NEW HIRE GUIDE – 2025

Local Government Employees & COBRA Participants

PARTNERS FOR HEALTH

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PARTNERS FOR HEALTH

Benefits Administration, a division of the Department of Finance and Administration, manages the State Group Insurance Program. Partners for Health is the official logo and brand for the State Group Insurance Program.

Eligibility

Eligible

- Any employee scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position
- Any member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation)
- Utility board members appointed or elected pursuant to TCA 7-82-307, but only during their term of service
- County officials as defined in TCA 8-34-101(9) (A) and (B), regardless of whether the agency participates in the plan, pursuant to TCA 8-27-704(a)
- All other individuals cited in state statute, approved as an exception by the Local Government Insurance Committee or defined as full-time employees for health insurance purposes by federal law

NOT Eligible

Individuals who do not meet the employee eligibility rules outlined above are ineligible UNLESS otherwise authorized under applicable law.

Dependents

If you enroll in health, vision or dental coverage, you may also enroll your eligible dependents.

Eligible

- Your spouse (legally married); individual agencies may deny eligibility to the spouses of employees who are eligible for group health insurance through the spouse's employer
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian, custodian or conservator

Proof of the dependent's eligibility is also required and must be submitted to Benefits Administration no later than 10 business days after the 30-day enrollment deadline. Refer to the dependent definitions and required documents chart at **tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf** for the types of proof you must provide.

Not Eligible

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency who are placed with the head of contract for temporary or long-term foster care
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

A dependent can only be covered once within the Local Government Plan but can be covered under two separate plans (state, local education or local government). Dependent children are usually eligible for coverage through the last day of the month of their 26th birthday. Orders for guardianship, custody or conservatorship may expire at an earlier age. If you have a dependent who is not your child, but is placed with you by a placement order, coverage will be terminated when the order expires unless additional eligibility requirements are met.

Children who are mentally or physically disabled and not able to earn a living may continue health, dental and vision coverage beyond age 26 if they were disabled before their 26th birthday and they were already insured under the State Group Insurance Program. The child must meet the requirements for dependent eligibility listed above. A request for extended coverage must be provided to Benefits Administration before the dependent's 26th birthday. The insurance carrier will decide if a dependent is eligible based on disability. Coverage will end and will not be restored once the child is no longer disabled.

An employee may not be enrolled as both head of contract and dependent within the Local Government Plan. A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who is not currently enrolled. The employee spouse will have dependent status unless he or she requests to change during the Annual Enrollment period or later qualifies under the special enrollment provisions.

All eligible dependents must be listed by name on the enrollment change application in part 3 **www.tn.gov/content/dam/tn/partnersforhealth/documents/2024_forms/1043_2024.pdf**. You are also required to provide a valid Social Security number for a dependent (if they are eligible for one). Other required information includes date of birth, relationship, gender and acquire date.

Enrollment and Effective Date of Coverage

Enrollment must be completed and submitted to Benefits Administration within 30 calendar days of your hire date or date of becoming eligible. The 30 days includes the hire date or other date you become eligible. You should enroll as quickly as possible to avoid the possibility of double premium payroll deductions.

If you are a newly hired employee (including someone moving between local government agencies or someone coming from a local education agency, the state plan or a higher education institution), coverage will start on the first day of the month following your hire date or date of becoming eligible.

If you are an existing employee gaining eligibility for coverage (including part-time to full- time employment), coverage starts the first day of the month following gaining eligibility for coverage and your submission of a completed enrollment form to BA.

If you enroll dependents during your initial enrollment period, their coverage starts on the same day as yours. If served with a Qualified Medical Child Support Order that requires a child to be enrolled on the local government plan, the child will be enrolled, and the child's coverage will start according to the terms of the order.

If you do not enroll in health coverage by the end of your enrollment period, you must wait for the Annual Enrollment period, unless you have a qualifying event during the year. Refer to the special enrollment provisions in this guide for more information.

Insurance cards will be mailed to you three to four weeks after your application is processed. You may call the insurance carrier to ask for extra cards or print a temporary card from the carrier's website.

Choosing a Premium Level

There are four premium levels for health, dental and vision coverage. You may choose the same or different levels for health, dental and vision.

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

If you enroll as a family, which is any coverage level other than Employee Only, all of you must enroll in the same health, dental and vision insurance. However, if you are married to an employee who is also a member of the state, local education or local government plan, you can each enroll in Employee Only coverage if you are not covering dependent children. If you have children, one of you can choose Employee Only and the other can choose Employee + Child(ren). Then you can each choose your own benefit option and carrier.

Edison

You will need to log in to Edison at **www.edison.tn.gov/** to enroll. Your agency may also process your enrollment for you. Reach out to your agency benefits coordinator for more information.

Premium Payment

There is no state premium support for local government employees. Agencies may pay all, a portion or none of an employee's insurance coverage. Your agency benefits coordinator can explain when your premium will be taken from your paycheck.

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

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

Updating Personal Information

You can update personal information, such as home address and email, in Edison or by contacting your agency benefits coordinator. You can also call the Benefits Administration service center (800.253.9981 or 615.741.3590) to request an address change or email address change. You will be required to provide your Social Security number or Edison ID, date of birth, previous address and confirm authorization of the change before BA can update your information.

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

Cancelling Coverage

Outside of the Annual Enrollment period, you can only cancel coverage for yourself and your covered dependents, IF:

- You lose eligibility for the State Group Insurance Program (e.g., changing from full-time to part-time)
- You experience an event as detailed in applicable plan documents and certificates of coverage

How to Enroll

If you want to enroll in health insurance, you can choose your health insurance option, carrier and network by enrolling in Edison **at www.edison.tn.gov.**

You must notify your agency benefits coordinator of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When cancelled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for dependent children generally ends on the last day of the month in which the child reaches age 26, unless otherwise stated in plan rules.

Divorce — If you request to terminate coverage of a dependent spouse while a divorce case is pending, your request will be processed and final, subject to plan provisions. It is your responsibility to comply with all requirements of Tennessee Code Annotated 36-4-106 and to provide notice of termination of health insurance to the covered Dependent spouse as required Tennessee Code Annotated Section 56-7-2366.

Cancelling coverage in the middle of the plan year
You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you lose eligibility or you experience an event as described in the medical plan document or applicable certificate of coverage. There are no exceptions. You have 60 days from the date that you and/or your dependents lose eligibility or become newly eligible for other coverage to turn in an application and proof to your agency benefits coordinator **www.tn.gov/content/dam/tn/partnersforhealth/documents/2024_forms/1047_2024.pdf.** Cancellation reasons and required proof are shown on the application.

The coverage end date will be either:

- The end of the month of the loss of eligibility
- The end of the month the form and required proof are received

You may request to cancel the Dental Health Maintenance Organization (Prepaid Provider) plan if there is no participating general dentist within a 25-mile radius of your home address.

Moving Between Plans

If you are eligible for coverage under more than one state-sponsored plan, you may move between the state, local education and local government plans. You may apply to change plans during the plan's designated Annual Enrollment period with an effective date of January 1 of the following year.

If You Don't Apply When First Eligible

If you do not enroll in coverage when you are first eligible, you must wait for the Annual Enrollment period. You can apply to enroll or make changes to your coverage during the year, but ONLY if you experience a special qualifying event, or you have a recognized status change as described in the chart below.

Special Enrollment Provisions and Enrollment Due to Mid-Year Events

Special Enrollment for Health Coverage — If you or a dependent lose eligibility for coverage under any other group health insurance plan, or if you acquire a new dependent during the plan year, the federal Health Insurance Portability and Accountability Act may provide additional opportunities for you and eligible dependents to enroll in health coverage.

Enrollments Due to Mid-Year Events - You or eligible dependents may also enroll in voluntary dental and vision if you meet the requirements stated in the certificates of coverage for those programs.

NOTE: Application for special enrollment or enrollment due to a Mid-Year Event (https://www.tn.gov/content/dam/tn/partnersforhealth/documents/2024_forms/1043_2024.pdf) must be made within 60 days of the loss of eligibility for other health insurance coverage or the new dependent's acquire date. Application must be made within 30 days of a birth or adoption for the coverage to be retroactive to the date of birth/adoption.

You must also submit proof as listed on the enrollment application.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) is not allowed except if the application and proof are submitted within 30 days in the event of birth, adoption and placement for adoption. For all other events, and when application is submitted for births, adoption, or placement for adoption between 30 and 60 days after the event, the earliest effective date allowed for coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Note: Effective dates for voluntary dental and vision are always prospective and are specified in the certificates of coverage for those programs. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date.

The chart on page 2 of the enrollment change application explains the kinds of events that allow special enrollment or enrollment due to a Mid-Year Event, the effective dates of coverage and the documentation you will need to provide.

Important Reminders

- If you are adding dependents to your existing coverage, you can choose a different carrier or health care option, if eligible.
- If you or your dependents had Consolidated Omnibus Budget Reconciliation Act or COBRA continuation coverage under another plan and coverage has been exhausted, enrollment requirements will be waived if application is received within 60 days of the loss of coverage.
- Loss of eligibility does not include voluntary actions resulting in loss of coverage (such as voluntary cancellation of coverage and cancellation for not paying premiums), electing to cancel, waive or decline coverage during another plan's enrollment period, or termination of coverage for cause.
- Premiums are not prorated. If approved, you must pay premium for the entire month in which the effective date occurs.

Continuing Coverage During Leave or After Termination

EXTENDED PERIODS OF LEAVE

Family and Medical Leave Act

FMLA allows you to take up to 12 weeks of leave during a 12-month period for things like a serious illness, the birth or adoption of a child or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to get the portion of your health insurance premium that your employer would pay if you were in a positive pay status. Initial approval for family and medical leave is up to each agency head. You must have completed a minimum of 12 months of employment immediately before the onset of leave. Cancellation due to failure to pay premiums does not apply to FMLA.

Leave Without Pay — Health Insurance Continued

If continuing coverage while on an approved leave of absence you must pay the total monthly health insurance premium once you have been without pay for one full calendar month. You will be billed at home each month for your share and the employer's share. The maximum period for a leave of absence is two continuous years. At the end of the two years, you must immediately report back to work for no less than one full calendar month before you can continue coverage during another leave of absence. If you do not immediately return to work at the end of two years of leave, coverage is cancelled and COBRA eligibility will not apply.

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages.

To Reinstate Coverage After You Return

Benefits will be reinstated prospectively upon return from leave with the same elections in place at the commencement of the leave subject to any changes in benefit levels that may have taken place during the leave period and provided you continue to meet all plan eligibility requirements. If returning from a Non-Military, non-FMLA leave that is more than six months, the effective date is the first day of the month following one full calendar month after you return to work.

Reinstatement for Military Personnel Returning from Active Service

An employee who returns to work after active military duty will be reinstated upon return from leave with the same elections in place at the commencement of the military leave subject to any changes in benefit levels that may have taken place during the leave period. You will be enrolled in the same plan options you were previously enrolled in upon notice of return, effective the first day of the month following the notice of return (prospective) or you may elect an effective day of the first day of the month in which you return to work (retroactive).

Leave Due to a Work-related Injury

If you have a work-related injury or illness, contact your agency benefits coordinator about how this will affect your insurance.

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration. A COBRA notice to continue health, dental and vision coverage will be mailed to you.

If your spouse is also insured as a head of contract under either the state, local education or local government plan, you have the option to move to your spouse's contract as a dependent. Application must be made within 60 days of your loss of eligibility for other coverage. See section on special enrollment provisions for details.

Continuing Coverage through COBRA

You may be able to continue health, dental and/or vision insurance under a federal law known as COBRA. This law allows employees and dependents whose insurance would end to continue the same benefits for specific periods of time. You may continue health, dental or vision insurance if:

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

BA will send you a COBRA packet to the address on file within 7-10 days after receiving notification of your coverage ending. Make sure your correct home address is on file with your agency benefits coordinator. You have 60 days from the date coverage ends or the date of the COBRA notice, whichever is later, to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. If you do not receive a letter within 30 days after your insurance ends, you should contact BA.

Continuing Coverage at Retirement

Your agency must have opted in to offering the continuation of coverage on the retirement group health plan in addition to other eligibility criteria. There are separate eligibility guides for retirement insurance. The Guide to Continuing Insurance at Retirement for Local Government is available on the Partners for Health website under "Publications" at **www.tn.gov/partnersforhealth**.

Coverage for Dependents in the Event of Your Death

If you die while actively employed, your covered dependents will be offered continuation of whatever state health, dental and vision insurance they have on the date of your death. Your surviving dependent(s) should contact Benefits Administration to confirm the type of coverage continuation for which they are eligible.

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

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

If eligible, premiums for continued coverage of your eligible surviving dependents will be deducted from your monthly TCRS pension check if a covered dependent is your desig-

nated pension beneficiary. Covered surviving dependents must submit insurance premiums directly to Benefits Administration if your TCRS pension check is insufficient to cover the premiums or if your designated pension beneficiary is someone other than a dependent covered on your insurance at the time of your death.

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

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

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

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

If You Are Covered Under COBRA

Your covered dependents will have up to a total of 36 months of COBRA, provided they continue to meet the eligibility requirements.

Other Information

Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together to determine which plan will pay first, how much each plan will pay, and how much you will pay. When this plan pays secondary you will pay your member cost share as noted in this guide on the Benefit Comparison. At no time should payments exceed 100% of the eligible charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, if you have other health coverage as the head of contract, the oldest plan is your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his/her employer, that coverage would be primary for your spouse and secondary for you. Generally, Medicare will pay secondary

unless the covered individual is enrolled in Medicare due to end stage renal disease or disability, as other coordination of benefits rules may apply.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.

From time to time, carriers will send letters to members asking for other coverage information because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. The carriers may also attempt to gather this information when members call. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

If you do not respond to requests for other coverage information, your claims may be pended or held for payment. When claims are pended, it does not mean that coverage has been terminated or that the claims have been denied. However, claims will be denied if the requested information is not received by the deadline. Once the carrier gets the requested information, they will update the information regarding other coverage, and claims that were pended or denied will be released or adjusted for payment.

Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover the following:

- Any payments made as a result of injury or illness caused by the action or fault of another person
- A lawsuit settlement that results in payments from a third party or insurer of a third party
- Any payments made due to a workplace injury or illness

These payments would include payments made by worker's compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses for which the plan has already paid, you may be subject to collections activity.

On-the-job Illness or Injury

Work-related illnesses or injuries are not covered under the plan. The plan will not cover claims related to a work-related accident or illness regardless of the status of a worker's compensation claim or other circumstances.

Fraud, Waste and Abuse

Making a false statement on an enrollment or claim form is a serious matter. Only people defined by the group insurance program as eligible may be covered. Eligibility requirements for employees and dependents are covered in detail in this guide.

If your covered dependent becomes ineligible, you must inform your agency benefits coordinator and submit an application to drop coverage for that dependent within one full calendar month of the loss of eligibility. Coverage of the dependent will terminate at the end of the month in which the dependent ceases to be eligible. Once a dependent becomes ineligible for coverage, he/she cannot be covered even if you are under court order to continue to provide coverage.

UPDATING PERSONAL INFORMATION

You can update personal information, such as home address and email, in Edison or by contacting your agency benefits coordinator. You can also call the BA service center to request an address change or email address change. You will be required to provide your Social Security number or Edison ID, date of birth and confirm authorization of the change before BA can update your information.

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

If there is any kind of error in your coverage or an error affecting the amount of your premium, you must notify your agency benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your health care. It is estimated that between 3–14% of all paid claims each year are the result of provider or member fraud. You can help prevent fraud and abuse by working with your employer and plan administrator to fight those individuals who engage in fraudulent activities.

How You Can Help

- Pay close attention to the explanation of benefits forms sent to you when a claim is filed under your contract and always call the carrier to question any charge that you do not understand

Report anyone who permits a relative or friend to "borrow" his/her insurance identification card

Report anyone who makes false statements on their insurance enrollment applications

Report anyone who makes false claims or alters amounts charged on claim forms

Please contact Benefits Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

To File an Appeal

If you have a problem with coverage or payment of medical, behavioral health and substance use or pharmacy services, there are internal and external procedures to help you. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

You should direct any specific questions regarding initial levels of appeal (the internal appeal process) to the insurance carrier member service numbers provided in this guide. You can also find those numbers on your insurance cards. Benefits Administration is not involved in the appeal process. The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

Benefit Appeals

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

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

Appealing to the Insurance Company

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

The insurance company will process internal levels of appeal — Level I and Level II appeals. Decision letters will be mailed to you at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

Annual Enrollment Period

Benefit information is sent to you each fall. This information is also published on our Partners for Health website at **tn.gov/partnersforhealth**. Review this information carefully to make the best decisions for you and your family members. The Annual Enrollment period gives you a chance to enroll in health, dental and vision coverage. You can also make changes to your existing coverage, like transferring between health, dental and vision options and cancelling insurance.

Employees have one opportunity to revise Annual Enrollment elections as described in Plan Document Section 2. The Plan Document is posted on the Partners website under Publications at tn.gov/PartnersForHealth.

Annual Enrollment benefit selections will remain in effect for a full year (January 1 through December 31). You may not make changes to coverage outside of the enrollment period unless eligibility is lost or there is a qualifying event. For more information, see the sections on cancelling coverage and special enrollment provisions in this document.

How to Enroll

If you want to enroll in health insurance, you can choose your health insurance option, carrier and network by enrolling in Edison **at www.edison.tn.gov.**

2025 Health Benefits

Health Plan Options

You have a choice of four health plans from Partners for Health. Each health care plan has different out-of-pocket costs. Examples of these costs include your copays, deductibles and coinsurance.

All health plan options cover the same services and treatments, but coverage decisions may vary by carrier (see Health Plan Carrier Networks). Eligible preventive care is free with all plans if you use an in-network provider.

Here is a comparison of the four plans:

Premier Preferred Provider Organization: Higher monthly premium, lower out-of-pocket costs (deductible, copays and coinsurance).

Standard PPO: Lower monthly premium than Premier PPO, higher out-of-pocket costs.

Limited PPO: Lower monthly premiums than the other PPOs, higher out-of-pocket costs than the other PPOs.

Local Consumer-driven Health Plan/Health Savings Account: Lowest monthly premium. In-network preventive care has no member cost. For most other services, you pay your deductible first before the plan pays anything. Then you pay coinsurance, not copays.

Learn more about Health Savings Accounts

There are limits on how much money you can put in your HSA in 2025:

- $4,300 for employee-only coverage;
- $8,550 for all other family tiers; and
- Members 55+ can add $1,000 more each year.

These limits include any contributions your employer may make to your HSA. HSA contributions more than the IRS maximums listed above are not tax deductible and are subject to a 6% excise tax. Monitor your HSA contributions carefully.

Local government employees who enroll in the Local CDHP will need to check if your employer allows you to contribute to your HSA through payroll deduction. You may need to update this amount each year. You would provide this amount to your employer.

With the HSA, your total contribution is not available upfront. Your pledged amount is taken out of each paycheck, if your employer offers payroll deduction. You may only spend the money that is in your HSA at the time of service, but you can pay yourself back later with HSA funds. Newly enrolled members get a debit card from Optum Financial to use for qualified expenses. Current enrolled members who stay in the Local CDHP/HSA will use their same debit card.

Local CDHP HSA and FSA restrictions: There are certain restrictions about who can enroll in a plan with an HSA. If you enroll in the Local CDHP/HSA, you cannot enroll in another medical plan, including any government plan, and cannot have a medical flexible spending account or health reimbursement account, among other restrictions. You can enroll in the Local CDHP/HSA and a limited purpose FSA for dental and vision costs if one is offered by your employer.

If you enroll in Social Security at age 65, you'll automatically be enrolled in Medicare Part A, and if enrolled in a CDHP, this may have tax consequences affecting your HSA contribution. Consult your tax advisor for advice.

Go to the end of this guide for website links to more information about health plans, HSA restrictions, maximum contribution amounts and debit card details. Click the premiums link in this guide for all premiums.

Health Plan Carrier Networks

BlueCross BlueShield of Tennessee and Cigna, our health insurance carriers, offer expansive networks of doctors, hospitals and facility providers.

You can choose from four carrier networks for your medical care.

BlueCross BlueShield Network S
Cigna LocalPlus

These networks include many providers, hospitals and facilities throughout Tennessee and across the country. Not all providers and hospitals are in the BlueCross Network S and Cigna LP networks, which helps keep premiums and claims costs low. **There is no additional monthly cost added to the premium for these networks**.

BlueCross BlueShield Network P
Cigna Open Access Plus

These networks include more hospitals and facilities. **There is an additional cost added to the monthly premium for these networks.**

- Additional $75 per month for the employee-only tier
- Additional $85 per month for the employee + child(ren) tier
- Additional $150 per month for the employee + spouse and employee + spouse + child(ren) tiers

You'll see the total cost for these networks in the premium chart. **You may also pay more per claim because the costs for services in these networks are generally higher** than the other two networks.

It's important to check the networks carefully. The network choice you make is for the entire calendar year (Jan. 1 until Dec. 31). You may be able to make changes allowed by the plan if you have a qualifying event. Information about qualifying events is in the Enrollment Change Application.

Network providers and facilities can and do change. Benefits Administration cannot guarantee all providers and hospitals in a network at the beginning of the year will stay in that network for the entire year. A provider or hospital leaving a network is not a qualifying event and does not allow you to make changes to your insurance choices.

Covered Services

Covered services are generally the same whether you choose BlueCross BlueShield or Cigna. For some procedures, different medical criteria may apply based

on the carrier you select. For detailed information on covered services, exclusions and how the plans work, view the BCBST or Cigna member handbook and your Local Government Plan Document by **going to the Publications webpage**. If you have questions about your benefits or medical criteria for a specific service, contact the carriers' member services.

Go to the end of this guide for Partners for Health carrier network website links and carrier contacts information.

Click here to view Insurance Comparison Charts

Included Health Benefits

Along with your medical coverage, your health plan provides the following benefits: pharmacy, behavioral health, an emotional wellbeing solutions program and a wellness program. Learn about benefits such as telehealth, the Diabetes Prevention Program, behavioral health virtual visits and more by going to **Included Benefits Extras**.

Pharmacy

Managed by CVS Caremark

All health plans include full prescription drug benefits. The health plan you choose (Premier PPO, Standard PPO, Limited PPO or Local CDHP/HSA) determines your out-of-pocket prescription costs, including copay, coinsurance, deductible and out-of-pocket maximum.

How much you pay for prescriptions depends on three things:

- the drug tier – if you choose a generic, preferred brand, nonpreferred brand or specialty drug (three different cost tiers in the PPOs);
- the quantity, also known as the days supply, you receive; and
- where you fill your prescription – at a retail, Retail-90 or mail order pharmacy.

Go to the end of this guide for the pharmacy website link and contact information for CVS Caremark.

Behavioral Health

Managed by Optum Behavioral Health

All health plans include access to outpatient and facility-based behavioral health and substance use disorder services. Optum Behavioral Health can help members and eligible dependents find a provider for in-person or virtual visits, explain benefits, identify best treatment options, schedule appointments and answer questions.

Your benefits include applied behavior analysis therapy. You have access to preferred substance use treatment facilities at no cost for PPO plans and no coinsurance after deductible for the Local CDHP plan.

Go to the end of this guide for the behavioral health website link and Optum Behavioral Health contact information.

Emotional Wellbeing Solutions

(formerly called Employee Assistance Program)

Managed by Optum Behavioral Health

Emotional wellbeing services are available to all enrolled local government health plan members and their eligible dependents, even if your dependents are not enrolled in a health plan.

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

- Five counseling visits, per problem, per year, per individual at no cost to you.
- In-person or virtual visits in the privacy and comfort of your own home.

Your benefits include **Talkspace** online therapy; and **Take Charge at Work**, a coaching program that helps those working and eligible for EWS deal with stress and depression.

Go to the end of this guide for the Emotional Wellbeing Solutions website link and Optum Behavioral Health contact information.

Wellness Program

Managed by Sharecare

To help you achieve your health goals, the wellness program is available for local government employees, spouses and adult dependents enrolled in the health plan.

Members enrolled in health benefits will have access to the Sharecare member platform, Sharecare mobile app, RealAge Test, lifestyle management coaching, chronic condition management coaching, the Eat Right Now weight management program, Onduo intensive diabetes management program, quarterly challenges and biometric screenings. A Diabetes Prevention Program will also be offered to members who qualify through insurance carriers BlueCross or Cigna.

Go to the end of this guide for the wellness program website link and Sharecare contact information.

Additional Benefits

Along with health insurance, you may be offered dental and vision insurance through Partners for Health. These benefits provide additional coverage for you and your eligible dependents. Typically, employees pay 100% of the dental and vision premiums. Your employer may contribute to the premium in some instances.

Dental Insurance

Offered through Cigna and Delta Dental of Tennessee
(if offered by your agency)

Partners for Health offers two different dental plans.

Cigna: Dental Health Maintenance Organization – Prepaid Provider

You are required to select and use a Cigna network general dentist. You must notify Cigna of your choice. Find the list of dentists at **cigna.com/stateoftn**.

Members pay copays. Review the patient charge schedule before having procedures performed. Lab fees may apply for some procedures.

Completion of crowns, bridges, dentures, implants or root canals already in progress on a new member's effective date will not be covered.

Members can contact Cigna customer service for additional information about coverage for orthodontic services in progress.

Delta Dental: Dental Preferred Provider Organization

Use any dentist but save money by choosing an in-network dentist.

Discuss any estimated expenses with your dentist or specialist. Charges for dental procedures are subject to change. Members pay deductibles and coinsurance.

Waiting periods apply to select procedures.

The premium rates for the Cigna DHMO plan are less than for the DPPO plan; however, the network options are fewer in the DHMO. You should carefully review all details of each plan before making a selection. To learn about all dental benefits, find the Cigna DHMO handbook, Cigna patient charge schedule and the Delta Dental DPPO handbook by **clicking on Publications**.

Go to the end of this guide for the dental insurance website link for more information and a comparison of the two plans. Click on the premiums link in this guide, click on Dental premiums, and then go to **Other Insurance Coverages – Dental.** Find contact information for dental vendors Cigna and Delta Dental at the end of this guide.

Vision Insurance

Offered through EyeMed
(if offered by your agency)

Choose from two vision insurance options, the **Basic Plan** or **Expanded Plan**.

All members in both vision plans get:

- Routine eye exam every calendar year
- Choice of eyeglass lenses or contact lenses once every calendar year
- Low vision evaluation and aids available once every two calendar years

Basic Plan: Pays for your eye exam after you pay a $10 copay and provides various allowances (dollar amounts paid by the plan) for materials such as eyeglass frames and contact lenses.

- Frames available once every two calendar years.

Expanded Plan: Free routine eye exam annually. Includes greater allowances versus the Basic Plan.

- Frames available once every calendar year.

In both plans, you pay copays; or when the cost exceeds the allowed dollar amount paid by the plan, you pay the cost of materials and services above the allowance. You'll save money when using in-network providers. Find the EyeMed handbook by clicking on Publications and Vision Insurance. Discounts may be available for select

materials. Find the EyeMed handbook by clicking on Publications and Vision Insurance.

Go to the end of this guide for the vision insurance website link for more information and a comparison of both plans. Click on the premiums link in this guide, click in Vision premiums, and then go to **Other Insurance Coverages – Vision.** Find contact information for EyeMed at the end of this guide.

Legal Notices

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615.532.9617.

If you think you have been denied services or treated differently for any of the above stated reasons, please find the TN Department of Finance and Administration's Non Discrimination and Complaint Policy at https://www.tn.gov/finance/looking-for/policies.html for guidance or contact the Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov or 615.532.9617 for assistance.

You may request information regarding anti-discrimination or a Civil Rights Complaint form by mail to: State of Tennessee, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243 or by email to FA.CivilRights@tn.gov.

You may also request information regarding anti-discrimination from or submit a Complaint to:

U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1.800.368.1019 or TTY/TDD at 1.800.537.7697; OR

U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531; OR

Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? If you speak a language other than English, help in your language is available for free. If you have a disability and need an auxiliary aid or service, for instance sign language, Braille, or large print, help is available for free. Please request language assistance by emailing **renee.woodall@tn.gov** and **FA.CivilRights@tn.gov** or calling 615.253.9926.

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

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

Chinese
注意：如果您會說中文，則提供免費的語言協助服務。 請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese
CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

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

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian
ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298.

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

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

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

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

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

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

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

The Notice of Privacy Practice

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

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practices is located on the Partners for Health website at **https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/hipaa.pdf**. You may also request the notice in writing by emailing **benefits.privacy@tn.gov**.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage is available to everyone with Medicare. However, as a member of the State Group Insurance Program (SGIP), you have options for your drug coverage. For information about your current prescription drug coverage with the SGIP and your options under Medicare's prescription drug coverage, review this notice on the Partners for Health website: **www.tn.gov/content/dam/tn/finance/fa-benefits/documents/medicare_part_d_notice.pdf**.

Summary of Benefits and Coverage

As required by law, a Summary of Benefits and Coverage is available which describes your 2025 health coverage options. The SBC will be available for review at **https://www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage** no later than Sept. 1. The digital benefits guide contains much of the same information. To get an SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

Plan Document and Certificates of Coverage

The information contained in this guide provides a summary of the benefits available to you through the State of Tennessee. Specific plan information is contained within the formal plan documents and certificates of coverage. If there is any discrepancy between the information in this guide and the formal plan documents and certificates of coverages, the plan documents and certificates of coverage will govern in all cases. You can find a copy of these documents on the Benefits Administration website at **www.tn.gov/PartnersForHealth/publications/publications.html**

Other Publications

In addition to the documents mentioned above, the Partners for Health website contains many other important publications, including, but not limited to, brochures and handbooks for medical, pharmacy, dental and vision and the brochure and handbook for the Supplemental Medical Insurance for Retirees with Medicare.

Notice Regarding Wellness Program

The Partners for Health Wellness Program is a voluntary wellness program available to all state, higher education, local education, local government employees, spouses and adult dependents as well as retirees enrolled in health coverage. Only active state and higher education employees and enrolled spouses are eligible to earn cash incentives. The program is administered according to federal rules permitting employer-sponsored wellness

programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the assessment or other medical examinations. Although you are not required to complete the health questionnaire, only active state and higher education employees and spouses who do so are eligible to receive cash incentives. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Partners for Health Wellness Program at 888.741.3390. The information from your health questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer you services through wellness programs such as weight management, Diabetes Prevention Program, and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information (PHI). Although the wellness program and the State of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the Partners for Health Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law and the State of TN's contract with Sharecare to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive, if eligible. Anyone who receives your information for purpose of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness vendor (nutritionists, nurses, nurse practitioners, registered dietitians, health coaches, and other health care professionals) and their vendor partners (case managers with the medical and behavioral health vendors, diabetes remission program vendor, and the biometric screening vendor) to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate safeguards will be taken to avoid any data breach, and in the event a data breach occurs involving information in connection with the wellness program, you will be notified promptly. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Partners for Health at **partners.wellness@tn.gov**.

2025 Active Employees Monthly Health Premiums

ALL REGIONS	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
PREMIER PPO				
Employee Only	$839	$839	$914	$914
Employee + Child(ren)	$1,302	$1,302	$1,387	$1,387
Employee + Spouse	$1,931	$1,931	$2,081	$2,081
Employee + Spouse + Child(ren)	$2,269	$2,269	$2,419	$2,419
STANDARD PPO				
Employee Only	$772	$772	$847	$847
Employee + Child(ren)	$1,198	$1,198	$1,283	$1,283
Employee + Spouse	$1,777	$1,777	$1,927	$1,927
Employee + Spouse + Child(ren)	$2,088	$2,088	$2,238	$2,238
LIMITED PPO				
Employee Only	$627	$627	$702	$702
Employee + Child(ren)	$973	$973	$1,058	$1,058
Employee + Spouse	$1,443	$1,443	$1,593	$1,593
Employee + Spouse + Child(ren)	$1,695	$1,695	$1,845	$1,845
LOCAL CDHP/HSA				
Employee Only	$579	$579	$654	$654
Employee + Child(ren)	$898	$898	$983	$983
Employee + Spouse	$1,331	$1,331	$1,481	$1,481
Employee + Spouse + Child(ren)	$1,564	$1,564	$1,714	$1,714

The premium amounts shown reflect the total monthly premium. Please see your agency benefit coordinator for your monthly deduction and your employer's contribution, if applicable.

2025 Monthly Vision Premiums

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.18	$6.30
Employee + Child(ren)	$6.35	$12.60
Employee + Spouse	$6.03	$11.98
Employee + Spouse + Child(ren)	$9.33	$18.54
COBRA PARTICIPANTS		
Employee Only/Single	$3.24	$6.43
Employee + Child(ren)	$6.48	$12.85
Employee + Spouse	$6.15	$12.22
Employee + Spouse + Child(ren)	$9.52	$18.91
COBRA DISABILITY PARTICIPANTS		
Employee Only/Single	$4.77	$9.45
Employee + Child(ren)	$9.53	$18.90
Employee + Spouse	$9.05	$17.97
Employee + Spouse + Child(ren)	$14.00	$27.81

Click to view premiums webpage

2025 Monthly Dental Premiums

	CIGNA DHMO (PREPAID PROVIDER) PLAN			DELTA DENTAL DPPO PLAN		
ACTIVE MEMBERS	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM
Employee Only	$14.69	$7.34	$7.35	$20.32	$10.16	$10.16
Employee + Child(ren)	$30.50	$15.25	$15.25	$54.03	$27.01	$27.02
Employee + Spouse	$26.03	$13.01	$13.02	$39.96	$19.98	$19.98
Employee + Spouse + Child(ren)	$35.79	$17.89	$17.90	$82.75	$41.37	$41.38
COBRA PARTICIPANTS						
Employee Only/Single	$14.98			$20.73		
Employee + Child(ren)	$31.11			$55.11		
Employee + Spouse	$26.55			$40.76		
Employee + Spouse + Child(ren)	$36.51			$84.41		
COBRA DISABILITY PARTICIPANTS						
Employee Only/Single	$22.04			$30.48		
Employee + Child(ren)	$45.75			$81.05		
Employee + Spouse	$39.05			$59.94		
Employee + Spouse + Child(ren)	$53.69			$124.13		

2025 Health Plan Comparison of Member Costs — Local Education and Local Government

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.
Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY								
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, tobacco cessation counseling & other	$0	$45	$0	$50	$0	$50	$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use[2] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teledoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	N/A
Chiropractic and Acupuncture • Annual limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $75/visit 21-50	$35/visit 1-20 $55/visit 21-50	$55/visit 1-20 $80/visit 21-50	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	$14/$60/$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	$28/$120/$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order[3]	$7/$40/$160	N/A - no network	$14/$50/$180	N/A - no network	$14/$60/$200	N/A – no network	20% before deductible	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generics Tier 1	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A – no network	30%	N/A - no network
Preferred Brands Tier 2	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A – no network	30%	N/A - no network
Non-Preferred Brands Tier 3	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	30%	N/A – no network

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE – OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY								
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans [5]	$0	40%	$0	40%	$0	50%	$0	50%
OTHER SERVICES								
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health and substance use [2] [6]	15%	40%	20%	40%	30%	50%	30%	50%
• Emergency room services [7]	15%		20%		30%		30%	
Maternity • Global billing after first visit; Routine services & labor and delivery	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%	30%	50%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%	30%	50%	30%	50%
X-Ray, Lab and Diagnostics (Excludes advanced studies below) [5]	15%		20%		30%		30%	50%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%		30%		30%	
Ambulance (air and ground)	15%		20%		30%		30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Limited Dental benefits, Hospice Care and Out-of-Country Charges. See Member Handbook for coverage details.							
DEDUCTIBLE — ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE								
Employee Only	$750	$1,500	$1,300	$2,600	$1,800	$3,600	$2,000	$4,000
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$2,500	$4,800	$4,000	$8,000
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$2,800	$5,500	$4,000	$8,000
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,600	$7,200	$4,000	$8,000
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES FOR MEDICAL, BEHAVIORAL AND PHARMACY, COMBINED, INCLUDING DEDUCTIBLE								
Employee Only	$3,600	$7,200	$4,400	$8,800	$6,800	$13,600	$5,000	$10,000
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200	$13,600	$27,200	$10,000	$20,000
Employee + Spouse	$7,200	$14,400	$8,800	$17,600	$13,600	$27,200	$10,000	$20,000
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000	$13,600	$27,200	$10,000	$20,000

For PPO Plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of- pocket maximum, it will be met by all covered family members. **For CDHP Plan**, the deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied.

[1] Subject to maximum allowable charge. The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] Additional information on the maintenance drug benefit and a list of participating Retail-90 pharmacies can be found at **https://www.tn.gov/partnersforhealth/health-options/pharmacy.html**.

[4] Prior authorization required for non-emergent services. When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

[5] For PPO plans, the deductible DOES NOT apply to IN-NETWORK outpatient PT/ST/OT/ABA and other PPO services as noted.

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

[7] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

Important Partners for Health Website Links and Contact Information

Partners for Health Website Links:

Health Plans

CDHP/HSA Insurance Options

Carrier Information (BlueCross BlueShield and Cigna)

Pharmacy

Behavioral Health

Included Benefits Extras

Dental Insurance

Vision Insurance

Wellness Program

Emotional Wellbeing Solutions

Contact Information:

Benefits Administration
800.253.9981 or 615.741.3590
Monday - Friday, 8 a.m. - 4:30 p.m. CT
Fax: 615.741.8196
e-mail: **benefits.administration@tn.gov**

Health Insurance

BlueCross BlueShield of Tennessee
800.558.6213
Monday - Friday, 7 a.m. - 5 p.m. CT
bcbst.com/members/tn_state/

Cigna
800.997.1617
24/7
cigna.com/stateoftn

Health Savings Account

Optum Financial
866.600.4984
24/7
optumbank.com/Tennessee

Pharmacy

CVS Caremark
877.522.TNRX (8679)
24/7
info.caremark.com/stateoftn

Behavioral Health/ Emotional Wellbeing Solutions

Optum Behavioral Health
855.HERE4TN (855.437.3486)
24/7
Here4TN.com

Wellness Program

Sharecare
888.741.3390
Monday - Friday, 8 a.m. - 8 p.m. CT
sharecare.com/tnwellness/

Dental Insurance

Cigna Dental Health Maintenance Organization - Prepaid Provider
800.997.1617
24/7
cigna.com/stateoftn

Delta Dental – Dental Preferred Provider Organization
800.552.2498
Monday - Friday, 7 a.m. to 5 p.m. CT
DeltaDentalTN.com/StateofTN

Vision

EyeMed
855.779.5046
Mon.-Sat., 7 a.m. – 10 p.m. CT, Sun. 10 a.m. – 7 p.m. CT,
eyemed.com/stateoftn

PARTNERS FOR HEALTH

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