

Questions and Answers

(updated March 1, 2012)



Enrollment & Eligibility

1. Will there be an Open Enrollment for health insurance every year?

Open enrollment is not guaranteed in future years. The Insurance Committees make this decision yearly.

2. Why can't members, other than Local Government, be offered or enroll in the Limited PPO?

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

3. Can children under age 26 be covered if they are eligible for their own coverage (e.g., at another job)?

Yes, access to other coverage is not a factor.

4. 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.

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

We will adjust the late applicant fee each year. We will revise the fee to reflect the actual claims costs of late applicants. Because claims costs were less than estimated, the fee for 2012 is lower than in 2011. However, each year the fee could increase or decrease, subject to claims information for that year.

6. Is the late applicant fee lower for 2012 for the members who joined the plan through the open enrollment period in 2010?

Yes, for 2012 the late fees is lower for all members including those who enrolled in 2010.

7. How long will I have to pay the late applicant fee?

You must pay the late applicant fee each month as long as you are covered through December 31, 2013. At that time, the late fee will stop for all members.

8. If an employee joins the plan and pays the monthly late applicant fee and later has a special enrollment qualifying event, will he/she still have to pay the late fee?

No. An event that would normally make a member eligible for coverage will cancel the late fee, and the fee will no longer have to be paid.

9. If an employee joined the plan during the Annual Enrollment Transfer Period and later retires, will he/she have to pay the late fee?

No. Although retirement is not a special qualifying event, Benefits Administration will recognize termination of employment (including final termination of employment for retirement) as a qualifying reason to drop late applicant fees.

10. Does the late applicant fee apply to children?

No. Dependent children are not subject to the late applicant fee.

11. 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; it does not mean that you can only go to doctors and hospitals in your area. You will always have access to doctors across Tennessee and across the country.

12. If two plan members are married, do they have to choose the employee + spouse premium level, or can they each sign up for employee only coverage? What if they have children?

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

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

Coverage can only be dropped during the Annual Enrollment Transfer Period or if a member has a qualifying family status change.

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

The 12-month pre-existing condition exclusion applies to any employee or employee's spouse who cannot show proof of prior creditable coverage. This does not apply to pregnancy, newborns or covered children of any age.

Partnership Promise

1. What is required for the 2012 Partnership Promise?

There are two things you must do in 2012:

- Members (and spouses on their insurance) must take part in health coaching if an opportunity to improve their health is identified by ParTNers for Health Wellness staff during 2012.*
- Members must keep their address, phone number and email, if they have one, current with their employer.

* If it is unreasonably difficult because of a medical or mental health condition for you to achieve the standards to fulfill the Partnership Promise, or if it is medically inadvisable for you to attempt to fulfill the Partnership Promise, call our ParTNers for Health Wellness Program at 1.888.741.3390, and they will work with you to develop an alternate way to fulfill the Promise.

2. What is different this year?

In 2012, we are asking you to take a more active role in managing your health. Members with certain health conditions or risk behaviors will need to work with a health coach to establish goals to improve their health and reduce identified health risk behaviors.

Members will also have to keep their contact information up to date with their employers in 2012. If a member's information changes during the year, it is the member's responsibility to make sure the employer has the correct information on record.

3. How is this different from the 2011 Promise?

The 2011 Partnership Promise asked you to be more aware of your health. To do this you were asked to fill out a questionnaire and get a screening to learn important health "numbers" (like body mass index, blood pressure, cholesterol and blood sugar levels). However, in 2011 members were not asked to take any action. **In 2012, we are asking you to take a more active role in managing your health** by working with a health coach.

4. Do I have to get a health screening and fill out an online questionnaire in 2012?

No, not in calendar year 2012.

5. If my spouse and children are covered by my insurance, do they have to fulfill the 2012 Partnership Promise too?

Both you and your covered spouse will have to meet the 2012 Partnership Promise in order to remain in the Partnership PPO in 2013. Children do not have to fulfill the Partnership Promise.

6. Are adult children (age 19 and up) required to fulfill the Partnership Promise?

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

Please note, if your child ages off of your coverage and enrolls in COBRA, he/she would need to fulfill the Partnership Promise at that time.

7. What is health coaching?

A health coach is a trained health care professional who is here to help you reach your health goals. Coaches will work with you to set goals, provide tools, track progress and offer information to help you make better choices and manage your health.

What you talk about with your health coach is confidential and cannot be shared with your employer, BlueCross BlueShield or Cigna (your health insurance carrier), or the State of Tennessee Group Insurance Program (your insurance company). Information is shared with your doctor only with your permission.

Your coach can help you:

- Understand your medications
- Understand any lab test results or doctor's directions
- Set goals for healthier living
- Plan healthy meals and exercise
- Find a doctor, if you need one

There are two types of health coaching programs:

- **Lifestyle Management programs** can help you improve your health by changing habits. They can help with high blood pressure, high cholesterol, tobacco cessation and weight management.
- **Disease Management programs** are for people with a chronic health condition. The health coach works with you and your doctor to help you with self-management skills to make sure that you are taking your medicines and are getting the right care. Disease management programs are available for asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), depression, diabetes, obesity and musculoskeletal conditions such as low back pain and arthritis.

8. How is participation in Health Coaching defined?

To be considered an active participant, you need to:

- Work with a health coach to improve or maintain your health. The health coach will assess your health and lifestyle, work with you to set long- and short-term goals, and help you avoid barriers to achieving good health.
- Work with a health coach to create a plan of care specific to your needs. Your plan can include talking with your doctor about needed preventive care (see number 15 below) for your age and gender.
- Communicate (via phone or email) with a health coach as needed.
- Take part in other health and wellness events such as webinars, community events or on-line health modules provided by the ParTNers in Health Wellness Program.
- Work toward making improvement and meeting the goals on your plan.

Failure to follow the plan you agreed to can make you ineligible for the Partnership PPO and transfers you to the Standard PPO in 2013 with a higher premium, deductible and out-of-pocket costs.

9. When will someone contact me for health coaching?

A ParTNers for Health wellness coach may contact you at any time during the plan year (January 1 – December 31, 2012). You may talk via phone or email. There is no set number of phone calls or emails. You and your coach will talk as needed and will develop a schedule that works best for you. Coaches are available Monday – Friday from 8:00 a.m. until 8:00 p.m. CST.

10. Who do the health coaches work for and what are their credentials?

All health coaches are employees of APS Healthcare. This is the company that the State has contracted with to manage the wellness program. The ParTNers for Health Wellness Program health coaches have wide expertise. They include registered nurses and licensed dieticians, clinical social workers, certified health educators and those with degrees in exercise physiology, exercise science and health promotion. This vast experience allows you access to speak with coaches based on your needs and personal health goals.

11. How will I know if I need to participate in health coaching?

ParTNers for Health Wellness health coaches will contact eligible members for enrollment in a disease management or lifestyle management program by telephone. Any Partnership PPO member contacted by a health coach **MUST** participate in health coaching. However, any member may also choose to participate in a health coaching program.

Members enrolled in the Standard PPO may also choose to enroll in health coaching with no additional cost; however, they will not receive the discounted premiums, co-payments or out-of-pocket costs as Partnership PPO participants.

12. How will the ParTNers for Health Wellness staff decide whether or not I must participate in health coaching to remain in the Partnership PPO?

Coaches will contact members based on their current health conditions, risk behaviors and potential opportunities to help improve their health. Coaches will contact members who have an opportunity to improve their health or change behaviors that may cause long-term health issues.

13. Who is likely to be contacted to participate in the health coaching program?

ParTNers for Health Wellness coaching staff will decide who should participate based on medical conditions and behaviors that may negatively affect your health and/or cause long term health issues. Health conditions and behaviors are determined using information from medical and pharmacy claims, results from the health questionnaire and health screening results.

Opportunities to improve health and habits are based on national standards and guidelines scientifically proven to help a person's health or prevent the chance of chronic health conditions. Examples of opportunities to improve someone's health and wellness include:

- A member with diabetes and high blood sugar may benefit from help with nutrition, blood sugar monitoring, weight loss and education.
- A member who has been in the hospital for heart disease or heart failure may need help understanding discharge instructions, managing medicines and following his or her plan once he or she is released.
- A member with asthma or chronic obstructive pulmonary disease (COPD) who is often short of breath or has infections requiring emergency room visits can benefit from coaching on use of an inhaler, self-monitoring of symptoms or peak flow measurements at home or getting a flu or pneumonia shot.
- A member who uses tobacco or has unhealthy eating habits that cause weight gain can benefit from coaching to make lifestyle improvements.
- A member with arthritis or low back pain can benefit from coaching to provide support and help in dealing with symptoms and maintaining the ability to perform normal activities.

14. What are examples of personal health goals?

Examples of possible health goals include:

- Walk three times a week
- Making an appointment with a doctor to discuss whether a blood pressure medication is right for you

15. You said a plan of care could include receiving the right preventive care services. What are some examples of these services?

Preventive health care includes flu and pneumonia shots, annual physical exams, cholesterol tests, colon cancer screenings, annual well-woman visit, osteoporosis screening and screening for breast or cervical cancer (women only) or prostate (men only).

16. If I am able to meet my goals for better health, will I still be required to work with a health coach? For how long?

If you are eligible for a disease or lifestyle management program, you will need to take part in the ParTNers for Health Program until your health goals are met. If you are able to improve your health and lower your health risk behaviors, you will graduate from coaching.

Those with chronic conditions such as diabetes, heart disease, COPD, etc., will benefit from remaining in a coaching program for the entire time, but they may not have to talk to a coach as often if they improve and meet some of their goals.

Future change in your health might cause your coach to follow up with you to enroll in a disease or lifestyle management program again. You may choose to opt-out of a program but it will impact your eligibility for the Partnership PPO in 2013.

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

As long as you are making an effort to work towards your goals and tell your health coach about your challenges and successes, you can stay in the Partnership PPO. Your health coach will work with you to create reasonable and achievable goals that can be changed at any time when appropriate.

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

No. Talking to your doctor does not take the place of participation in the program. Health coaching is not intended to replace your doctor but instead should be in addition to the care you receive from your doctor.

19. Will the health 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 health care team. With your permission, your coach can talk with your doctor to share your health goals and plan of care.

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

20. Will I be able to keep the same health coach throughout my program?

Each member in a program will have a health coach assigned to him or her based on specific needs. Members usually keep the same coach, as long as there is no change in a condition that would require transfer to a different program.

We use a team approach that allows each member to talk to coaches with other areas of specialty (such as dietitians, social workers or exercise specialists) while keeping their primary coach. The team approach also allows for another coach to assist a member in a timely manner when their primary coach is not available.

21. How often, when and how do I have to communicate with my health coach? What if I miss a call or an email?

You may talk via phone or email. There is no set number of emails or phone calls. You and your coach will talk as needed and will develop a schedule that works best for you. The coaches are available Monday – Friday from 8:00 a.m. until 8:00 p.m. CST. If you miss a call, the coach will try and call you back or you can contact him/her. You will need to talk with your coach more often if you have significant health concerns and less frequently if you have less severe health concerns.

22. What happens if my health coach is unable to reach me?

If the ParTNers for Health Wellness Program health coach cannot reach you after four tries, he or she will send a letter to your home address and then it is up to you to contact your health coach. If you do not follow up with your health coach, you will not be eligible for the Partnership PPO the next year.

23. How do I update my contact information? Who collects this 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 1.800.253.9981 and selecting option 6.

24. 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.

25. What do you mean when you say “unreasonably difficult due to a medical or mental health condition” when talking about fulfilling the Partnership Promise?

If you cannot fulfill the Partnership Promise because of a physical or mental health condition, your health coach will work with you to come up with a different way to keep your Promise.

26. Can Standard PPO participants use the ParTNers for Health Wellness Program services without additional cost?

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

27. How does APS decide who will be contacted for coaching if the health screening and questionnaire are not required in 2012?

The ParTNers for Health wellness staff will decide who will be contacted for health coaching based on medical conditions and behaviors that affect your health and/or cause long-term health issues. These are determined using information from health insurance and pharmacy claims, and your 2011 health questionnaire and health screening results, including cholesterol levels, blood pressure, blood sugar levels and body mass index (BMI).

28. Are new members required to get a health screening and complete a health questionnaire?

No, not in 2012.

29. I do not remember signing the Partnership Promise again for 2012. Was I supposed to sign a new document?

No, if you choose to stay in the Partnership PPO for 2012, the Promise you signed in 2011 will do.

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

When you sign the enrollment form or click “OK” in Edison employee self service to enroll in the Partnership PPO, you are agreeing to fulfill the 2012 Partnership Promise.

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

We will announce the new Partnership Promise each summer. In 2013, members will likely be required to complete the questionnaire and health screening again.

32. If I break the Partnership Promise, will my claims still be paid?

Yes. The plans will continue to pay eligible claims for the calendar year, even if you do not meet the Partnership Promise. However, you will not be able to stay in the Partnership PPO for the following year if you do not fulfill your Partnership Promise. The Standard PPO will still be available to you.

33. If my spouse does not meet his or her Partnership Promise for 2012 and I drop him or her from my coverage, can I re-enroll in the Partnership PPO for 2013?

Yes. If the head of contract fulfills the Partnership Promise but the dependent spouse does not, the head of contract may re-enroll in the Partnership PPO the following year ONLY if the non-compliant spouse is dropped from coverage.

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

No. There will be no “target weights” for members. If you are contacted for health coaching in 2012, you will work with your health coach to establish short- and long-term goals. The requirement is to show that you are making a sincere effort to meet your health goals.

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

No. There is no surcharge for tobacco use. However, the Partnership PPO does offer resources to help you quit by working with a health coach.

ParTNers for Health Wellness Program

1. What security information will health coaches ask for to identify members on the phone?

To ensure privacy and security, APS will ask the member to verify his or her name, mailing address, date of birth and member ID located on the Caremark prescription card. APS will not ask for the member's Social Security Number. However, if the member is unable to verify his or her personal information, APS will not be able to release any information to the member at that time. In such a case, the member would need to call back when they can verify all personal information. APS Healthcare strives to protect the personal health information of all members while providing the best customer service.

2. Who should I contact if I have trouble creating or logging in to my online account?

To create an online account, please refer to the directions at <http://www.partnersforhealthtn.org/Files/Forms/Instructions.pdf>. Please note that the Organization or Group ID is “Partners for Health” for all members and should appear in the Group ID field. If the Group ID is empty when you register, please type in “Partners for Health,” using a space between each word.

If you need help creating an account or accessing your account, please contact APS Healthcare at 1.888.741.3390 between 8 am and 8 pm CDT Monday – Friday.

3. How does the spouse of an employee create an online account if he/she wants to do the online health questionnaire?

No one has to complete the online questionnaire in 2012; however, anyone can if he or she wishes to do so. If your spouse would like to complete one, he or she will need to create an online account. Your spouse will simply enter his or her personal information (i.e., name and date of birth) and use the member ID listed on his or her Caremark prescription card to login the first time. Your spouse can then create a unique login and password.

4. Will the State offer wellness incentives or discounts for fitness centers?

Fitness center discounts are available to all State Group Insurance Program Members. Certain fitness centers have agreed to offer a discount on their regular member price and/or initiation fees. A list of participating fitness centers is available at www.tn.gov/finance/ins/.

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

The State partners with Weight Watchers to offer Weight Watchers at Work and other weight management programs. Weight Watchers offers all employees a discount for these programs. To find out more, visit www.tn.gov/finance/ins/.

Pharmacy

1. Are diabetic drugs and supplies still free?

No, diabetic drugs and supplies are no longer free. However, they are included in the new low-cost maintenance drug tier. With this new drug tier, the plans are making other drugs more affordable. Studies show that diabetics often have other conditions that call for long-term use of statins (cholesterol lowering drugs) and/or high blood pressure drugs.

About 75 percent of our 25,273 diabetic members have another condition requiring one of these drugs. For this reason, most members will see their overall costs go down, even with the small rise in the cost of diabetic drugs. In addition, about 85,000 of our members do not have diabetes but do need one of these drugs to treat high blood pressure or high cholesterol. This new drug tier will help these members by lowering their out-of-pocket costs.

2. What are the pharmacy benefit enhancements for 2012?

Co-pays are lower for certain medications if purchased from a 90-day network pharmacy or via mail order. These medications include:

- Oral diabetic medications, insulins and supplies (test strips, lancets & needles)
- Statins (cholesterol lowering drugs)
- Antihypertensives (blood pressure medications)

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

90-Day Maintenance Co-Pays			
Tier	Partnership PPO	Standard PPO	Limited PPO
Generic	\$5	\$10	\$10
Preferred Brand	\$30	\$40	\$40
Non-Preferred Brand	\$160	\$180	\$180

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

You can call CVS Caremark at 1.877.522.TNRX (8679) to find out if your drug may qualify.

4. Are flu and pneumococcal shots free?

Yes. Members can get a free flu shot and/or pneumococcal vaccine at a participating vaccine network pharmacy or at an in-network doctor’s office. To get a flu shot at a vaccine network pharmacy, use your Caremark prescription card. To find a participating pharmacy, log in to www.Caremark.com, click on Order Prescriptions then select Forms to Print. The link for participating vaccine network pharmacies is listed at the bottom of the page under Additional Information. You may also view this list at www.pharmacyshots.com/vaccine_network_01.pdf.

If you get a flu shot from an in-network doctor’s office, use your medical insurance card. You will not have to pay a co-pay unless you are treated for another illness or discuss another condition at the same visit.

5. Are tobacco cessation drugs and quit aids covered by our insurance?

Yes. Currently our prescription benefit covers Chantix and Bupropion (generic Zyban) as the "medications" used for tobacco cessation – up to two, 12-week courses of treatment each year (168 days of therapy) with no lifetime limits. The quantity limit is two cycles annually, and the quantity limit resets every calendar year. These medications are covered at \$0 co-pay to the member.

Over-the-counter quit aids are also covered with an annual limit of a 168-day supply (two, 12-week courses of treatment). These include generic Nicotine replacement products such as Nicotine patch, gum and lozenges and are covered at \$0 co-pay to the member. (Nicotine inhalers are not included or covered in this benefit.)

A written prescription by a licensed clinician is required to receive any or all tobacco cessation products at no cost, including over-the-counter aids.

Smoking cessation counseling is available from health coaches through our ParTners for Health Wellness Program. To speak to a health coach call 1.888.741.3390.

6. Does a deductible or out-of-pocket maximum apply for pharmacy benefits?

Only the Limited PPO has an additional deductible for pharmacy benefits. The Partnership and Standard PPOs do not have an additional deductible for pharmacy.

7. Where can I find the drug list for CVS Caremark?

For a complete list you can contact Caremark at 1.877.522.TNRX (8679) or visit www.caremark.com.

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

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

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

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

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

All appeals are handled by CVS Caremark, our pharmacy benefits manager. Call Caremark at 1.877.522.8679 to begin the process, to ask questions about how to appeal and to check the status of your appeal.

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

Contact your doctor and ask him or her to call Caremark directly to request prior authorization for your prescription.

Health & Other Benefits

1. Do behavioral health services need prior authorization, or can I go to any provider in the network?

Members must call Magellan Health Services at 1.800.308.4934 for prior authorization of services.

2. Is vision coverage offered as part of the plan design?

Vision coverage to determine the need for glasses is not a covered service in the State Group Insurance Program. However, the insurance carriers do have some discount programs available.

The medical plan covers a visual impairment screening by an ophthalmologist for children and adults, only if medically necessary in the treatment of an injury or disease, including:

- Screening for all children for visual or ocular disorders (i.e. pediatric amblyopia and strabismus) at each preventive care visit beginning at birth;
- Visual screenings conducted by objective, standardized testing (i.e., Snellen letters, Snellen numbers, the tumbling test or HOTV test) at 3, 4, 5, 10, 12, 15 and 18 years of age; and
- Routine screenings among the elderly is considered medically necessary for Snellen acuity testing and glaucoma screening.

Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

Radial keratotomy, LASIK or other surgical procedures to correct refractive errors and the costs for contact lenses, eyeglasses, sunglasses or for examinations for prescription or fitting of eyeglasses or contact lenses are not covered under our plans.

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

Preventive care refers to services or tests that help identify health risks and are covered at no cost to you. For example, preventive care includes mammograms, annual wellness exam/physical and immunizations, as well as regular blood pressure checks. 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 co-pay 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 routine.

4. Do I have to pay a co-pay 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 both the Partnership and Standard PPOs, female members can have a well-woman visit and a physical from a family doctor or internist each year. Both of these visits are covered at no cost to the member.

5. How are mammograms covered by our insurance plan?

Our benefit covers screening mammograms every 1-2 years for women age 40 and older or when prescribed by a physician and determined to be medically necessary. This benefit is based on recommendations by the United States Preventive Services Task Force (USPSTF). Benefits Administration added “or when prescribed by a physician and determined to be medically necessary” to acknowledge that there might be instances where screenings should begin at an earlier age and/or occur more frequently.

Our benefit language as written doesn't mean that we are limiting women to every two years. The intent is that our female members who are age 40 or older take preventive measures by having screenings no less frequently than every two years. If you go annually, that is equivalent to every one year and should be covered since the USPSTF recommended range is every 1-2 years.

Mammogram screenings that fall outside the general guidelines (those occurring more than once a year or earlier than age 40) will only be covered if prescribed by a physician and determined to be medically necessary.

Diagnostic mammograms are also covered under the plan. As with other non-preventive x-rays, labs and diagnostics, the in-network benefit is 100 percent including reading, interpretation and results AFTER any applicable office visit co-pay.

6. 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.

Providers typically perform diagnostic colonoscopies when risk factors other than age are present or when problems are detected. For example, lab results indicating iron deficiency anemia of unknown cause or a complaint of persistent abdominal pain might lead to diagnostic testing. Also, a colonoscopy that begins as a screening may become diagnostic if findings lead to an unplanned biopsy or removal of lesions or polyps. These services would be subject to the same member cost sharing as other non-preventive surgical benefits.

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

If you get an allergy shot at your doctor's office and you don't talk to the doctor about any other conditions, the shot will be covered at 100 percent. If you talk about or are treated for any other conditions during the same visit, you may have to pay a co-pay.

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

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

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

Members will pay co-insurance for dialysis and be subject to the deductible. This means the member is protected by the out-of-pocket maximum. Because dialysis visits happen often, this approach for dialysis benefits the member the most.

10. How are maternity benefits covered?

It is important to note that ALL OB/GYN doctors are considered primary care doctors so you will pay the primary care co-pay. You only have to pay a co-pay 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. Keep in mind, this is for a normal pregnancy. 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 co-pay or co-insurance.

11. How is chemotherapy covered? Is it a co-pay or is it subject to deductible and co-insurance?

The member pays a co-pay if the therapy is done in a doctor's office, but he or she would have to pay co-insurance if the therapy is done in an outpatient facility or hospital.

12. How is durable medical equipment (DME) covered?

Durable medical equipment is subject to the deductible and co-insurance. Members are responsible for 10 percent coinsurance in-network in the Partnership PPO and 20 percent coinsurance in-network in the Standard PPO after meeting their deductible.

BlueCross BlueShield & Cigna

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

Yes. All members are eligible for both the Partnership PPO and the Standard PPO. One exception to this is the Limited PPO option available to local government employees.

2. Does everyone have a choice of insurance carriers?

Yes. Every plan member can choose between two insurance carriers – BlueCross BlueShield of Tennessee and Cigna. Both carriers offer the Partnership PPO, Standard PPO and Limited PPO options.

3. Are the network providers the same for both carriers?

No. Each carrier has its own network of preferred doctors, hospitals and other health care providers.

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

1. Call the carriers Customer Service staff:
 - a. BlueCross BlueShield of Tennessee at 1.800.558.6213
 - b. Cigna at 1.800.997.1617
2. Search for your providers online through the carriers' websites:
 - a. BlueCross BlueShield of Tennessee (www.bcbst.com/tools/findadoctor and look for Network S; out of state look for the BlueCard Program)
 - b. Cigna (www.cigna.com and look for OpenAccess Plus Network)
3. View a PDF of the provider directory:
 - a. [BlueCross BlueShield of Tennessee Directory](#) (2.42MB)
 - b. [Cigna Directory](#) (5.59MB)

NOTE: The information in the PDF directories is only 100 percent accurate on the day it is printed. It is not uncommon for this information to change as providers and facilities join and leave the carrier's networks. Both directories were printed in August 2011. You can find the most up to date information by calling member services or doing an online search.

4. Which hospitals are in each carrier’s provider network in upper east Tennessee?

Cigna advised the State that the agreement between Mountain States Health Alliance (MSHA) and Cigna ended January 1, 2012. This means that the hospitals, facilities and physicians of MSHA are considered out-of-network providers for the State of Tennessee Group Insurance Program.

The following is a list of upper east Tennessee hospitals that are in the BlueCross BlueShield (BCBST) Network S and Cigna OpenAccess Plus provider networks for the 2012 plan year.

Acute Care Facility	City/State	County	Cigna	BCBST
Sycamore Shoals Hospital	Elizabethton, TN	Carter	No	Yes
Laughlin Memorial Hospital Inc	Greeneville, TN	Greene	Yes	Yes
Takoma Regional Hospital	Greeneville, TN	Greene	Yes	Yes
Morristown Hamblen Hosp Assoc Inc	Morristown, TN	Hamblen	Yes	Yes
Lakeway Regional Hospital	Morristown, TN	Hamblen	Yes	Yes
Hancock County Hospital	Sneedville, TN	Hancock	Yes	Yes
Hawkins County Memorial Hospital	Rogersville, TN	Hawkins	Yes	Yes
Johnson County Community Hospital	Mountain City, TN	Johnson	No	Yes
Select Specialty Hospital Tri Cities Inc	Bristol, TN	Sullivan	Yes	Yes
Bristol Regional Medical Center	Bristol, TN	Sullivan	Yes	Yes
Indian Path Medical Center	Kingsport, TN	Sullivan	No	Yes
Holston Valley Hospital and Medical Center	Kingsport, TN	Sullivan	Yes	Yes
Unicoi County Memorial Hospital Inc	Erwin, TN	Unicoi	Yes	Yes
Franklin Woods Community Hospital	Johnson City, TN	Washington	No	Yes
Johnson City Medical Center Hospital Niswonger Children’s Hospital	Johnson City, TN	Washington	No	Yes
James H. & Cecile C. Quillen Rehabilitation Hospital	Johnson City, TN	Washington	No	Yes

Networks do change from time to time. This is not a complete listing of all the providers in upper east Tennessee. Call the BCBST and Cigna service centers to make sure that the facilities and doctors you want to use are in the 2012 provider network.

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

No. Our PPOs have what’s known as an “out-of-pocket maximum.” Once you pay this amount, the health insurance options will pay 100 percent of the co-insurance for your covered expenses. This protects members who have very high medical bills.

6. Why are the monthly premiums different among regions?

This is due to the reimbursement rates the carriers (BlueCross and Cigna) negotiated with their network providers. These payments are higher in some regions than others depending on the carrier.

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

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