules are based on the Centers for Disease Control and Prevention guidelines and are subject to change. We follow the CDC recommendation on age, which is that vaccination begins at age 60. There are no anticipated changes in regards to the Shingles vaccine at this time. Current guidelines can be found under the CDC schedules at [cdc.gov/vaccines](http://cdc.gov/vaccines).

**3. What is the maintenance tier?**

There are lower copays and coinsurance on a large group of maintenance drugs from the special, less costly 90-day network. To utilize the maintenance tier and to receive the lower cost associated with it, you must fill a 90-day supply either through a 90-day network pharmacy or via mail order. These medications include:

- Oral diabetic medications, insulin and supplies (test strips, lancets & needles)
- Statins (cholesterol-lowering drugs)
- Antihypertensives (blood pressure medications)
- Depression
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)

Some of the more common drugs that are eligible for the reduced copay are: Metformin, Glimepiride, Actos, Januvia, Novolog, Simvastatin, Crestor, Atorvastatin, Pravastatin, Lovastatin, Lisinopril, Hydrochlorothiazide, Amlodipine and Atenolol.

Tier	90-Day Maintenance Copay			90-Day Maintenance Coinsurance	
	Partnership PPO	Standard PPO	Limited PPO	Local HealthSavings	State/Higher Ed HealthSavings
Generic	\$7	\$14	\$14	10%	10%
Preferred	\$40	\$50	\$60	10%	20%
Non-Preferred	\$160	\$180	\$200	10%	20%

**4. How can I find out if my drug is included in the maintenance drug list?**

You can call Caremark at 877.522.TNRX (8679) to find out if your drug qualifies.

**5. I have diabetes. Can I use any lancets and test strips?**

This benefit changed effective January 1, 2015. See this [flier](#) for important details.

You can use any lancets and test strips, but you will pay more if you use a non-preferred brand (Tier 3).

OneTouch test strips and lancets are the only preferred brand products available.

**6. What if I take a drug that is not on the Caremark drug list?**

You need to contact Caremark about your options if the drug you are taking is not covered under the approved drug list. Most non-preferred brand name medications are covered, but in choosing to fill these you will have to pay more.

**7. I tried to get a prescription filled but my claim was denied because the medication is now available over the counter. Does this mean my pharmacy benefits are becoming more limited?**

As medications become available in over-the-counter forms, such as Allegra (fexofenadine), Claritin (loratidine) and Zyrtec (ceterizine), the insurance plans no longer cover them, and members must purchase these out-of-pocket at the pharmacy or store without a prescription. This requirement has existed for years and serves to save the plans money, which in turn helps to keep premium increases to as low of a percentage as possible.

The plan benefits are not decreasing; it is impossible for the insurance plans to continue to cover every single drug once it loses its patent and becomes available over the counter. If the plans continued to cover those medications indefinitely, the increase in premiums would be much higher than employee groups and employees see each year. The plans still serve their intended function to protect plan members and employees against catastrophic loss in the event of a major health issue.

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

For some drugs, there may be a post-quantity limit authorization available. Your doctor will need to contact Caremark and provide clinical information to request an amount over the plan limit. As the plan's pharmacy benefits manager, Caremark will review this information and decide if the insurance plans should cover the amount above the limit.

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

All appeals are handled by Caremark, our pharmacy benefits manager. Call Caremark at 877.522.8679 to begin the process, to ask questions about how to appeal and to check the status of your appeal. If your drug is denied, both you and your doctor will receive a denial letter explaining the reason why it was denied as well as your options for appeal and how to go about filing an appeal.

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

Contact your doctor and ask him or her to call Caremark directly at 800.626.3046 (doctors only) to request prior authorization for your prescription.

## Other Covered Services

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### 1. What is considered preventive care and what is covered?

Preventive care refers to services or tests that help identify health risks and is covered at no cost to you when received in-network. For example, preventive care includes screening mammograms, annual wellness exam/physical and immunizations. In many cases, preventive care helps a patient avoid a serious or even life-threatening disease.

If your annual preventive visit includes discussion or treatment of a specific health issue, you may be required to pay the copay or coinsurance for a regular office visit. Claims are processed based on the diagnosis submitted by the provider, so it is important for the provider to file the claim as preventive.

### 2. Do I have to pay a copay or coinsurance for an annual well-woman visit if I also have an annual physical with my internist or family doctor?

A well-woman visit is an annual preventive visit just like an annual physical or exam. As part of your health insurance, female members can have a well-woman visit and a physical each year. Both of these visits are covered at no cost to the member when received in-network.

### 3. How are mammograms covered by our insurance plan?

Our benefit covers screening mammograms based on your doctor's recommendations. You do not have to pay if you receive a screening mammogram in-network. To learn more about evidence-based recommendations from the U.S. Preventive Services Task Force (USPSTF) and coverage for preventive services required by the Affordable Care Act, visit [uspreventiveservicestaskforce.org](http://uspreventiveservicestaskforce.org).

Diagnostic mammograms are also covered under the plan. As with other non-preventive x-rays, labs and diagnostics including reading and interpretation (not including advanced x-rays, scans and imaging), the in-network benefit on the PPO plans is a coinsurance percentage without first meeting your deductible. The in-network benefit on the HealthSavings CDHPs is covered with applicable coinsurance after you have met the deductible.

### 4. How are colonoscopies covered by our insurance plan?

All in-network preventive services, including screening colonoscopies, are covered at no charge. Diagnostic colonoscopies are also covered but require a member payment. Providers determine which type of testing is appropriate based on factors such as a patient's history, other tests and current symptoms and complaints. Payment for colonoscopy services is driven by the provider's billing.

Under current coverage guidelines, a screening colonoscopy every ten years is considered medically necessary for asymptomatic individuals age 50 or older. If medically necessary, due to certain risk factors, screening may begin at an earlier age and occur more frequently.

### 5. What is the difference between a screening and diagnostic colonoscopy?

A screening colonoscopy is performed on an individual without symptoms, who has not been diagnosed with colorectal cancer or additional risk factors for colorectal cancer, such as polyps or inflammatory bowel disease, prior to the start of the screening exam. Please be aware that the insurance companies must process claims based on the provider's billing. If you have a preventive screening colonoscopy billed as a diagnostic exam instead, you should contact the provider's office to discuss the services received and to ask if the claim can be resubmitted with preventive coding. If the provider's office does not agree to resubmit the claim, you should contact the insurance carrier to request a review of the claim. It's possible that claims

originally billed as diagnostic may be reprocessed or adjusted to pay as preventive but only if it can be verified through the provider's office that the exam started out as a preventive screening.

**6. Are allergy shots covered?**

Yes, allergy shots are covered. If you are in one of the PPO plans, there is no copay for the allergy shot but you could be asked to pay an office visit copay if your doctor's office charges for an office visit in addition to the allergy shot. If enrolled in a HealthSavings CDHP, your doctor's office may charge the cost of the office visit or you may pay the coinsurance rate, depending on if your deductible has been met.

**7. Do advanced imaging and outpatient surgery require a copay or coinsurance?**

The deductible, coinsurance and the out-of-pocket maximum will apply to advanced imaging and outpatient surgery.

**8. Does dialysis require a copay or coinsurance?**

Dialysis is subject to the deductible and coinsurance. This means members are protected by the out-of-pocket maximum. Because dialysis visits happen often, this approach benefits members the most.

**9. How are maternity benefits covered?**

It is important to note that ALL OB/GYN doctors are considered primary care doctors. If enrolled in a PPO plan, you will pay the primary care copay. You only have to pay a copay for your first visit to confirm your pregnancy. You will then pay for the delivery, which is subject to the deductible, coinsurance and out-of-pocket maximum. If enrolled in a HealthSavings CDHP, your doctor's office may charge the cost of the office visit or you may pay the coinsurance rate, depending on if your deductible has been met.

If you have any difficulties and need to see a specialist other than your OB/GYN or need extra time in the hospital, those services will have either a copay or coinsurance and the deductible will apply.

**10. How is chemotherapy covered?**

If enrolled in a PPO plan, you will pay a copay if the therapy is done in a doctor's office. If the therapy is done in an outpatient facility or hospital coinsurance will apply. If enrolled in a HealthSavings CDHP, you may be charged the negotiated rate of the service or the coinsurance rate, depending on if your deductible has been met.

**11. How is durable medical equipment (DME) covered?**

Durable medical equipment is subject to the deductible and coinsurance. For in-network services, members are responsible for the following after the deductible has been met.

Partnership PPO	10%
Standard PPO	20%
Limited PPO	30%
HealthSavings CDHP	20%
Local HealthSavings CDHP	30%

**12. What happens if I have a high medical bill? Will I have to pay coinsurance for the whole amount?**

No. Our health plans have what is known as an out-of-pocket maximum. Once you pay this amount, your health plan will pay 100 percent of your covered expenses the rest of the plan year. This protects members who have very high medical bills.

## BlueCross BlueShield & Cigna

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For general information about carrier information including provider directories and premiums costs, visit the [Carrier Information](#) page.

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

All of the healthcare options offer the same services and treatments. State and higher education employees are eligible for the Partnership Promise PPO, No Partnership Promise PPO, Standard PPO, Promise HealthSavings CDHP and No Promise HealthSavings CDHP. Local education and local government employees are eligible for the Partnership Promise PPO, No Partnership Promise PPO, Standard PPO, Limited PPO, and the HealthSavings CDHP

**2. Does everyone have a choice of insurance carriers?**

Yes. Every eligible member can chose between two insurance carriers – BlueCross BlueShield and Cigna. Both carriers offer all of the health plan options.

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

You should always carefully review your explanation of benefits (EOB) and contact your insurance carrier if you have any questions. Contact information for your carrier is printed on the back of your insurance card.

**4. If I live in the east region, does that mean I can only go to doctors in that region?**

No. The regions just show where our members live and work. This does not mean that you can only go to doctors and hospitals in your area. In both BlueCross BlueShield and Cigna plans, you will always have access to doctors and medical facilities across Tennessee and across the country.

**5. What is the Informed Choice Outreach Program offered by Cigna?**

Cigna’s MedSolutions national program features a support and outreach program called Informed Choice. The goal of the program is to educate members undergoing an MRI, CT or PET scan about their options for geographically convenient and cost-effective facilities as they and their doctors choose where to have the tests done.

After a physician contacts MedSolutions for precertification of coverage of an MRI, CT or PET scan, a specially trained representative may contact the member by phone and provide information about conveniently located credentialed participating facilities (hospitals or free-standing facilities) and offer appointment options. MedSolutions representatives can also provide cost comparison information, so that members are aware of the financial impact of their choices.

MedSolutions can assist members in scheduling an appointment at the individual’s facility of choice and complete the referral for the services that have been authorized for coverage. In addition, if the member has additional questions about benefits, account-based balances (e.g., HRA or HSA), or other plan details, the MedSolutions representative can connect directly with Cigna's customer service team.

This proactive outreach occurs only when true opportunities for choice exist, such as when the ordering physician has requested a higher cost radiology center or hospital for services and other participating credentialed centers offer the same services at a lower cost.

**6. Is the plan design any different for the Cigna LocalPlus, Cigna Open Access Plus or the BCBS Network S?**

No. The health plans all cover the same general benefits. The only difference is in the network of available doctors and facilities.

**7. What happens when I go to a provider outside LocalPlus but within other Cigna networks?**

When a customer visits a non-LocalPlus provider within the LocalPlus area, coverage will be at the out-of-network rate. When a customer is outside of the LocalPlus service area, but the provider is within the Cigna OAP network, coverage will be at OAP in-network rates. As a reminder, if the provider is out-of-network, coverage will be at the out-of-network rate.

**8. What network options are offered by the State of Tennessee?**

The State of Tennessee offers BlueCross BlueShield Network S, Cigna LocalPlus and Cigna Open Access Plus.

BlueCross BlueShield offers a national and international network. Cigna offers the LocalPlus Network in certain areas nationally. Cigna Open Access Plus is a new, larger network. You will have a choice of more doctors and facilities, including Baptist Memphis, but will pay more. The following surcharges will apply:

- \$40 more for employees only and employee + child(ren) coverage
- \$80 more for employee + spouse and employee + spouse + child(ren) coverage

It is best to contact the carriers directly for more information on specific providers.

## ParTNers Employee Assistance Program (EAP)

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For general information about EAP including services and behavioral health information, visit the [EAP](#) page or [www.Here4TN.com](http://www.Here4TN.com).

**1. How many sessions do I have through the EAP?**

You receive up to five, no cost to you, sessions per separate incident. Your EAP is available 24/7 every day of the year. Preauthorization is required to use the EAP but can easily be obtained by either going to [HERE4TN.com](http://HERE4TN.com) or calling 855.437.3486.

**2. What happens if I utilize all of my available EAP sessions, but would like to continue seeing my provider?**

If you are a member of the state group health insurance program, you may continue to receive services under your behavioral health benefit. The majority of EAP providers are also behavioral health providers, so many times you are able to continue to see the same provider if that relationship is working well for you.

**3. Is preauthorization required for outpatient behavioral health?**

You do not need to obtain preauthorization for most outpatient behavioral health services. Preauthorization is required for some treatments including psychological testing, electroconvulsive therapy, applied behavioral analysis and transcranial magnetic stimulation.

- 4. If I am contacted by Optum for case management, what do I need to do to fulfill my Partnership Promise?**  
If you are contacted by Optum and asked to participate in their case management program, you are required to engage to continue in the Partnership Promise PPO or Promise HealthSavings CDHP.

## Voluntary Vision

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For general information about vision including benefits and provider information, visit the [Vision](#) page. For information about vision insurance at retirement, visit the [Retirement](#) page.

**1. How often can I get an eye exam and materials?**

On either plan (basic or expanded), you can have an eye exam once every calendar year. You can get standard plastic/glass lenses or contacts once every calendar year and frames once every two calendar years.

**2. How does the frame allowance work?**

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

If you choose the expanded plan and use a network provider, you will not have to pay anything for your frames if they cost \$115 or less. If the frames are over \$115, you will get a 20 percent discount on the balance of the monies you owe.

**3. My doctor is not listed in the EyeMed network? Can I still get some reimbursement if I continue to see him?**

You can get an eye exam at your non-network provider but your benefit will be much less than if you used a network provider. You might want to consider filling your vision prescription at one of EyeMed's network providers in order to save money. If you are seeing the doctor for a medical reason (other than a routine eye exam) the charges will have to be submitted to your medical plan.

**4. Do I need to file a claim?**

No, you do not file claims if you use an in-network provider. However, if you do not use a network provider you will need to file an out-of-network claim form, which is located on the EyeMed [website](#). If you have an issue with a claim, contact the EyeMed Customer Care Center at 855.779.5046 with any questions pertaining to your claim.

**5. Do I need my ID card in order to use my benefit or discount?**

No, you do not need your ID card in order to use your EyeMed plan. Once you have your card, we recommend taking it with you because it saves time and helps the provider correctly apply your benefit. However, if you have lost your card, simply let the provider's office staff know that you are an EyeMed member. They will have to verify your eligibility and plan details for you.

**6. How do I print or request additional or replacement ID cards?**

If you need more ID cards or a replacement for a lost or damaged card, you can print a card once you register or log onto the EyeMed [website](#) or by calling their customer care center at 855.779.5046.

**7. How can I request that my provider be added to the EyeMed network?**

If your provider is not currently participating in the EyeMed network, you can recommend them by submitting a provider nomination form. The form, including instructions, can be found on the EyeMed [website](#).

**8. What if I need to see a provider outside of Tennessee?**

The EyeMed network is national. You can locate an in-network provider throughout the United States and they will submit all claims for you.

**9. Who should I contact if I have trouble logging into the EyeMed member website?**

Call the EyeMed Customer Care Center at 855.779.5046 for assistance with logging into the website.

**10. Can I get a discount on additional replacement contact lenses?**

After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member's home.

**11. Can I use a portion of my allowance during the calendar year and then use the remaining balance during that same calendar year?**

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

**12. Who is eligible to enroll in the state EyeMed vision plan?**

All state and higher education employees and their qualified dependents are eligible. Employees and their qualified dependents of local education and local government agencies are eligible if the agency has added the vision insurance program to their benefits. The following retiree groups are eligible for vision coverage **if enrolled in the medical plan**:

- Retirees receiving TCRS benefit
- Retirees who participated in a higher education optional retirement plan
- Dependents of a currently enrolled retiree

## **VSP Questions for TBR employees only**

**The Tennessee Board of Regents' (TBR) separate vision plan with VSP will terminate as of January 1, 2017.**

**13. If I work for a Tennessee Board of Regents (TBR) institution can I enroll in the state EyeMed Vision Program?**

Yes, you may choose to enroll in the EyeMed plan offered by the state by using Edison Employee Self Service (ESS). Members in the VSP plan will not be automatically transferred to EyeMed.

## Voluntary Dental

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For general information about dental including benefits and provider information, visit the [Dental](#) page.

### 1. Why are there waiting periods for some dental services?

Unlike our health insurance options, which are self-insured, our dental products are fully insured. This means that the insurance carriers, not the state, are the ones that assume the risk of premium payment versus claims cost.

The Cigna Prepaid Dental (DHMO) plan does not require any waiting periods before services will be covered. This is because the prepaid plan pays a fee each month to the participating dentists for each enrolled member and in turn the dentists have agreed to deep discounts in their fees.

The MetLife Dental Preferred Provider Organization (DPPO) plan does require a waiting period before certain more expensive services will be covered. A six-month waiting period applies for implants, bridges, partial dentures, full dentures, crowns and cast restorations. A twelve-month waiting period applies for orthodontic treatment. This discourages members from joining for one year just to receive expensive major services while only paying premiums for one year. Waiting periods cannot be appealed through the state. Please direct any questions concerning waiting periods to MetLife at 855.700.8001.

### 2. What happens if my dentist leaves Cigna's dental network?

When a dentist leaves the network, he/she must provide Cigna with a 90-day notice. Cigna will mail a letter to all members who selected the terminating dentist 30 days prior to him/her leaving the network. The letter will also ask affected members to select a new general dentist.

### 3. Do I have to select a primary dentist in the Cigna Prepaid Dental plan? Can I change my dentist?

Yes, you will need to select a primary dentist from the list of general dentists. Each family member can select a different primary dentist. Your dentist selection and/or change to your dentist selection should be made by the 15th of the month for the change to be effective by the first of the following month.

### 4. How do I find a Cigna Prepaid Dental network dentist?

You can go online [here](#) and follow the instructions on locating a Cigna dental provider. You can also call Cigna at 800.997.1617.

### 5. What if I am out of the area and need emergency care? Will Cigna Prepaid Dental cover some or all of the services?

In the case of an emergency and you cannot see your selected dentist, you can file a claim for a reimbursement. You will need to provide documentation to Cigna within 30 days of the actual treatment. The out-of-area emergency care is limited to emergency care up to \$25 per occurrence.

### 6. How do I find a network dentist in the MetLife network?

Your dentist must be in the MetLife PDP network to receive the in-network benefit. Members can receive services from a dentist not in MetLife's network, but these dentists are considered out-of-network and you will have to pay the out-of-network rates.

To find a dentist:

- Go to [mybenefits.metlife.com/StateOfTennessee](https://mybenefits.metlife.com/StateOfTennessee) and enter "State of Tennessee" if not already shown.
- Call MetLife at 855.700.8001

**7. How can I find out how much a procedure will cost under my MetLife DPPO plan?**

Ask your dentist to request a pre-treatment estimate, which will tell you if a service is covered, how much it may cost and what your share may be. Pre-treatment estimates are not required but are highly recommended for procedures with significant costs such as crowns. Pre-treatment estimates are not a guarantee of benefits or costs.

## Voluntary Long-Term Care Insurance

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For general information about long-term care insurance, visit the [Long-Term Care Insurance](#) page.

**1. Who is eligible to enroll in the state’s long-term care insurance plan?**

All state and higher education employees and their qualified dependents are eligible. Employees and their qualified dependents of local education and local government agencies are eligible if the agency has added the long-term care insurance program to their benefits. An employee’s parents and parents-in-law are also eligible.

**2. What are the eligibility requirements for a retiree to enroll in long-term care insurance?**

You are eligible for long-term care insurance if you are a retiree receiving a TCRS pension or participated in an optional retirement program.

**3. When can I enroll in the long-term care insurance plan?**

You may apply for enrollment in the long-term care insurance plan at any time. Eligible new hires may enroll within 90 days of their hire date and not have to answer health underwriting questions. Employees who did not enroll during their initial 90-day guarantee issue period may still apply at any time by submitting an application with answers to specific health questions.

**4. How do I get more information on enrolling in long-term care insurance?**

Contact MedAmerica at 866.615.5824 or visit [ltc-tn.com](http://ltc-tn.com)

## Life Insurance - State and Higher Education Only

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For general information about life insurance, visit the [Life Insurance](#) page.

### Basic Term Life Insurance/Basic AD&D Insurance

**1. Does coverage reduce as I age?**

The face amount of coverage declines when an employee reaches age 65, 70 and 75.

**2. Can I take my coverage with me when I leave?**

You are able to convert basic term life coverage to an individual life insurance policy without answering any health related questions. Premiums may be higher for the individual life policy than those paid for the group term policy.

## Voluntary Term Life Insurance

### 3. Can I increase the amount of coverage I have?

You may increase your coverage by the annual guaranteed issue amount of \$5,000 during the fall annual enrollment period if you receive a letter or postcard from Minnesota Life notifying you that you are qualified for the increase based upon your salary and current level of coverage.

You may submit an evidence of insurability application (required answers to specific health questions) to increase your coverage amount above the guaranteed issue amount up to the overall maximum amount during the fall annual enrollment period.

### 4. Can I decrease the amount of coverage I have?

Yes, you may decrease your coverage amount during annual enrollment (to a minimum of \$5,000). While changing your coverage amount can only be done during annual enrollment, you may cancel your coverage at any time. The decrease in coverage will be effective on the following January 1.

### 5. How can I find out who I designated as the beneficiary?

Minnesota Life has the beneficiary information for each certificate holder. You can review your designated beneficiary information by logging onto your account on the Minnesota Life website [lifebenefits.com/stateofmn](http://lifebenefits.com/stateofmn) or you may contact their customer service center at 866.881.0631 Monday through Friday from 7 a.m. to 6 p.m. Central. It's always a good idea to check the beneficiary information periodically to be sure the designation is current.

### 6. May a spouse, who is also a state or higher education employee, enroll as an employee and as a dependent of the other spouse?

No, both spouses must enroll as employees.

### 7. What option do I have for voluntary term life if I am rehired?

Coverage lost upon employment termination will be automatically reinstated if rehired within 90 days. Payment of premiums for past periods will be withheld from your paycheck upon your return to active employment.

## Voluntary Accidental Death and Dismemberment (AD&D) Insurance

### 8. May two employees cover the same dependent children?

No, one employee should select single coverage while the other employee selects family coverage.

### 9. If I did not enroll when I was first hired, may I enroll later?

Yes, you may enroll with no health questions asked during the fall annual enrollment period.

### 10. How much coverage will I have?

Coverage is based upon the employee's salary with the maximum amount of coverage being \$60,000.

## Voluntary Universal Life Insurance

The plan is closed to new enrollments.

### 11. Can I decrease the amount of coverage I have?

You may ask to decrease the face amount on your policy as long as your request is submitted in writing to Unum at least 45 days prior to the anniversary date, which is January 1 of each year. If your decrease is approved, it will take effect on the January 1 following your request for the decrease.

Please note: decreases cannot reduce the face amount to less than the minimum of \$5,000. Unum reserves the right to decline to make any change that Unum determines will cause the coverage to fail to qualify as life insurance under applicable tax law.

### 12. Can I increase the amount of coverage I have?

No, the plan is closed to increases in coverage.

### 13. How can I find out who I designated as the beneficiary?

Unum maintains the beneficiary information for each certificate holder. You can contact their customer service center at 866.298.7636 Monday through Friday 7 a.m. to 7 p.m. Central. It's always a good idea to check the beneficiary information periodically to be sure the designation is current.

## Affordable Care Act (ACA)

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### 1. What is required of me?

If someone does not have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee. Employer sponsored coverage (such as the state group health insurance program) is considered minimum essential coverage.

### 2. The new healthcare law states that employees must now have health insurance coverage. Does that mean I have to sign up now if I do not have coverage?

To meet the requirements, you need to enroll in the state group insurance program during open enrollment or purchase your own health insurance through the Marketplace ([Healthcare.gov](https://www.healthcare.gov)).

### 3. What if I already have coverage through my spouse's employer?

As long as you have minimum essential coverage (through the state group insurance program or elsewhere) you have satisfied the requirements of the healthcare law.

### 4. Do the ParTNers for Health plans meet the healthcare reform law's minimum value requirements?

Yes, all ParTNers for Health plans meet this requirement.

### 5. If I drop my health coverage, am I subject to the healthcare reform law's penalty?

Yes, to avoid the fee you need insurance that qualifies as minimum essential coverage, which simply means that your plan will pay at least 60 percent of the total cost of medical services.

**6. What is the Health Insurance Marketplace?**

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Ask your employer for information about the Marketplace or log onto [Healthcare.gov](https://www.healthcare.gov).

**7. Can I get insurance through the Marketplace?**

If you have a special qualifying event, you may sign up for the Marketplace. If not, the Marketplace open enrollment is from November 1 to January 31.