

TEAMHealth

Frequently Asked Questions

Vendor Information

My benefits are effective and I have to go to a provider. I do not have my cards yet. What should I do?

Once you have faxed or mailed your information to the Benefits Center, vendors will have your information within about a week of our receiving your enrollment worksheet. Even though you may not have your cards, you may certainly go to a provider. You can give the provider the following information along with your SSN and they can verify eligibility:

UnitedHealthcare (group #702703)

Phone 866-675-1608

Caremark (prescription coverage)

Phone 800-841-5550

Pharmacy Helpline 800-421-2342

Group Code TEAM

Plan Code CRK

Delta Dental of Tennessee (group #4073)

Phone 800-223-3104

EyeMed Vision

Phone 866-723-0513

If they do not yet have your record, you can pay for the claim out-of-pocket and then download and submit a claim form from the benefits website to be reimbursed, or you can ask that they resubmit the claim at a later time. You can also print temporary cards at www.myuhc.com (UnitedHealthcare) and www.deltadentaltn.com (Delta Dental).

Is the deductible year the same as the plan year?

Our plan year is October 1 through September 30. All UnitedHealthcare plans, except for the high deductible plan, have a deductible year of January through December. The high deductible plan follows our plan year (October through September). The Delta Dental deductible year is also January through December.

I received an Explanation of Benefits (EOB) and I do not understand the charges. What should I do?

We recommend contacting the insurance carrier first as they have a record of your claims and can usually answer your questions very quickly. For example, if you received an EOB from UnitedHealthcare and you disagree with how the claim was processed, it is best to start by calling United. If you are not getting anywhere and need additional assistance, call the Benefits Center at 877-516-7492.

Benefits Enrollment

How do I enroll in benefits?

Enclosed in your new-hire benefits packet is a benefits enrollment worksheet. Complete the form and fax or mail back to the Benefits Center at 888-422-0106 as soon as possible. We will send a confirmation statement to you within a week of receiving your paperwork. If your confirmation statement does not look correct, call the Benefits Center immediately to have the error corrected.

When are my benefits effective?

Your benefits are effective the first of the month following 30 days of employment. For example, if you are hired on April 5, your benefits are effective June 1.

When is my benefits paperwork due?

We request that you fax or mail your paperwork back within 10 days of receiving your benefits packet. If we do not receive it within 30 days of your benefits effective date, you will not be allowed to enroll until Open Enrollment. Any delay in sending the worksheet back may result in your health, dental, or prescription cards being sent after your effective benefits date.

What is Open Enrollment?

Open Enrollment occurs every year and marks the period in which employees are allowed to make changes in their benefits without a qualifying event.

When is Open Enrollment?

Our new benefits year begins October 1. You will receive Open Enrollment information in late August/early September. At that time, you are allowed to make changes to your benefits for any reason. A qualifying event is not required. Evidence of Insurability (EOI) is required for changes to life, LTD, or STD insurance.

Benefits Changes

Can I make changes to my benefits at any time?

Once you elect benefits, either as a new-hire or during Open Enrollment, you are locked into those benefits until the next Open Enrollment *unless* you have a qualifying event (not applicable to 401k – changes may be made at any time). If you have a qualifying event and need to make a change to your coverage, call the Benefits Center at 877-516-7492 within *30 days* of the event.

Common qualifying events:

- Losing coverage through spouse – need to add TH insurance
- Gaining coverage through spouse – need to drop TH insurance
- Dependent eligible for insurance elsewhere – need to drop TH insurance
- Child adoption – need to add child to insurance
- Child birth – need to add child to insurance

I just had a baby. How do I add the child to my medical insurance?

Congratulations! Call the Benefits Center at 877-516-7492 and we will add the child to your insurance. We will need the name and date of birth. We must be informed within *30 days* of the birth. Please also forward the child's social security number as soon as you receive it.

How do I change my 401(k) election?

You can make changes at any time by contacting Charles Schwab at 800-724-7526 or www.schwabplan.com. Your username is your SSN and your pin is the month and date you were born (if

you were born on March 6, your pin would be 0306). Any change made by the 20th of the month will be effective the first of the following month. Your information will not show at Schwab until you have received your first paycheck.

Flexible Spending

I need to find the form to submit a claim for my flexible spending. Where should I go?

The benefits website (<http://benefits.teamhealth.com>) contains almost every form you will ever need. Summaries, descriptions, and contact information are also housed on the site.

My spouse does not work and is not a full-time student. Can I enroll in the dependent care spending account?

If you are married, in order to participate in the dependent care spending account, your spouse must be employed, actively looking for employment, a full-time student, or disabled.

Life Insurance

I thought I received company-paid life insurance. I am looking at my enrollment paperwork and I see where I am being charged for that coverage.

The charge is in reference to supplemental coverage. Any coverage that has a cost associated with it regards coverage that is in addition to the company-paid insurance.

Contact Information

I have additional questions. Who should I contact?

The TeamHealth Benefits Center can be reached by calling 877-516-7492 or emailing benefits@teamhealth.com. We stand ready to help you in any way we can.

What is Coordination of Benefits?

If you're fortunate enough to be covered by two medical plans, you have what is called dual coverage. Dual coverage doesn't mean that your benefits are doubled. What it does mean is that you may potentially enjoy lower out-of-pocket costs for your medical care.

How does dual coverage work?

If you are covered by two programs (dual coverage), non-duplication of benefits is a term used to describe how UnitedHealthcare when identified as the secondary carrier will calculate its portion of the payment. If UnitedHealthcare is the secondary carrier, the plan calculates what it would have paid if it were the primary plan and subtracts what the other plan paid. For example, if the primary carrier paid 80 percent, and the secondary carrier normally covers 80 percent as well, the secondary carrier would not make any additional payment. If the primary carrier paid 50 percent, however, the secondary carrier would pay up to 30 percent.

How are primary carrier and secondary carriers determined?

The first or primary carrier is the one that covers you as a primary enrollee (e.g., your employer rather than your spouse's employer). If you have two jobs, the plan that has covered you longer is considered primary.

For your children's coverage, the primary carrier is determined by the birthday rule: coverage of the parent whose birthday (month and day, not year) comes first in the year is considered to be your children's primary coverage. The birthday rule may be superseded by a divorce agreement or other court ruling.

Why not twice as many benefits?

Why don't you receive double the benefits when you have two medical programs? Dual coverage limitations, like all other program limitations, are built into TeamHealth's contract and into the costs we incur for your coverage. These contracts are set up to provide affordable health care to a maximum number of people. Given the choice between doubling one individual's benefits or providing a greater scope of benefits to more people in the group, most group purchasers choose to spread their benefit dollars more evenly.