Questions and Answers

(updated March 12, 2018)

PARTNERS FOR HEALTH

Enrollment & Eligibility

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.

6. **Can any School Board member enroll in the State's health insurance plan?**
   Yes. There is no preexisting condition exclusion for anyone of any age and no proof of creditable coverage is required.

   Yes, State law says a school board member of a Local Education Agency (LEA) may participate in the State's health insurance plan if the member pays the total monthly premium for the coverage, unless the LEA assumes liability for all or a portion of the cost. The LEA does not have to participate in the State plan for its school board members to be eligible to enroll in the State's health insurance plan. The board member is not eligible to enroll in any other coverage offered by the State, i.e. vision or dental insurance.

   When can a School Board member enroll in the State's health insurance plan?

   You may enroll within 31 days of being sworn into office, or during the State's fall Annual Enrollment Period. You may also make changes if you have a Special Qualifying Event, as outlined on page 3 of the enrollment application (www.tn.gov/finance/fa-benefits.html). Your eligibility date is date you were sworn in or no later than the end of the subsequent month. Coverage starts on the first day of the month after your eligibility date.

How does a School Board member enroll in the State's health insurance plan?

If your school system participates in the State Group Insurance Program, the Human Resources staff will provide information about your options and premiums and help you enroll. If not, the Benefits Administration Service Center will help. Call 800-253-9981. Be prepared to fill out an Enrollment Change Application found on the forms page of Benefits Administration (BA) website at www.tn.gov/finance/fa-benefits.html. In addition to the Application, you will need to provide:

- A letter from the school district on official school board stationary stating the date you were sworn in and the date your term ends. Your coverage will continue as long as you serve on the school board. We must have this documentation for our annual audit purposes. You will be eligible for COBRA when you leave office.
- The required verification documents listed on page 2 of the Application if you want to enroll any dependents.
- An Authorization Agreement for Preauthorized Payment (ACH) available from your HR office or the BA Service Center (800-253-9981) and a voided check.

ParTNers for Health Wellness Program

1. **2018 Wellness Program Update**
   Following the award of the wellness program contract back in July, one of the proposers filed a protest. The protest process is still on-going. All parties involved are expediting the process and it is anticipated that a hearing on the issues will be scheduled in March. What this means for members is that we will not have a wellness program in place until resolution of the litigation. Please check back for updates. Or, you can contact the Benefits Service Center at 800-253-9981.

2. **Do I have to complete the Partnership Promise requirements (Well-Being Assessment or WBA, and biometric screening) in 2018?**
   No. The Partnership PPO went away in 2017 and was replaced with the Premier PPO. There is no Partnership Promise in 2018. So there is no March 15 deadline for the WBA and no July 15 deadline for the biometric screening. Members who were enrolled in the Partnership PPO in 2017 and made no changes during annual enrollment were moved to the Premier PPO.

CDHP/HSA and Local CDHP/HSA

The HSA administrator is PayFlex: stateoftn.payflexdirect.com

1. **What is the CDHP/HSA (or Local CDHP/HSA) insurance plan?**
   The 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 at 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 enroll in the CDHP, the state will put money into your HSA in 2018: $250/individual only coverage and $500/family coverage. If your coverage effective date is after September 2, 2018, the state contribution for 2018 is not available. If you stay enrolled in the CDHP in 2018, then the state will add the funds to your HSA in early January 2018.

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. **Does the 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.

3. **Why might I choose the CDHP option?**
   You need to look at your choices very carefully. 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 health plan option).
   - 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 CDHP and the PPOs use the same networks and offer the same discounted network rates.

4. **Who is eligible for the CDHP?**
   Employees who meet eligibility requirements for health insurance benefits as defined in the State Group Health Insurance Plan documents may choose the CDHP option.

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

   - Be covered under the CDHP
   - Have no other health coverage
   - Not be covered by an FSA or an HRA. This means that if your spouse works elsewhere and even has access 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 (VA) in the past three months unless the care was received for a service-connected disability (and it must be a disability), nor have received care from the Indian Health Services (IHS).
   - Not be claimed as a dependent on someone else's tax return

5. **Can I have “gap” insurance or other health coverage and the CDHP?**
   According to the IRS, 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.

6. How is the CDHP similar to the Premier, Standard and Limited PPOs?
They are all insurance plans. The 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.

7. How is the CDHP different from Premier, Standard and Limited PPOs?
It has a health savings account (HSA) and the cost sharing is different. The 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 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, diabetes, depression, asthma/COPD, coronary artery disease, congestive heart failure), 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 educations employees: The Limited PPO has a $100 per plan member pharmacy deductible that must be met each year before the Limited PPO plan begins paying anything toward your prescription drugs. After that, your applicable copayments will apply. The CDHP does not have a separate pharmacy deductible or out-of-pocket maximum.

8. **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.

9. **Does the coinsurance amount for a maintenance drug count towards the deductible?**
   No, but it does go towards the out-of-pocket maximum.

10. **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
    - Cigna: cigna.com/stateoftn

    Prescription drugs costs:

    - CVS/caremark: info.caremark.com/stateoftn

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

11. **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

12. **Can I change from the CDHP to one of the PPO options next year and then rejoin the 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 CDHP to a PPO, you will have to pay administrative fees (up to approximately $5/month) on your HSA account and these monthly fees will be deducted from your HSA. The state covers the fees for CDHP actively-enrolled members only.

13. **What if I want to choose the 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.

14. **What if my spouse and I both work for the same employer, what are our CDHP enrollment options?**
If you want to enroll in the CDHP as a family, one of you will choose family coverage, 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 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

15. **How do I pay claims with a 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 expense 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)

1. **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.

2. **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.

3. **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.

4. **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). Any money left at the end of the year is yours to keep in your HSA for future health expenses.

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

5. **How do I contribute and is there an annual limit?**
   After you enroll in the 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 2018, you can contribute up to $3,450 (single) or $6,850 (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, and **the state will contribute $250 (single only coverage) or $500 (family coverage) into your HSA account.** If the coverage effective date for a plan member is anytime from September 2, 2018, through the end of 2018, then the employee will not receive a contribution 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.

6. **How and when is money contributed to my HSA?**
   Once your PayFlex HSA 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 you enroll in the CDHP during the annual enrollment period, the state's contribution will be deposited in your HSA account in early 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.

7. **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.

8. **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 (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

9. **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). For 2018, the current limits for the following attained ages before the close of the tax year are:
  - 40 or less $420
  - More than 40 but less than 50 $780
  - More than 50 but less than 60 $1,560
  - More than 60 but less than 70 $4,160
  - More than 70 $5,200

- For 2017,
  - 40 or less $410
  - More than 40 but less than 50 $770
  - More than 50 but less than 60 $1,530
  - More than 60 but less than 70 $4,090
  - More than 70 $5,110

  These amounts change each year, so check the IRS website each year for the new amounts.

- 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)

10. **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 (see page 5). Ultimately, the HSA funds and how they are used are ***your*** responsibility and **you should keep all receipts for purchases using your HSA funds**. This will help you in case of an IRS audit.

11. **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.

12. **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 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.

13. **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.

14. **Is the HSA opened for me automatically?**
    If you choose the 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. Also, PayFlex will need your street address, not a P.O. Box. 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. They will send up to three letters to you and if you never respond to you, the HSA will be closed and any funds contributed by your employer will be returned to your employer.

    State and higher education employees: The state's contribution of $250 (single coverage) or $500 (family coverage) will be deposited into your HSA once it is set up. If your coverage effective date is after September 2, 2018, the state contribution for 2018 is not available. However, if you stay enrolled in the CDHP into 2019 and state HSA funds are offered, then you will receive the state contribution to your HSA in early January 2019.

15. **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 8/31/17 is 0.05% and increases as your deposit account (the non-invested portion of your HSA) balance goes up, but is subject to change quarterly, as determined by the HSA administrator.

16. **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.

17. **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.

18. **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 FSA in 2017 as follows:

    - For State and Higher Education employees who in 2017 have either a healthcare FSA or limited purpose FSA, they may carry over up to $500 into 2018. Any balances in those accounts greater than $500 on December 31, 2017 will be forfeited. Members can log into the PayFlex website at any time and view their claims, balances, and detailed activity for the flex accounts. Local Education and Local Government plan members who are considering enrolling in a CDHP for 2018 should ensure that they are not enrolled in a healthcare FSA with their employer in 2018 and any healthcare FSA that they have in 2017 has a zero balance by December 31, 2017.

    - Plan participants who only have an L-FSA in 2017 (*regardless of whether they carry over any funds from 2017 into 2018*) may immediately enroll in a CDHP for 2018 if they choose to, and a HSA will be opened for them and available to use on January 1, 2018.

    - Participants in a healthcare FSA are not eligible to contribute to an HSA. Therefore, if a 2017 healthcare FSA participant has a carryover amount and wants to participate in an HSA in 2018, they must use all of the funds in their FSA by December 31, 2017 or their HSA will not be opened until April 1, 2018, and any funds contributed to it (employer or employee contributed funds) could only then be used for claims with dates of service of April 1, 2018, or later.

19. **If I enroll in the 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 if your spouse has an HRA (health reimbursement account) through his or her employment. At this time, the state-sponsored insurance plans do not offer an HRA.

20. **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.

21. **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.

22. **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.

23. **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 monthly account maintenance account fees that the state was covering ($5/month) from the account.

24. **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).

25. **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 $3,450 it will be $1,725. Any contributions (both yours and your employers) above that amount that year will be subject to tax. For additional details, please see your tax advisor.

26. **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 CDHP.

27. **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. This IRS transfer does apply to your contribution limit for the year.

28. **Will I receive any regular reporting on my account?**
    Statements are available monthly online. You can request a paper statement from PayFlex.

29. **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.

30. **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 CDHP. You are responsible for investments fees. You are also responsible for standard banking fees such as non-sufficient funds and stop payments. If you choose to invest any of your HSA funds once your balance grows over $1,000, there are no investment fees.

    - Non-Sufficient Funds (NSF) Fee (Overdraft) - $25.00 per instance
    - Deposit Item Returned – $25.00 per instance
    - Overdrafts - $25.00 per instance
    - Stop Payment (per check) - $25.00 per instance
    - Wire Transfer (per instance) - $15.00 per instance

31. **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.

32. **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.

33. **Can I make post-tax contributions? And if so, will I get the tax benefit?**
    Yes, and then it can be claimed as an above the line deduction on your annual tax return.

34. **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.

35. 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.

36. Are the PayFlex HSA funds FDIC insured?
Yes, the funds in the HSA deposit 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.

37. 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 is 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.

38. If I am eligible to receive free health care at any Veterans Affairs (VA) facility, 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 (HSA) 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

CDHP/HSA and Medicare

Medicare, Medicaid, TennCare with CDHP

When looking at the 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**
- **IRS Publication 502 - irs.gov/pub/irs-pdf/p502.pdf**

39. Can I enroll in the CDHP if I have Medicare?
No, you are not eligible to enroll in the state's CDHP if you receive Medicare or any other government program coverage (Medicaid, known as TennCare in Tennessee], or TRICARE).

40. What if I enroll in the CDHP and then enroll in Medicare Part A later in the plan year?
You will be able to remain in the CDHP 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 CDHP plan for the following year.

41. 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.

42. If my spouse is on Medicare, can I choose the 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 CDHP.

43. If my dependent child is on Medicaid (TennCare), can he or she be covered by the CDHP?
Yes. Your dependent child can also be covered by the 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.

44. **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). 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

Flexible Spending Account (FSA)

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 medical 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 medical 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

   For a more complete list, please go to the PayFlex website found here

7. **Will dependent care FSA funds be available on the PayFlex debit card?**
   No. Those funds will not be loaded onto the debit card. For dependent care claims, you will need to file a paper claim with PayFlex for reimbursement. You can find your reimbursement form on the PayFlex website found here. You can also set up your bank account information on the PayFlex website so that you can issue a payment directly from PayFlex to your dependent care provider. Or, you can make a payment via your own personal check. You'll need to keep your provider's receipt for tax purposes and then deduct the funds from your dependent care FSA to go back into your bank account. Please keep copies of all receipts for IRS tax purposes or in case of audit.

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. Some common expense can be found on the PayFlex website in the consumer center found here.

11. **Where can you use the card?**
    - Physician and dentist offices, vision care providers and hospitals
    - Grocery stores, discount stores, web-based merchants for IRS approved expenses only
    - Drug stores and retail pharmacies for IRS approved expenses only

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 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 FSA in 2017 as follows:

    - For State and Higher Education employees who in 2017 have either a healthcare FSA or limited purpose FSA, they may carry over up to $500 into 2018. Any balances in those accounts greater than $500 on December 31, 2017 will be forfeited. Members can log into the PayFlex website at any time and view their claims, balances, and detailed activity for the flex accounts. Local Education and Local Government plan members who are considering enrolling in a CDHP for 2018 should ensure that they are not enrolled in a healthcare FSA with their employer in 2018 and any healthcare FSA that they have in 2017 has a zero balance by December 31, 2017.

    - Plan participants who <u>only</u> have an L-FSA in 2017 (*regardless of whether they carry over any funds from 2017 into 2018*) may immediately enroll in a CDHP for 2018 if they choose to, and a HSA will be opened for them and available to use on January 1, 2018.

    - Participants in a healthcare FSA are not eligible to contribute to an HSA. Therefore, if a 2017 healthcare FSA participant has a carryover amount and wants to participate in an HSA in 2018, they must use all of the funds in their FSA by December 31, 2017 or their HSA will not be opened until April 1, 2018 and any funds contributed to it (employer or employee contributed funds) could only then be used for claims with dates of service of April 1, 2018 or later.

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 medical 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.
    - You have 90 days after you terminate employment to file claims for services incurred up through your termination date. After 90 days, any funds remaining in your flex account(s) are forfeited.

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.

19. Who manages the FSA accounts?

Medical, Limited Purpose and Dependent Care FSAs are managed by PayFlex. Transportation and Parking FSA benefits are managed by Benefits Administration.

20. Which types of FSA come with a debit card?

Medical FSA and L-FSA come with a debit card. Dependent care and parking and transportation do not.

21. How do you register your PayFlex FSA online?

DIRECTIONS TO SET UP YOUR PAYFLEX ACCOUNT FOR STATE EMPLOYEES

If you have not set up your online account/profile with PayFlex to view your FSA balances and account activities, follow these directions to set up your online access:

1. Go to **stateoftn.payflexdirect.com**
2. *Click on "REGISTER NOW" button*
3. Enter your Member ID (SSN) and home zip code
4. Click on "REGISTER"
    - *If the member has an active or pending debit card, the member will be asked to provide the last 4 digits of the debit card number. The member must provide the correct last 4 digits before being taken to the next step in the registration process (username and password selection).*
    - *If the member does not have a debit card (for example, someone with only a dependent care account will not receive a debit card since the debit card is not set up to work at these facilities), then this new authentication check is not required and the member, upon identification, will be taken directly to the username/password selection page (as is consistent with current functionality).*
    - *If the member cannot provide the correct last 4 digits of the debit card number, then the member will not be permitted to complete registration.*
5. You'll then be brought to a screen to create a username and password
6. If you have questions, please contact PayFlex customer service at 1-855-288-7936

22. How do you access your FSA funds?

Medical FSA

You should use your PayFlex debit card to pay for pharmacy and medical expenses that are approved by the IRS. Once you register on the PayFlex site, you may click "My Resources" and scroll to the bottom of the page to see IRS Publication 502 which details the approved expenses eligible for reimbursement. You may also go to **Resource Center > Planning Tools > Common Eligible Expense Items** to determine if your expenses are eligible or ineligible for reimbursement and for any associated requirements.

Limited Purpose FSA

You should use their PayFlex debit card to pay for vision and dental expenses that are approved by the IRS. Once you register on the PayFlex site, you may click "My Resources" and scroll to the bottom of the page to see IRS Publication 502 which details the approved dental and vision expenses eligible for reimbursement.

NOTE: While the debit card may be used to pay for expenses from your FSA and limited purpose FSA, it is a ***benefit*** and not a ***right***. There may be times when PayFlex allows a payment to process because the card identifies the merchant as a dentist or a pharmacy, but they cannot see that it is for an IRS approved expense. If this is the case, they will send you a letter, email, or alert depending on your preferences when you set up your online access. If you receive such a letter, please provide the full explanation of benefits from your dental or medical insurance company (not a summary sheet). The IRS requires this of companies such as PayFlex. You may upload the substantiating documentation on the PayFlex website or app, fax, email, or mail it to PayFlex. If you do not provide the requested documentation, your card will be deactivated and you will still have access to your funds, but you will be required to file paper claims with PayFlex.

Dependent Care FSA

You can only spend what you have contributed to your Dependent Care account. For dependent care claims, you will need to file a paper claim with PayFlex for reimbursement. You can also set up your bank account information on the PayFlex website so that you can issue a payment directly from PayFlex to your dependent care provider. Or, you can make a payment via your own personal check. You'll need to keep your provider's receipt for tax purposes and then deduct the funds from your dependent care FSA to go back into your bank account. Please keep copies of all receipts for IRS tax purposes or in case of audit. To view account balance, please see above "How do you register your PayFlex FSA online?" Once you log in, you will be at the **Dashboard** screen. Locate your DC-FSA account in the center of the screen and click on the link that says "**View Account Details**" or "**View My Account**." This will show you all of your account deposits, claims, and payment activity.

Transportation and Parking

Please send all 2017 and 2018 Transportation and Parking reimbursement requests to Benefits Administration (BA) for processing. You will need to use the new form found on the BA website under the heading Flexible Benefits Reimbursement.

Here is the 2017 and 2018 reimbursement form:
Reimbursement Request for Transportation & Parking Accounts

Fill it out and return it to BA by mail, fax or email by following the instructions on the form. After your claim has been received, audited and entered into Edison, you can generally expect your reimbursement in two to four business days. The funds that are reimbursed will be deposited into the same account that your payroll check goes into.

If you have questions, please call Benefits Administration at 800-253-9981 and select option 6.

23. **The $500 maximum carryover for FSM and LFSA will be effective for the ending of 2017 plan year going into the new 2018 plan year thus eliminating any grace period. What is the deadline for members to submit their 2017 FSAM and LFSA claims to PayFlex?**

The State allows members 120 days from the end of the plan year to submit claims for the prior year.

24. **Will the prior plan year carryover funds be available on January 1, 2018 for the members to use in the new plan year?**

Yes, we will use carry over funds first before using any new elections

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.

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.

	90-Day Maintenance Copay			90-Day Maintenance Coinsurance	
Tier	Premier PPO	Standard PPO	Limited PPO	Local CDHP/HSA (local ed and local gov only)	CDHP/HSA

Generic	$7	$14	$14	20% w/o first having to meet deductible	10% w/o first having to meet deductible
Preferred	$40	$50	$60	20% w/o first having to meet deductible	10% w/o first having to meet deductible
Non-Preferred	$160	$180	$200	20% w/o first having to meet deductible	10% w/o first having to meet deductible

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. 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.

11. **Help! My specialty prescription has gone way up in cost (even to $150). What is going on?**
    Specialty medications used to treat rare and costly medical conditions, are continuing to increase in cost to the state-sponsored health insurance plans every month. In fact, about 2% of our plan members and 1% of all prescriptions account for 34% of the total prescription drug costs. Because, in aggregate, the plans had been paying 99% of the overall cost of specialty medications the Insurance Committees (State, Local Education, and Local Government) voted in summer 2016 to institute a 10% coinsurance on specialty medications for the PPO options, with a minimum member out of pocket of $50 and a maximum of $150. The CDHP regular coinsurance applies, as it always has. This helps the plan to better share in the cost of costly specialty medications with plan members. Also, the plan requires that any specialty medication only be filled for a 30-day supply (to eliminate waste) and that all specialty medications must be filled through a pharmacy in the CVS/caremark Specialty Network (though not necessarily CVS/caremark's own specialty pharmacy). To find a specialty pharmacy, go to info.caremark.com/stateoftn and click on the "Specialty Pharmacy List" link in the Network Lists box.

Other Covered Services

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.

   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 CDHP/HSA 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 bills for an office visit in addition to the allergy shot. If enrolled in a CDHP, you will pay deductible plus coinsurance for allergy shots and office visits.

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.

9. **How are maternity benefits covered?**
   It is important to note that ALL OB/GYN doctors are considered primary care doctors. You will only pay for your first primary care visit to confirm your pregnancy. If enrolled in a PPO plan, you will pay the primary care copay. If enrolled in a CDHP, you will pay the deductible plus coinsurance. For all plan options, you will then pay for the delivery, which is subject to the deductible, coinsurance and out-of-pocket maximum.

   If you have any difficulties and need specialized care for complications of pregnancy or you need extra time in the hospital extra costs 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 deductible and coinsurance will apply.

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.

Premier PPO	10%
Standard PPO	20%
Limited PPO	30%
CDHP/HSA	20%
Local CDHP/HSA	30%

12. **What happens if I have several covered medical expenses within the same year? Will I have to keep paying part of the cost?**
    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. However, you will have separate limits for in-network and out-of-network expenses.

BlueCross BlueShield and Cigna

For general carrier information including provider directories and premiums costs, visit the Carrier Information page.

1. **Do all plan members have the same health insurance choices?**
   State and higher education employees are eligible for the Premier PPO, Standard PPO and CDHP/HSA. Local education and local government employees are eligible for the Premier PPO, Standard PPO, Limited PPO and Local CDHP/HSA.

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. Using in-network providers is recommended as using out-of–network providers will cost you more.

5. **What is the Informed Choice Outreach Program offered by Cigna?**
   eviCore healthcare (formerly known as MedSolutions) is Cigna's exclusive radiology benefits manager, performing precertification of high-tech radiology services (MRI, CT, and PET) and high-tech radiology diagnostic cardiology services.

   Cigna’s 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 eviCore healthcare 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. eviCore healthcare representatives can also provide cost comparison information, so that members are aware of the financial impact of their choices.

eviCore healthcare 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 eviCore healthcare 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 networks (available doctors and facilities) are different, however, and medical policies for specific services may vary from one carrier to another.

7. **What happens when I go to a provider outside LocalPlus but within other Cigna networks?**
   When a LocalPlus member visits a non-LocalPlus provider within the LocalPlus area, coverage will be at the out-of-network rate. When a LocalPlus member is outside of the LocalPlus service area, but the provider is within Cigna's national Open Access Plus (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 (OAP).

   BlueCross BlueShield members have access to Network S providers inside Tennessee as well as BlueCard providers outside Tennessee and BlueCard Worldwide providers outside the U.S. Cigna offers the LocalPlus Network in certain areas nationally. Cigna members can choose either the LocalPlus Network with providers and facilities across Tennessee and some other areas nationally, or the Open Access Plus, a larger state-wide and national network. OAP members will have a choice of more doctors and facilities, 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)

For general information about EAP including services and behavioral health information, visit the EAP page or https://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 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 fulfill your Partnership Promise for 2017.

Voluntary Vision

The state will offer voluntary vision benefits through a new vendor in 2018, Davis Vision.

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 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 an In-Network provider, you will not have to pay anything for your frames if they cost $55 or less. If the frames are over $55, you are responsible for paying 80% of the balance over $55.

   If you choose the Expanded Plan and use an In-Network provider, you will not have to pay anything for your frames if they cost $150 or less. If the frames are over $150, you are responsible for paying 80% of the balance over $150.

3. **My doctor is not listed in the Davis Vision network? Can I still get some reimbursement if I continue to see him or her?**
   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 Davis Vision'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 Davis Vision website here. If you have an issue with a claim, contact the Davis Vision Customer Care Center at

800.208.6404 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 Davis Vision 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 a Davis Vision member. They will then 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 Davis Vision website or by calling their customer care center at 800.208.6404

7. **How can I request that my provider be added to the Davis Vision network?**
   If your provider is not currently participating in the Davis Vision network, you can recommend them by submitting a provider nomination form. The form, including instructions, can be found on the Davis Vision website here.

8. **Who should I contact if I have trouble logging into the Davis Vision member website?**
   Call the Davis Vision Customer Care Center at 800.208.6404 for assistance with logging into the website.

9. **Can I get a discount on additional replacement contact lenses?**
   After initial purchase, replacement contact lenses may be obtained via the website davisvisioncontacts.com at substantial savings and mailed directly to the member's home.

10. **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.

11. **Who is eligible to enroll in the state Davis Vision 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 an eligible retiree

Voluntary Dental

For general information about dental including benefits and provider information, visit the Dental page.

1. **Why are there waiting periods for some dental services?**
   The MetLife Dental Preferred Provider Organization (DPPO) plan requires a waiting period before certain more expensive services will be covered. A 6-month waiting period applies for implants, bridges, partial dentures, full dentures, crowns and cast restorations. A 12-month waiting period applies for initial placement of bridge or denture to replace one or more missing natural teeth. A 12-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.

Unlike our medical 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.

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 to the Cigna website 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 https://www.metlife.com/stateoftn.
   - 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.

Life Insurance - State and Higher Education Only

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.

3. **How do I designate a beneficiary or see who I have named as a beneficiary?**
   - Go to the Edison homepage: https://sso.edison.tn.gov/psp/paprd/EMPLOYEE/EMPL/h/?tab=PAPP_GUEST
   - Login through the employee portal login. Once you are logged in, follow this path to update beneficiaries: self-service > employee work center > life insurance beneficiaries > update beneficiaries.

Voluntary Term Life Insurance

4. **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 Securian (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 request an increase in your coverage above the Guaranteed Issue amount, up to the overall maximum amount during the fall Annual Enrollment period.

5. **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). The decrease in coverage will be effective on the following January 1. While changing your coverage amount can only be done during annual enrollment, you may cancel your coverage at any time.

6. **How can I find out who I designated as the beneficiary?**
   Securian (Minnesota Life) has the beneficiary information for each certificate holder. You can review your designated beneficiary information by logging onto your account on the Securian (Minnesota Life) website lifebenefits.com/stateoftn 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.

7. **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.

8. **May I continue my voluntary term life insurance when I retire or terminate employment?**
   Yes, you may continue (port) one-half (1/2)the coverage amount and pay the same premium rates as active members.

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

9. **May two employees cover the same dependent children?**
   No, only one employee is allowed to add a child term rider to his/her certificate of coverage.

10. **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.

11. **How much coverage will I have?**
    Coverage is based upon the employee's salary with the maximum amount of coverage being $60,000.

12. **May I take the Voluntary AD&D coverage with me if I retire or terminate employment?**
    No, there is no continuation of coverage available.

Voluntary Universal Life Insurance

The plan is closed to new enrollments.

13. **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.

14. **Can I increase the amount of coverage I have?**
    No, the plan is closed to increases in coverage.

15. **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.

Disability-State and Higher Education Only

Please note that the following Long Term Disability Insurance (LTD) FAQs are for State employees only. The State of TN does not offer Long Term Disability Insurance to Higher Education employees. If you are a Higher Education employee, direct questions on LTD to your Agency Benefits Coordinator.

1. **What is Disability Insurance?**
   It is insurance to protect your income when you are unable to work due to illness or injury.

2. **What is Short Term Disability (STD) Insurance?**
   Short Term Disability Insurance replaces a portion of your income during the initial weeks of a disability.

3. **What is Long Term Disability (LTD) insurance?**

Long Term Disability Insurance replaces a portion of your income during a disability that lasts for an extended period of time, typically longer than 90 or 180 days, depending on which plan you choose.

4. **Am I required to enroll in the Short Term and Long Term Disability plans?**

No. However, if you think that enrolling in the STD and LTD plans may be an option you will consider later, be aware of the following.

If you do not enroll during your initial 31 day eligibility enrollment period, you cannot enroll until the Annual Enrollment Period, except in cases of a Special Qualifying Event. During the Annual Enrollment Period, or when you experience a Special Qualifying Event, you will have to provide evidence of insurability by answering certain health related questions and providing other information, if required. Coverage is not guaranteed.

Here are two examples that will show you how your initial 31 day eligibility enrollment period will differ from future Annual Enrollment Periods:

Example 1: Employee is currently pregnant and chooses both Short and Long Term Disability Insurance during the initial 31 day eligibility enrollment period. She can enroll in both Short and Long Term Disability insurance. When her baby is born, she is eligible for Short Term Disability benefits, and, potentially Long Term Disability benefits should any complications arise, if she was Actively at Work on the date her insurance became effective.

Example 2: Employee waived coverage during the initial 31 day eligibility enrollment period. She now wants to enroll during a future Annual Enrollment Period and is pregnant during the Annual Enrollment Period. She would need to submit an application to the disability carrier to be reviewed for medical Evidence of Insurability (EOI). A question on the EOI form is 'Are you now pregnant?' Since she would answer 'yes' to this question, she would not be allowed to enroll for either the Short Term or Long Term Disability coverage.

5. **When am I eligible to enroll in Short Term and Long Term Disability plans?**

You will be eligible to enroll in the STD and LTD plans on the first day of the calendar month following the date you complete a waiting period of one full calendar month, if you are (i) an employee working not less than 30 hours per week, or (ii) a seasonal employee hired prior to July 1, 2015 with 24 months of service and certified by your appointing authority to work at least 1,450 hours per fiscal year (July-June), or (iii) deemed eligible by applicable federal law, state law, or action of the State Insurance Committee. You then have 31 days to enroll from the date you became eligible.

6. **Is Disability Insurance right for me?**

Disability insurance might be right for you if you:

- Have little or no annual or sick leave saved up
- Don't have much in the way of savings or an emergency fund
- Take part in high-risk activities, for example sky diving, etc.

7. **How much does Disability Insurance cost?**

Rates for your plan(s) can be found on the following websites, as well as in the Member Handbook.

- Microsite: metlife.com/stateoftn
- ParTNers for Health website

8. What is the Short Term Disability benefit, and what amount will I receive?

There are two benefit options from which to choose:

- Option A: Pays 60% of your Pre-Disability Salary, up to a maximum of $2,500 per week, with an Elimination Period of 14 days.
- Option B: Pays 60% of your Pre-Disability Salary up to a maximum of $2,500 per week with an Elimination Period of 30 days.

Example: if a person's Annual Pre-Disability Salary equals $65,000, simply divide by 52 (weeks,) and multiply by the benefit percentage of 60% to find out your weekly benefit.

$65,000 / 52 x .60 = $750.00 per week of STD benefit

9. What is my Long Term Disability benefit, and what amount will I receive?

There are four benefit options from which to choose:

- Option 1: Pays 60% of your Pre-Disability Salary up to a maximum of $7,500 per month with an Elimination Period of 90 days.
- Option 2: Pays 60% of your Pre-Disability Salary, up to a maximum of $7,500 per month with an Elimination Period of 180 days.
- Option 3: Pays 63% of your Pre-Disability Salary up to a maximum of $10,000 per month with an Elimination Period of 90 days.
- Option 4: Pays 63% of your Pre-Disability Salary up to a maximum of $10,000 per month with an Elimination Period of 180 days.

Example: A person's Pre-Disability Salary equal $60,000. Divide by 12 (months) and then multiply by the benefit percentage you choose, either 60% or 63%, to find out your monthly benefit amount.

$60,000 / 12 x .60 = $3,000.00 per month of LTD benefit

Or

$60,000 / 12 x .63 = $3,150.00 per month of LTD benefit

10. What do the terms "Disabled" and "Disability" mean? How are they defined?

Short Term Disability

"Disabled" means that, due to an injury or illness, you cannot perform the duties of your Own Job and are unable to earn 80% or more of your Pre-Disability Salary.

Long Term Disability

"Disabled" or "Disability" means that, due to sickness, or as a direct result of accidental injury, you cannot perform the duties of your Own Occupation for any employer in your Local Economy during the Elimination Period and the next 24 months or 36 months (depending on the LTD plan you choose) or cannot earn 80% or more of your Pre-Disability Salary.

At the end of the Own Occupation period, you will be considered "Disabled" if you cannot perform the duties of Any Occupation for which you are reasonably qualified; taking into account your training, education and experience; for any employer in your local economy, or cannot earn 60% or more of Your Pre-Disability Salary.

You will need to receive Appropriate Care and Treatment from a doctor and comply with this treatment.

11. What is my Pre-Disability Salary, and when is it determined?

Your gross base annual salary is defined as your Pre-Disability Salary. The gross base annual salary you make on September 1 of each calendar year determines the benefit you are eligible for beginning October 1 of each calendar year.

- For new hires, Pre-Disability Salary will be based on your date-of-hire salary, and coverage will be effective after you complete one full calendar month of employment.
- Annually, there will be a benefit and premium level adjustment. If your salary has changed from the prior year, your benefit and premium will change accordingly using the gross base annual salary you make on September 1. This adjustment will become effective on October 1.

12. How long can I receive benefits under Short Term Disability Insurance?

The Maximum Benefit Period for Short Term Disability is 26 weeks and begins on the benefit start date, which is the day after you satisfy the Elimination Period of either 14 days or 30 days. Please note – because every disability is different, not every disability may last for the Maximum Benefit Period.

For example, some disabilities, such as pregnancy, often have a defined benefit period of six to eight weeks unless there are complications. However, if you break a bone, for example, MetLife will work with your doctor and employer to determine your benefit period. The length of the benefit period depends on your disability, and every disability is different.

13. How long can I receive benefits under Long Term Disability Insurance?

Monthly payments may last up to your Social Security Normal Retirement Age after you satisfy the Elimination Period. If you are 65 or older on the date of disability, your maximum benefit period is as follows:

Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 & over	12 months

Please note – every disability is different. Not every disability may last for the Maximum Benefit Period. MetLife will determine your benefit period based on your medical and other information. The length of the benefit period depends on your disability.

14. What is the Elimination Period and why is it important?

The Elimination Period means "the period of your disability during which MetLife does not pay benefits." It's your waiting period. The Elimination Period starts on the day you become disabled and runs for the period of time specified below. During the Elimination Period you may be entitled to pay for Accrued Leave, Sick Leave and Compensatory Leave or pay withdrawn from the Sick Leave Bank.

For Short Term Disability, there are two Elimination Period options available to employees:

- Option A has an Elimination Period of 14 days for both accident and sickness.
- Option B has an Elimination Period of 30 days for both accident and sickness.

For Long Term Disability, there are two elimination period options:

- Options 1 and 3 have an Elimination Period of 90 days .
- Options 2 and 4 have an Elimination Period of 180 days .

The length of the Elimination Period affects the premium rate. A shorter Elimination Period means your monthly premium will be higher. A longer Elimination Period means you pay a lower monthly premium because you wait longer to receive a benefit.

15. How do Short Term Disability Insurance payments work?

Once you satisfy the Elimination Period and are deemed disabled by MetLife, you will be eligible to receive weekly benefit payments once all Accrued Leave, Sick Leave and Compensatory Leave has been exhausted. Benefit payments will be issued weekly each Tuesday for the prior week's benefits and can be issued via paper check and mailed to you at your address on file with MetLife. Direct Deposit/EFT is also available and once enrolled, payments will be deposited into the designated bank account within 3 days of being issued. The weekly benefit checks cannot be sent to your employer, a doctor, or hospital.

16. How do Long Term Disability Insurance payments work?

Once you meet the Elimination Period and are deemed disabled by MetLife, you will be eligible to receive monthly benefit payments once all Accrued Leave, Sick Leave and Compensatory Leave has been exhausted. Benefit payments are issued on a rolling calendar month for the prior 30 day benefit period and can be issued via paper check and mailed to you at your address on file with MetLife. Direct Deposit/EFT is also available and once enrolled, payments will be deposited into the designated bank account within 3 days of being issued. The monthly benefit checks cannot be sent to your employer, a doctor, or hospital.

17. When will I receive my disability benefit payment?

Short Term Disability benefits are issued weekly. MetLife will process claims within 5 business days of receiving all required information. Once an approval decision is rendered, benefit payments will be issued weekly each Tuesday for the prior week's benefit period. Payments are issued via paper check. Direct Deposit/EFT is also available and payments will be deposited into the designated bank account within 3 days of being issued.

Long Term Disability benefits are issued monthly based on a 30 day rolling calendar month which begins on the benefit start date. MetLife will process claims within five business days of receiving all required information. Once an approval decision is rendered, benefit payments will be issued monthly and are for the prior 30 day period of disability. Therefore, benefit payments are not issued on the same day each month for all LTD claimants. Payments are issued via paper check. Direct Deposit/EFT is also available and payments will be deposited into the designated bank account within three days of being issued.

18. Will I have to pay my Short Term Disability (STD) Insurance premiums while I am disabled?

Yes. You are required to pay your STD premiums while you are out on disability to keep your STD insurance in force. You will be direct billed for Short Term Disability premiums just as you are for other benefits such as Medical and Dental.

19. Will I have to pay my Long Term Disability (LTD) Insurance premiums while I am disabled?

Yes. You must pay your LTD premiums during the Elimination Period to keep your LTD insurance in force. You will be direct billed for Long Term Disability premiums just as you are for other benefits such as Medical and Dental. Once you are eligible to receive Long Term Disability benefits, premiums will be waived.

20. If I am currently disabled, and my Short Term Disability (STD) Insurance coverage ends, will my benefits end?

No. If you were eligible for STD coverage on your date of disability, then your benefits will not be impacted and will continue to be administered according to the rules outlined in the plan.

21. If I am currently disabled, and my Long Term Disability (LTD) Insurance coverage ends, will my benefits end?

No. If you were eligible for LTD coverage on your date of disability, then your benefits will not be impacted and will continue to be administered according to the rules outlined in the plan.

22. Can I receive Short Term and Long Term Disability benefits if I return to work part-time?

Yes. MetLife will work with you to determine if you qualify to receive any benefits and what those benefits are.

23. What happens if my Short Term Disability is longer than the Maximum Benefit Period of 26 weeks?

Short Term Disability Benefit payments will stop. If you are enrolled in the LTD plan, you may begin to receive Long Term Disability benefits after your Short Term Disability benefits end.

24. Are there any income sources I might receive while I am disabled which will reduce my Short Term Disability benefit?

Yes. The following income sources will reduce your Disability benefit:

- Any Sick Leave, Accrued Leave, Compensatory Leave or other salary continuation that the Policyholder (the state) pays to you.
- Any disability or retirement benefits which you receive because of your disability or retirement under a Railroad Retirement Act or any state or public employee retirement or disability plan.
- Any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's (the state's) contributions.
- Any income received for disability under another Group Insurance Policy (for example, if you are a member of TSEA and have a group disability policy so are covered under both Disability plans)
- Any income received for workers' compensation

The above list is not all inclusive. Please read your Short Term Disability certificate for the full legal details.

25. Are there any income sources I might receive while I am disabled which will reduce my Long Term Disability benefit?

Yes. The following income sources will reduce your Disability benefit:

- Any disability or retirement benefits which you, your Spouse or child(ren) receive or are eligible to receive because of your disability or retirement under the Federal Social Security Act, Railroad Retirement Act, any state or public employee retirement or disability plan; or any pension or disability plan of any other nation or political subdivision
- Any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's (the state's) contributions
- Any income received for disability under another Group Insurance Policy (for example, if you are a member of TSEA and have a group disability policy so are covered under both Disability plans)
- Any sick pay, vacation pay or other salary continuation that the Policyholder (the state) pays to you
- Workers' compensation or a similar law which provides periodic benefits
- Any income that you receive from working while Disabled to the extent that such income reduces the amount of Your Monthly Benefit
- Other income in the form of a Single Sum Payment

The above list is not all inclusive. Please read your Long Term Disability certificate for the full legal details.

26. Am I allowed to have both a Workmen's Compensation (WC) claim and Short Term Disability (STD) or Long Term Disability (LTD) at the same time?

Yes. The STD or LTD claim will run concurrently with the WC claim and any income payments received from WC would be an offset to the STD or LTD benefit payments.

27. Are there any income sources I might receive while I am disabled which will NOT reduce my Short Term Disability Benefit?

Yes. The following income sources will not reduce your Disability benefit:

- Early retirement benefits that have not been voluntarily taken by you.
- Veteran's benefits.
- Individual disability income insurance policies.
- Benefits received from an accelerated death benefit payment.

This above list is not all-inclusive. Please read your Short Term Disability certificate for the full legal details.

28. Are there any income sources I might receive while I am disabled which will NOT reduce my Long Term Disability Benefit?

Yes. The following income sources will not reduce your Disability benefit:

- Cost of living adjustments that are paid under any above sources of other income
- Early retirement benefits that have not been voluntarily taken by you
- Veteran's benefits
- Individual disability income insurance policies
- Benefits received from an accelerated death benefit payment

This above list is not all-inclusive. Please read your Long Term Disability certificate for the full legal details.

29. I have "Leave" time accrued. Does this affect my Short Term and Long Term Disability benefit?

You ARE required to use all of your accrued leave before your disability payments begin. This includes all Sick Leave, Annual Leave, and Compensatory Leave. Any accrued leave that extends beyond the STD or LTD benefit start date will be an offset to the STD or LTD benefit. You will not be paid from two different sources for your disability. Your disability benefit payment from MetLife will begin after your pay from any accrued leave ends.

Every employee's situation is different. Consider how much accrued sick and annual leave you have when deciding whether to purchase Short Term and/or Long Term Disability Insurance.

Example: You chose Option A for your STD policy. Your STD Elimination Period is 14 calendar days, maximum duration is 26 weeks, benefit is 60% of pre-disability salary. You have 153 hours of accrued annual and sick leave, you are scheduled to work 7-1/2 hours per day M-F (37-1/2 hours per week). You are approved for disability starting Tuesday, April 3, 2018 and you continue to meet the definition of disability for 26 weeks.

Your date last worked is April 2, 2018 and your date of disability is April 3, 2018. The 14 calendar day Elimination Period begins on April 3, 2018. You will receive your accrued paid leave while satisfying your Elimination Period. The STD benefit start date is April 17, 2018 and the 26 week benefit duration begins. However, you continue to receive your accrued paid leave for another 2 weeks and 3 hours. The accrued paid leave is an offset to the STD benefits, so STD benefits will not be payable until all accrued paid leave is exhausted. After receiving three hours of accrued paid leave May 1, 2018, all accrued paid leave will be exhausted. Therefore, a partial benefit will be issued for May 1, 2018, then you will begin receiving your STD benefit payments equal to 60% of your pre-disability salary, paid weekly, for the remaining benefit duration until October 15, 2018. (April 17, 2018-October 15, 2018 is 26 weeks)

30. Will using days from the "Sick Leave Bank" impact my STD benefit payment?

You are NOT required to use days from the Sick Leave Bank. However, if you withdraw days from your Sick Leave Bank, any Sick Leave Bank days that extend beyond the STD benefit start date will be an offset to the STD benefit. You will not be paid from two different sources for your disability. Your disability payment from MetLife will begin after your pay from the Sick Leave Bank ends.

31. Will using days from the "Sick Leave Bank" impact my LTD benefit payment?

You are NOT required to use days from the Sick Leave Bank. However, if you withdraw days from your Sick Leave Bank, any Sick Leave Bank days that extend beyond the LTD benefit start date will be an offset to the LTD benefit. You will not be paid from two different sources for your disability. Your disability benefit payment will begin after your pay from the Sick Leave Bank ends.

32. How does Short Term Disability work with FMLA?

If you are on FMLA due to your own disability you may be eligible to receive disability benefits if you meet the definition of disability per the plan. If you are on FMLA for any other reason, such as care of a family member, for example, you are not eligible to receive disability benefits. While on FMLA leave, you will be billed for Disability coverage just as you are for other benefits, such as Medical and Dental.

You can take FMLA leave when your child is born, and therefore, you can use disability benefits due to the birth of a child. If you use FMLA for any reason other than a disability related to you, let's say you need to care for a family member, then you may continue your STD coverage while you are on leave. You will be billed for Disability premiums just as you are with other benefits offered such as Dental or Life.

33. How does Long Term Disability work with FMLA?

If you are on FMLA due to your own disability you may be eligible to receive disability benefits if you meet the definition of disability per the plan. If you are on FMLA for any other reason, such as care of a family member, for example, you are not eligible to receive disability benefits. While on FMLA leave, you will be billed for Disability coverage just as you are for other benefits, such as Medical and Dental.

34. What happens to my disability insurance coverage if I quit (lose) my job?

Your disability insurance coverage will end at midnight on the date you terminate employment. Members enrolled in the State's disability insurance program for at least 12 calendar months whose employment ends due to a reason other than disability may convert their coverage to an individual disability policy or a non-state sponsored group disability plan. They must do so within 31 days of the end of their Disability insurance coverage. MetLife will mail the eligible member an enrollment packet which includes an enrollment form, plan summary and premium rate sheet. This option is not available to a member whose coverage ends due to non-payment of premiums.

35. When can I cancel or change my Short Term and Long Term Disability coverage?

You may cancel coverage during Annual Enrollment or by giving at least 30 days advance written notice. You may change your coverage Option during Annual Enrollment or when you experience a Special Qualifying Event; however, if currently enrolled and increasing coverage, you will be required to submit an Evidence of Insurability application.

36. What happens if I die while I am disabled?

If you were receiving disability benefits under the Long Term Disability plan and been disabled for 180 or more days at the time of death, your beneficiary, designated for the LTD insurance program, will receive a benefit equal to 3 months of your gross disability benefit paid in a lump sum. If there is no designed beneficiary on file at the time of death, MetLife may determine the beneficiary according to the following order:

1. Your spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s)
5. Your estate, if there is no surviving sibling(s)

37. Can my spouse sign up for Long Term Disability insurance?

No. The program is for active and eligible employees only. If your spouse is also an active and eligible employee, he or she may apply as an employee.

38. Are there any exclusions to my Disability Insurance coverage?

Yes. Short Term and Long Term Disability insurance typically does not cover any disability caused or contributed to by any of the following means:

- Acts of War, Insurrections, Riots, Rebellion(s) or Terrorist acts.
- Intentionally self-inflicted injuries or attempted suicides.
- Commission of or attempt to commit a felony.
- Disability(ies) caused or contributed to by elective treatments or procedures include items such as Cosmetic Surgery(ies), Liposuction, or Visual correction surgery.

For a full list of exclusions, please read your Short Term Disability Insurance Certificate and/or your Long Term Disability Insurance Certificate.

39. Are there any limitations to my coverage?

Short Term Disability: No

Long Term Disability: Yes. Limitations to your benefit may apply if you are disabled due to one or more of the following medical conditions, your disability benefits will be limited to a lifetime maximum benefit equal to the lesser of 24 months or the Maximum Benefit Period: Alcohol, Drug or Substance Abuse or Addiction or Mental and Nervous Disorders or Diseases. Please review your Certificate of Insurance and Disability Member Handbook provided by your Employer for specific details or contact MetLife with any questions.

40. For Short Term Disability Insurance, are there any exclusions for Pre-Existing Conditions?

There are no exclusions for pre-existing conditions under Short Term Disability Insurance.

41. For Long Term Disability Insurance, are there any exclusions for Pre-Existing Conditions?

a) Yes. Under Long Term Disability Insurance, if you become disabled within the first 12 months of your coverage becoming effective, the plan will not cover a sickness or accidental injury for which you received treatment, consultation or care, or took medications or were prescribed medications in the 3 months prior to your participation in the plan.

42. Can I enroll for both Short Term Disability and Long Term Disability? How does this work?

Yes, you may enroll in either Short Term Disability (STD) insurance and/or Long Term Disability (LTD) insurance. Your LTD benefits, if enrolled, begin after your STD benefits have been exhausted and your LTD Elimination Period is satisfied. The disability insurance carrier will work with you when and if you need to transition from STD to LTD.

43. What are the rules of enrollment for newly eligible employees (new hire or transfer)?

Newly eligible employees have 31 days after their eligibility date to enroll and will not be required to answer health questions. If you do not enroll during your initial 31 day eligibility enrollment period, you must wait until the Annual Enrollment Period, or when you experience a Special Qualifying Event. Then, if you decide to enroll, you will have to answer questions about your health.

44. If I sign up for Disability Insurance when will my coverage be effective?

- If enrolled timely, as a newly eligible employee, coverage is effective on your eligibility date.
- If enrolled timely, with a Special Qualifying Event (within 60 days of the event date), you will be required to answer medical questions and coverage will be effective the later of the first day of the calendar month following the date MetLife approves the medical request if approval is made before the 15th of the month, or the first day of the second calendar month following the date MetLife approves the medical request if approval is made on/after the 15th of the month .
- If enrolled during the Annual Enrollment Period, you will be required to answer medical questions. If MetLife's approves your coverage, coverage will be effective the later of: the first day of the calendar year following the Annual Enrollment Period, or the first day of the calendar month following the date MetLife approves the medical request if approval is made before the 15th of the month, or the first day of the second calendar month following the date MetLife approves the medical request if approval is made on/after the

15th of the month.

45. Do I have to pay through payroll deductions?

Yes. Deductions will be made with “After-Tax” dollars which means the STD/LTD benefits will not be taxable. Deductions are taken in advance just as they are for other benefits, such as Medical and Dental.

46. I am interested in Disability Insurance. How do I enroll in coverage?

Enroll in Disability Insurance online in ESS during your initial 31 day eligibility enrollment period. If you are enrolling (or changing benefit plans) during the next Annual Enrollment Period or within 60 days from a Special Qualifying Event, then complete a paper Enrollment Change Application and follow further instructions provided by your Agency Benefits Coordinator. If you are newly eligible, then no health questions will be asked. If you are enrolling during the Annual Enrollment Period or with a Special Qualifying Event, then health questions will be asked. If an employee changes within 31 calendar days from an agency of the employer to another agency of the employer where coverage had not been available before, this is the first opportunity to enroll in STD and/or LTD, so he/she will be treated as a new hire. If the employee is already enrolled in STD and/or LTD, then the employee may transfer the STD and/or LTD coverage.

47. I enrolled for disability insurance and I think I have become disabled, what do I need to do?

You will need to file a Disability claim with MetLife.

48. How do I file a claim?

There are three (3) ways to file a claim.

1. Call the MetLife Claims Center at 1-855-700-8001 from 7:00 am – 10:00 pm CT, Monday – Friday
2. File a claim online at www.metlife.com/mybenefits
3. File a Paper Claim by downloading a form from www.metlife.com/mybenefits.
   Send your completed claim form to the MetLife Claim’s office address and or fax number below:
   Metropolitan Life Insurance Company
   PO Box 14590
   Lexington, KY 40512
   Fax: 1-800-230-9531

Whether you file by phone, online or by paper, you can track the status of your claim online or through MetLife’s “My Benefits” site: https://mybenefits.metlife.com, or via the MetLife US App. Simply search for "MetLife" on iTunes® App Store or Google Play to download the app.

49. What information will I need to provide to MetLife when submitting a disability claim?

- Name
- Social Security Number
- Contact Phone Number
- Job Title
- Supervisor’s Name
- Contact Information
- Reason for your absence

50. Who decides if I am disabled?

A MetLife Claim Specialist will be assigned to your claim. He or she will review the information on your claim. This includes medical reports from your doctors, information from your employer, and other sources necessary to make a determination of your claim.

The frequency of the medical and supporting information being requested will vary depending on the circumstances of each specific claim.

51. What happens if my request for Short Term and/or Long Term Disability benefit is denied? Is there an appeal process?

If your claim is denied, you may appeal the decision. Upon your written request, MetLife will provide you with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address on the claim form within 180 days of receiving MetLife's decision. Please see the Short Term Disability Insurance Certificate and/or the Long Term Disability Insurance Certificate of coverage for more information.

52. How will Short Term and Long Term Disability be listed on the timesheet?

Time away from work for Short Term and Long Term Disability will be coded as "Leave Without Pay".

53. Will leave time or service credits continue to accrue while on Short Term or Long Term Disability?

No. Time away from work for Short Term and Long Term Disability will be coded as "Leave Without Pay" which does not allow for accrual of leave time or service credit.

54. How does MetLife's Rehabilitation Program help employees return to work safely and effectively?

The MetLife Rehabilitation Program supports an employee with returning to work safely by providing resources to assist where appropriate. The Rehabilitation Program plan is managed as a team effort and involves the employee, the State of TN, the employee's treating provider(s) and MetLife clinical and return-to-work consultants. Each Rehabilitation Program is customized to meet the needs of the employee and is based on an assessment of the employee's capabilities and medical condition. The State of TN's Disability plan is designed to provide advantages and financial incentives for participating in MetLife's Rehabilitation Program. Participation in the State of TN Rehabilitation Program is mandatory when MetLife deems it is mandatory, and benefits will end on the date the employee ceases or refuses to participate in the program. The Rehabilitation Program may include, but is not limited to, an employee's participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

55. What if I am unable to contact MetLife to report my claim?

If you experience a disability that prevents you from calling MetLife to report your claim, someone can call MetLife (1-855-700-8001) and report the claim on your behalf. This can be someone from the State of TN HR team, a family member or other individual who is aware of your situation. They should be prepared to provide as much information as possible about your current condition, treating physicians, and/or hospital name/location including any relevant contact phone numbers that would be helpful for claims administration.

The State of TN does not offer Long Term Disability Insurance to Higher Education employees. If you

are a Higher Education employee, direct questions on LTD to your Agency Benefits Coordinator.

Affordable Care Act (ACA)

1. **The 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).

2. **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.

3. **Do the ParTNers for Health plans meet the healthcare reform law's minimum value requirements?**
   Yes, all ParTNers for Health plans meet this requirement.

4. **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.

5. **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.

6. **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 December 15